



Accepted monitoring or endured quarantine? Ebola contacts' perceptions in Senegal



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ABSTRACT

During the 2014–2016 West Africa Ebola epidemic, transmission chains were controlled through contact tracing, i.e., identification and follow-up of people exposed to Ebola cases. WHO recommendations for daily check-ups of physical symptoms with social distancing for 21 days were unevenly applied and sometimes interpreted as quarantine. Criticisms arose regarding the use of coercion and questioned contact tracing on ethical grounds. This article aims to analyze contact cases' perceptions and acceptance of contact monitoring at the field level. In Senegal, an imported case of Ebola virus disease in September 2014 resulted in placing 74 contact cases in home containment with daily visits by volunteers. An ethnographic study based on in-depth interviews with all stakeholders performed in September–October 2014 showed four main perceptions of monitoring: a biosecurity preventive measure, suspension of professional activity, stigma attached to Ebola, and a social obligation. Contacts demonstrated diverse attitudes. Initially, most contacts agreed to comply because they feared being infected. They adhered to the national Ebola response measures and appreciated the empathy shown by volunteers. Later, acceptance was improved by the provision of moral, economic, and social support, and by the final lack of any new contamination. But it was limited by the socio-economic impact on fulfilling basic needs, the fear of being infected, how contacts' family members interpreted monitoring, conflation of contacts as Ebola cases, and challenging the rationale for containment. Acceptance was also related to individual aspects, such as the professional status of women and health workers who had been exposed, and contextual aspects, such as the media's role in the social production of stigma. Ethnographic results show that, even when contacts adhere rather than comply to containment through coercion, contact monitoring raises several ethical issues. These insights should contribute to the ethics debate about individual rights versus crisis public health measures.

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1. Introduction

The 2014–2016 Ebola outbreak in West Africa brutally brought the issue of emerging epidemics as pandemic threats to the forefront. To date, as many as 28,629 reported cases and 11,318 deaths have resulted from Ebola virus disease (EVD) in Sierra Leone, Liberia, and Guinea, and on a marginal scale in Nigeria, Mali, Senegal, and beyond Africa (WHO, 2016). With no established treatment or vaccine, these countries were compelled to quickly implement public health measures to interrupt transmission chains

based on active Ebola case findings and monitoring of contacts, i.e., people exposed directly or indirectly to an EVD case (WHO, 2014a). WHO and CDC recommended *contact tracing and follow-up*, i.e., identification, daily checking for 21 days for the onset of specific symptoms (such as body temperature exceeding 100.4 °F), and immediately referring any contact subject with symptoms to a health facility with diagnosis, isolation, and treatment capacity. Ebola contact cases should apply social distancing, i.e., “Remain at home as much as possible and restrict close contact with other people” and “Avoid crowded places, social gatherings, and the use of public transport” (WHO Regional office for Africa, 2014: 4). During the Ebola outbreak, over 200,000 people throughout all West African countries underwent *contact tracing* (including follow-up; see WHO Regional office for Africa, 2014); this measure should undergo critical analysis for its social dimensions.

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The clinical daily check-up of contact subjects to diagnose symptoms as early as possible raised few issues among public health analysts, but the related social distancing measures for infection control were more controversial, since they were suggestive of “quarantine.” From an historical perspective, quarantine was applied in the XIVth century to sea travellers to European countries who were suspected of being possibly infected by diseases such as plague; ships of passengers who withstood 40 days in isolation without showing any symptoms were allowed to enter harbors and mix with the general public. Quarantine was considered archaic at the end of the XXth century when antibiotics and antivirals were believed to eradicate infectious diseases, until its widespread use during the recent *emerging epidemics with a global pandemic threat*: SARS (2003), H1N1 (2009), and MERS (2013) (Rothstein, 2015a). The word quarantine is still used with various meanings that differ among experts and between them and laypersons, with the underlying signification of separation and suspicion. For official institutions, quarantine has been defined by the International Health Regulations as “the restriction of activities and/or separation from others of suspect persons who are not ill [...] in such a manner as to prevent the possible spread of infection or contamination” (WHO, 2008: 16); in that context, quarantine is essentially applied following a legal prescription.

