

Ebola epidemic: West African governments prohibit public Christmas celebrations

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In the African countries afflicted by Ebola—Sierra Leone, Liberia and Guinea—all Christmas festivities were cancelled, church services largely halted and bars and restaurants remained closed. Over Christmas, when usually a carnival atmosphere prevails, the military is patrolling.

Northern Sierra Leone, where most of the Ebola deaths have been recorded, is being completely closed off for five days. On Wednesday, the deputy information minister Theo Nicol asserted that in this way the government would get “an accurate picture of the situation”.

According to regional minister Alie Kamara, no religious services are to be held during this time—neither Christian nor Muslim. In addition, all shops and markets were ordered to stay closed, and just vehicles with official permission are permitted to be on the road. Only the official teams dealing with the Ebola epidemic can travel between the different towns and villages.

In mid-December, the authorities prohibited public gatherings over the Christmas and New Year holidays. In this way, the government seeks to prevent the spread of the epidemic. However, the measures—more akin to those used by a police state to control the population—symbolise the inadequacy of the medical measures to fight the Ebola epidemic, which has spread like wildfire in West Africa, and is still out of control as the year ends.

According to the latest report from the World Health Organisation (WHO), issued December 24, a total of 19,497 people had been diagnosed with the Ebola virus or were suspected of having the disease. Of these, 19,463 people (99.8 percent) came from the three countries, Guinea (2,597 sufferers), Liberia (7,862 sufferers) and Sierra Leone (9,004 sufferers). Other cases of infections known to the WHO are in Mali (8), Nigeria (20), Senegal (1), Spain (1) and the US (4).

Since March this year, when the first cases of hemorrhagic fever caused by the Ebola virus were observed, 7,588 people have died as a result, according to the most recent WHO report. That is 38.9 percent of all those infected.

According to mid-November WHO statistics, of those health professionals involved in the treatment of Ebola patients (which includes nurses and doctors), 570 have so far become ill, 332 of them from Liberia, 128 from Guinea and 93 from Sierra Leone.

One Spanish and three US medical staff members have become ill.

Up to 14 November, 324 of them had died. That is 57 percent of all health professionals that contracted the virus.

An Ebola outbreak in the Democratic Republic of Congo affecting 66, of whom 49 have died, has now come to a halt. The WHO does not see this being linked to the large epidemic in the neighbouring countries.

What is Ebola and how has it spread so far?

The Ebola virus belongs to the family of RNA filoviruses and occurs in five subspecies. It has a living reservoir in the wild animals found in these African countries. It is thought that the virus carriers are most likely to be bats and flying foxes. These infect, for example, monkeys. If blood or bodily fluids from these infected monkeys then comes into contact with people (e.g., through consuming the animals as food), the virus is transferred to humans.

From then on, the disease spreads from person to person. Here too, direct contact with bodily fluids (e.g., saliva and urine) and blood plays a decisive role, and also with the cadavers of those who died of Ebola. The risk of infection through transmission by droplets, for example, by coughing and sneezing is not excluded, but there is also no definite proof of this.

The first two outbreaks of a considerably smaller epidemic were observed in 1976 in Nzara, Sudan, and in Yambuku in the Democratic Republic of Congo (then Zaire). The latter is located on the river Ebola, from which the virus takes its name.

These smaller epidemics occurred in remote villages near tropical rain forests. Between 1976 and 2012, 2,387 people contracted the virus, including 425 in the worst single epidemic in 2000 in Uganda. The mortality rate has ranged between 25 and 90 percent. A total of 1,590 people died in this period, representing two-thirds of all sufferers.

The Ebola virus disease, also known as hemorrhagic fever, is a serious infectious systemic disease that emerges two to 21

days after infection. Until the outbreak of symptoms, infected people cannot infect others.

After this incubation period, patients are suddenly hit with a very high fever and malaise, as well as muscle, head and neck pain.

