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The Ebola Crisis: Responses from India and China

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The biggest ever India-Africa summit to be held in Delhi in December 2014 was put off to an indefinite date by the Ministry of External Affairs due to the Ebola scare. This was at a time when India was making concerted efforts to renew its relations with Africa and for the first time had invited leaders of all the 54 countries (Iyer 2014). The fear of Ebola still looms large as countries all around the globe have warned their people against visiting the affected region and a few like Canada and Australia that have banned flow of people from the affected regions into their territories (*Reuters* 2014a).

There is enough evidence in history to prove that the political, social and economic consequences of epidemics can be severe. For the present, Ebola is still an epidemic but the threat of it becoming a pandemic is real as the risk of its spread still persists. Much depends on how governments respond along with coordinated efforts by global and regional organisations.

The Ebola Virus and the Causes of Fear

On 8 August 2014, the World Health Organisation (WHO) declared the Ebola outbreak a public health emergency; it is now aptly termed as a humanitarian crisis by Peter Piot, the microbiologist who discovered the virus in 1976 (WHO 2014; Mehta 2014). It is well established now that the international response was initially slow and inadequate and the crisis that has ensued was avoidable (Boseley 2014b). The WHO acknowledged in mid-October that it had botched up early attempts to stop the rapid spread (Cheng 2014). The first case was traced back to Guinea in West Africa in December 2013 which then spread to

neighbouring Liberia and Sierra Leone. These three West African countries have been the epicentre of this outbreak. According to the WHO, Ebola virus has killed over 7,000 people with over 16,000 infected as of end November 2014 (Johnston 2014). This has been the biggest outbreak ever since it was discovered in 1976 and has posed both public health and security challenges.

The virus is highly contagious but not air borne. It gets transmitted through body fluids and causes haemorrhagic fever with internal and external bleeding, vomiting and diarrhoea and has a high fatality rate of 70 per cent. As of now, there is no approved vaccine for prevention, post-exposure or treatment of Ebola.

Resurgence of epidemics is a marker of growing socio-economic inequalities and poor public health services. The West African countries at the epicentre are still emerging from effects of terrible civil wars, have high levels of poverty with health service systems that have collapsed and hence were ill-equipped and defenceless to stop the virus from spreading.

> *Given that both China and India have their business interests in Africa it is also imperative that as an external response both nations reach out and provide support to the affected regions as a humanitarian gesture.*

Apart from the West African countries, those affected include Nigeria, Senegal, Mali and the Democratic Republic of Congo in Africa and also the United States where there were four cases, Spain where there was one case and more recently India where one person who had recovered from the disease was quarantined as a precautionary measure as traces of the virus were found in his body (*Reuters* 2014b).

Most of the countries that managed to contain the spread of the virus like Nigeria were better prepared due to political will, an early detection and response system and a well-funded and accessible health service system. While the WHO has declared Nigeria, Senegal and the Democratic Republic of Congo free of the virus, in October 2014, it projected that a resurgence of the Ebola virus in the region could increase by as many as 10,000 new cases a week by December 2014, if steps were not taken to control it (Boseley 2014a). A more recent UN report shows that cases are no longer rising in Guinea and Liberia but the danger of spread still lurks as viruses are unpredictable and can take virulent forms (*UN News Centre* 2014).

The Global Response

Porous borders and greater connectivity increase the risk of infectious diseases travelling faster and becoming a larger threat to human security. Given the emergence and re-emergence of infectious diseases, like smallpox, plague and tuberculosis in the past, to HIV/AIDS, H1N1 (swine flu) and SARS (avian flu) more recently, there are several responses at work – at the global, national, local level. These responses intersect, interact with and inform each other in complex ways.

The response of any government to a pandemic scare works at two levels – at the internal level and the external level. The former includes actions to maintain internal security while the latter is determined by efforts to reach out to the affected areas through financial contributions, supplies of

medical equipment, drugs, human resources, and so on.