Debates around quarantine related to Ebola have especially centered on ethics, extending an existing debate about its use during the SARS outbreak in 2003 (Calain and Poncin, 2015; Rothstein, 2015b). Countries such as Guinea, Liberia, Mali, Nigeria, Sierra Leone, and the United States resorted to coercion to enforce quarantine measures that were authorized by exceptional legal measures and sometimes enforced by the military and the police; in Liberia, quarantine was applied through violent means with no health care interventions with the aim of controlling the population (Calain and Poncin, 2015). Besides the lack of any explicit and consistent legal framework for quarantine practices, criticized in the United States (Rothstein, 2015b), Calain and Poncin question “how patients’ autonomy has been sacrificed to the public-health necessities” and ask if it is acceptable to suspend the principles of ethics and human rights during an epidemic (2015: 126). These authors underscore the need to discuss how well the control measures taken during the Ebola epidemic comply with the UN Siracusa Principles and those of public health ethics that stipulate that restrictive measures on individual and collective rights during a crisis must meet the following conditions: “public necessity, demonstrated effectiveness and scientific rationale, proportionality and least infringement, reciprocity, justice and fairness” (2015: 128). Regarding EVD, the effectiveness of social distancing in terms of biosafety and public health has not been fully assessed yet on the basis of scientific evidence (Chowell and Nishiura, 2014); the other conditions mentioned above should also be assessed for any form of social distancing.

In the field, local interpretations of social distancing applied to Ebola contacts during the epidemic resulted in a wide range of social forms of separation and containment, combined with clinical follow-up, which differed depending on the sites, communities, time period, and public health officials’ approaches. Acceptance of social distancing measures by contacts might vary according to these social forms, and depend on the interconnection between the implementation of Ebola control measures, contacts’ social characteristics and the local communities’ background at the micro- or meso-social level. For instance, public health measures based on the separation of a sub-group of contacts may result in their stigmatization, particularly when they belong to an already stigmatized or low-status community; then, measures may engender contacts’ resistance and be counter-productive, since cohesion and trust at the population level are key for overcoming the Ebola

epidemic (Lancet, 2014). Moreover, ethical issues for those affected often rely on local practical and social arrangements that may not be considered at the macro-social or theoretical levels. Therefore, the ethics and public health debates about the relevance of quarantine for Ebola (for a broad strategy) and other social distancing control measures (for a variety of specific practices) should consider the social effects of their implementation in local contexts, on the basis of empirical data drawn from stakeholders’ experience in the field.

Although people’s attitudes about the Ebola epidemic in West African countries have been analyzed, especially their opposition to health interventions (Ravi and Gauldin, 2014; Johns Hopkins Center for Communication Programs, 2015; Fribault, 2015), few studies have examined how contact subjects have perceived contact monitoring. Did contact subjects experience these measures as acts of care or exclusion? Were these measures applied voluntarily or through coercion, and did contact subjects oppose them? What influenced contact subjects’ adherence, in conjunction with local social culture or with global measures? To answer these questions, this article will explore the meanings of social distancing in context, i.e., monitoring including follow-up and additional measures, for the contact persons who experienced it.

Various terms are used by health actors and institutions to describe *contact tracing* practices (*surveillance of contact cases, containment, social distancing, follow-up, cerclage*, etc.), diverging in their precision and focus and depending on social actors and languages. In this semantic grey area, partly tied to the diversity of practices in the field and to the discrepancies between lay and expert interpretations of the same words, definitions must be selected. The term *contact monitoring* will be used in this article, as a neutral term with few connotations that includes any intervention (i.e., clinical check-up, provision of information, supplemental social support, social distancing, and infection control measures), and does not convey the notion of legal prescription (as does *quarantine* in its acceptance by public health institutions) nor of case detection and quantification for epidemiological purposes (as does *surveillance*). Regarding physical separation measures, *social distancing* will be used as an overall term applied to contacts, different from *isolation* (applied to EVD cases). These terms are not used by contact subjects nor by the population, unlike other terms mentioned above.

2. Context: Ebola in Senegal

When the Ebola epidemic was declared by Guinea in March 2014, Senegal closed its border and mobilized its response plan. But on 29 August, a case of Ebola virus disease (EVD) was diagnosed in a Guinean student who was infected during his uncle’s burial in Guinea. Unaware that he was infected, he went on vacation to visit another uncle in Dakar, where the symptoms started, and he was treated in two health facilities. Some 74 people were subsequently traced as contacts and followed up for 21 days. The patient was hospitalized in isolation in the infectious disease department of a university hospital, the national reference center for Ebola, where his symptoms were treated. He was declared cured and accompanied back to Guinea on 19 September, the same day that the end of the monitoring was announced for the contact subjects with no reports of any secondary transmission (Bouso et al., 2015). On 17 October, WHO declared the end of the epidemic in Senegal and congratulated the country for managing the response well (WHO, 2014b).

From an epidemiological viewpoint, the seriousness of the situation in Senegal has no comparison with that of the three most affected countries. But in September 2014, the single case reported in Senegal required the mobilization of national and international

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