In the further course of the disease, there are gastric and intestinal disorders, with vomiting and diarrhea and skin rashes. Liver and kidney function worsens. There is internal and external bleeding as a result of damage to the clotting system, hemorrhaging. People often die of multi-organ failure. Mortality, as the epidemiological studies cited above, is very high.

Where there had only been small epidemics in isolated rural regions before 2012, the recent and largest Ebola epidemic has affected both large urban and rural areas. So far, three different Ebola virus strains are the causative agents.

This development is far from unpredictable. The increase in mobility inside and between the three countries, as well as the destruction of their social infrastructure, especially the health system, as a result of the International Monetary Fund (IMF) structural adjustment programmes begun in the 1980s, further intensified through the collapse of the world economy in 2008, and local wars made it only a matter of time before a large Ebola epidemic occurred.

The relevant publications concerning the previous Ebola epidemics clearly made the poor hygienic standards in these countries responsible for the rapid spread of the disease. Explicitly, the hospitals were the location for the spread of the disease as a result of missing personnel or faulty equipment necessary for the safe care and treatment of those affected by the disease. For example, one standard medical work, *Harrison's Principles of Internal Medicine*, observes that the "epidemics were associated with transfer from person to person (especially in hospitals), as well as the multiple use of unsterilised needles—a common practice in developing countries".

The spokeswomen for Medico International came to a similar conclusion, being quoted in October to the effect that the population regarded hospitals as sources of infection rather than places of healing. The links between the increased mobility of the population, worsening social infrastructure and the appearance of deadly epidemics are well known.

This is confirmed by a look back in history. One of the first large-scale devastating epidemics in Europe was the plague of 1346 to 1353. But it was only with the advancement of knowledge in the last two centuries that this relationship was understood. But even 100 years ago, in Hamburg in 1892, the largest cholera epidemic to date occurred, with 16,956 affected, of whom 8,605 died.

This happened not as a result of a lack of knowledge and resources, but was an expression of the conditions of capitalist exploitation at the end of the 19th century.

Poor sanitary facilities and "unhealthy apartments, breeding

grounds for every infection", above all in working class districts, resulted in this epidemic, wrote Robert Koch, who organised the medical countermeasures in Hamburg.

For years, the wealthy classes considered the construction of a water filtration plant and secure sewers to be unnecessary. The cholera-causing germ had already been identified in 1884 by Koch; the need for safe sewerage and water supply to prevent such epidemics was recognised as early as the 1860s by chemist and hygienist Max Joseph von Pettenkofer and implemented in Munich. The Social Democratic Party (SPD), which was then a mass socialist party, argued for the implementation of hygienic standards according to the most current scientific knowledge.

In relation to Ebola, the first results were published in 2005 regarding a genetically produced vaccine against a strain of the virus. This was tested on primates. But it is only now that serious work is being undertaken on the development of two different vaccines, with the aim of putting them into production in sufficient quantities next year.

The imperialist powers involved in the "struggle against Ebola" declare that they are providing "aid". The German army (Bundeswehr) has been praised for its rapid deployment in a campaign organized by the defence ministry. Not only are the Western powers the direct and indirect cause of this catastrophe through the destruction of social infrastructure, but they now use the crisis to try and recolonise the continent.

This too has a historical parallel. Following World War I, pharmaceutical giant Bayer's chief Carl Duisberg asked the German government for permission to test a drug developed by his firm (Bayer 205) for the treatment of sleeping sickness endemic in parts of Africa in the colonies ruled by British imperialism. As spokesperson for German big business, Duisberg had explicitly supported German annexation of Belgium during the war.

Duisberg received permission from the foreign ministry. This was justified on the grounds that it was a matter of the medium-term restoration of the reputation of German science and, in the long term, of refuting the "lies of colonial guilt". In reality, it concerned a new colonial settlement following Germany's defeat in the First World War, and the accompanying loss of colonies in Africa.



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