As a response to the present epidemic, international organisations and several governments have come together to assist the affected area. The United Nations Mission for Ebola Emergency Response (UNMEER) has the task of the overall planning and coordination, directing efforts of the UN agencies, national governments, and other humanitarian actors to the areas where they are most needed. At the global level, the WHO and the Centers for Disease Control and Prevention (CDC), Atlanta are providing the technical leadership.

In terms of responses to Ebola, both India and China come across as having taken effective measures. For both however, it is important to build their internal capacities as a priority and then provide external assistance with the help of global actors and other governments

While the developed world has the resources and can take pre-emptive measures to prevent and contain the spread of infectious diseases, developing countries are the ones at risk due to their poor public health capacity to respond.

India and China have especially been warned of the ramifications if the virus finds its way in. Peter Piot, has warned both countries of the imminent entry of the virus (Thornhill 2014; Mehta 2014). The warning comes with the knowledge that both are densely populated countries, have poor sanitation and hospital standards, and therefore, do not have the capacity to fight the virus adequately. This is especially true for India.

Both countries also have lessons to learn from the past - China from its SARS experience in 2003, which shed light on the poor state of its disease surveillance system and health services that had failed to respond and India during the plague epidemic in 1994 in Surat and swine flu outbreak in 2009 when almost 2,000 people died (Thakur 2014). The plague epidemic was attributed to the degradation of the environment compounded by inadequate sewage systems, poverty, and an unresponsive health care system (Shah 1997). The swine flu outbreak was exacerbated by the public hysteria over the disease, as well as failure of the health ministry to provide basic education to health workers who refused to take in cases.

Indian and Chinese Actions

Over the last decade, China and India have made substantial investments and are the two most important economic partners of Africa. China has 65,000 nationals in Nigeria alone. According to the Indian foreign ministry, there are nearly 45,000 nationals living and working in Guinea, Liberia, Sierra Leone and Nigeria out of which 300 are women troops from the Central Reserve Police Force (CRPF) deployed in peacekeeping operations in Liberia. There are almost 500 Indians in Republic of Guinea, 3,000 in Liberia and 1,200 in Sierra Leone while Nigeria has the most extensive presence of Indians with the number estimated to be 40,000 (official figures as cited in Jha 2014).

Both countries are aware that there is a mobile population, a percentage of which will possibly travel back and forth and hence

the surveillance system must be robust as an internal response.

The Indian government has been prompt with its response to Ebola. The Health Ministry in the initial days installed a surveillance system geared to screen and track the travellers for four weeks and to detect them early in case they develop symptoms (*The Hindu* 2014). In its latest move, India has identified ten additional labs to test for the Ebola virus and a four-member rapid response team from each state to quickly spot, isolate and trace people suspected (Kaul 2014).

As an external response, in early October, India was reported to be one of the top five countries to financially contribute to Ebola response after the US, European Union, Canada and Netherlands (*Press Trust of India* 2014). It pledged US$10 million as a response. India's response came up after Prime Minister Narendra Modi and US President Barack Obama's summit meeting in late September 2014 where India committed to respond to the Ebola crisis in Africa (Lakshman and Haidar 2014).

Meanwhile, Chinese authorities have taken similar steps to prevent an outbreak at home. People arriving from Ebola-affected countries in western Africa are screened for fevers and monitored for 21 days (Larson 2014)**.** The WHO praised China for the quick measures it took to strengthen its surveillance and screening systems. Local health departments were also urged to prepare for any cases of Ebola by equipping Ebola-designated hospitals with the necessary equipment, medicines, protective gears and other supplies (Zhuang 2014).

Given that Africa is its biggest trading partner, China came under fire for its initial slow external response to Ebola by the United Nations and the United States (Ramzy 2014). From mid-October 2014 though, Beijing has reached out to the affected areas in various ways. China offered assistance in cash to international and regional organisations such as the United Nations, the WHO and the African Union and it was the first country that sent an experimental Ebola drug to Africa for use by Chinese aid workers. In November, China sent medical aid and about 200 health workers to the affected countries (*CCTV* 2014a).

In addition to working with local health care practitioners, China's aid workers have also been tasked with educating their nationals about disease prevention. In a recent initiative, it has built a 100-bed Ebola treatment centre in Monrovia in Liberia. This is reportedly, the first centre that is built and managed by a foreign country (*CCTV* 2014b). China's assistance also includes material, food, mobile laboratory as well as testing and treatment, training and joint research offered by medical staff and public health experts.

Apart from this, Chinese President Xi Jinping has intermittently sent messages of condolences to the heads of the three African countries (*Xinhua* 2014; Embassy of the PRC in the Kingdom of Norway 2014).

Comparing the Responses

In terms of responses to Ebola, both India and China come across as having taken effective measures. For both however, it is important to build their internal capacities as a priority and then provide external assistance with the help of global actors and other governments in order to stop the spread of the virus at its origin and decrease the risk of its spread to other parts of the world. China seems to be more confident in

dealing with infectious diseases now, as post-SARS it has strengthened its disease surveillance system (Huang 2014) unlike India which still lacks such a system to monitor outbreaks. While both countries have established adequate surveillance measures at entry points, the real test of their public health capacities and responsiveness would come, if and when the virus gains entry into the countries.

Although China's external response was slow in coming, it has been more comprehensive than India's. China has reached out to its nationals in Africa and is also contributing by sending aid, material and human resources and the setting up of clinics in the affected region. India has contributed generously on the financial front but there is no news on how India is reaching out to its nationals in the affected areas or even to the Indian CRPF team in Liberia which is at present also guarding Ebola treatment units (Iyer 2014).

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To put things in context, a recent malaria outbreak in Bastar, Chhattisgarh that has severely affected the security personnel as well as local people, throws light on the New Delhi's inability, or apathy perhaps, in reaching out to its own people (*The Indian Express* 2014).

At the diplomatic level, India's response of putting-off the India-Africa summit might be seen as a kneejerk reaction and not the best diplomatic decision as few African countries are actually affected by the virus. According to the Indian Ministry of External Affairs, however, this was a coordinated decision with the WHO and African Union (*The Economist* 2014). This then could be an act of caution rather than a case of isolating Africa. Had this fact however, been more effectively conveyed through the publicity or media agencies, it would perhaps have influenced the manner in which the postponement was perceived.

Public Health Concerns or Security Concerns?

Emerging and re-emerging infectious diseases are being increasingly framed within a prism of non-traditional threats to security. While promoting security concerns, developed countries should also take into consideration the public health concerns of the developing world. Global health organisations like the WHO were primarily set up as specialised agencies to assist in preventing infections, promoting health and well-being and in building public health capacities especially of the developing world that lacked resources, so that they could respond to infectious diseases more effectively.

The traditional authority that the WHO enjoyed has eroded with the rise of multilateral agencies like the World Bank and foundations like the Bill and Melinda Gates Foundation; these new initiatives and institutions have challenged the WHO's role as a directing and coordinating authority in global health. The discourse within the WHO for over a decade now has shifted from prioritising public health concerns to those linked to security.

The national priorities of member states are different and the WHO prioritises the concerns of developed countries because they are the ones who provide the resources. Thus, in many instances global surveillance like bio-terrorism is prioritised over the

surveillance of infectious diseases and priorities shift from public health concerns of many countries to the security concerns of few (Jin 2010).

Indian and Chinese roles in the WHO are limited to work done at the regional level; which programmes get funded is determined by the countries and organisations (foundations, investment banks and multinational corporations) that fund the WHO and are not based on national priorities. The two countries thus still witness the loss of many lives due to tuberculosis – increasing numbers of which are multi-drug resistant cases – and the resurgence of dengue and other infectious diseases in recent years that do not pose a security threat to the outside world.

To take the case of the Ebola vaccine, it took almost 40 years to start serious research on it because it was endemic to Africa and had not affected the developed world (*The Independent* 2014). Despite the loss of thousands of lives in western Africa, it is only now that it poses a potential threat to the security of the developed world that there are some moves towards research on developing a vaccine for Ebola.■

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