

## Policy's Limited Helpfulness in the Response to the 2014 Ebola Outbreak

Whenever there is conflict, disorganization, or the need for progress, solutions are sought to improve the situation. People by nature seek progress, peace and fixes to problems, big or small. And whether implemented strictly, inattentively, or temporarily, every course of action proposed or enacted is a policy. Policy is the solution politicians, institutions and people see for all the issues they perceive in the world around them. Policies cover domains ranging from employee protocol in the workplace to economic regulation to disease prevention. When Ebola broke out in West Africa in 2014, organizations and governments around the world implemented policies to control the outbreak and save lives. Despite the facade of helpfulness portrayed by screening, travel bans, and quarantines, these policies rooted in fear, lacked scientific basis, and in fact crippled the response to the epidemic.

The United States Centers for Disease Control and Prevention (CDC) rejected the policy of quarantine in response to the Ebola outbreak; this stance, however, did not deter other people and organizations from implementing the policy (Sell 2016: 115). In the northeastern U.S., governors Andrew Cuomo and Chris Christie implemented a 21-day quarantine for those entering the country through Newark Liberty and Kennedy International Airport from Guinea, Sierra Leone and Liberia who had direct contact with any patients diagnosed with Ebola. Similarly, in the midwest, Illinois Gov. Pat Quinn instituted the same policy, a home quarantine of 21 days for those individuals. In response to the criticisms from many analysts, politicians and scientists, Christie said they are “no longer relying on [CDC] standards” (Frizell 2014). Quarantines found their way onto campuses, too. Two Yale University graduate students returned from Liberia after having no contact with any Ebola patients and were told by school

officials that they should isolate or quarantine themselves for 21 days. The students had been overseas working on the production of a surveillance system for Ebola-infected individuals. This unsound reaction to their return was reversed by the administration on the grounds that it was “unnecessary.” Shortly thereafter, student Ryan Bokyo developed diarrhea and a fever; he then tested negative for Ebola. However, officials mandated that he, along with his colleagues and several others from West Africa, serve a quarantine under 24-hour police surveillance (Willyard 2014: 3). During a quarantine, one cannot leave his or her home (or their location) and cannot have any visitors over. In a similar manner to quarantines, a misguided response to spread of the perilous virus, travel bans were implemented in the United States and other countries in an attempt to contain the disease and keep the healthy safe.

Implemented with regularity during the outbreak, travel bans sought to contain EVD to where it had already manifested and therefore keep those in other locations safe from the deathly disease. Just as quarantines were sometimes implemented by educational institutions, travel bans were used as well. In October of 2014, many American universities banned campus-sponsored travel to the three states where Ebola was most prevalent: Liberia, Sierra Leone, and Guinea. Moreover, they even discouraged travel to these countries for personal reasons such as volunteering. Examples of these strict regulations and suggestions came from two of America’s most prestigious schools: Stanford University’s medical school barred all Stanford-related travel to countries dealing with Ebola in Africa, and Columbia University advocated that its staff and students do not travel to West Africa. To make the trip, one had to sign a letter acknowledging that “evacuation of patients with Ebola symptoms may not be achievable” and also send in an emergency evacuation plan (Willyard 2014: 1-2). Down south, in New Orleans, a major health

conference between the American Society of Tropical Medicine and Hygiene (ASTMH) and the American Public Health Association (APHA) was approaching, taking place in November 2014. However, the Louisiana Department of Health and Hospitals and the Louisiana DHS announced a travel ban on all those attending the conference who had been exposed to Ebola patients or had been in EVD-affected countries in the last 21 days. Travel bans on those coming from West Africa were more common than bans on those desiring to go to Africa; in other words, the Stanford and Columbia policies were more of anomalies than the ban in the Louisiana case, and not just in the United States (Asgary 2015: 72-73). In the Caribbean, the Caribbean Community, known as CARICOM, imposed a travel ban on citizens from Sierra Leone, Guinea, and Liberia as part of their 10-point plan of action. Similar to the ban on Stanford-related travel to West Africa, Haitian authorities prohibited travel to Ebola-affected nations for volunteers (Clegg 2015: 65). These travel bans implemented all over the Western world were rooted in the idea of protecting people from those who could potentially pose a risk. Uber-precautionary policies such as travel bans and quarantines were accompanied by one other common policy in airports and public spaces: screenings, testings of people in specific locations — in this case, particularly travelers in airports — for symptoms of the disease.

Screenings were implemented in response to the Ebola outbreak as a policy that ensured less transmission of Ebola by taking measures to check the health of travelers. By checking the health of travelers arriving at a particular location, and therefore if they have any symptoms, travelers can then be monitored through health updates. The U.S. Department of Homeland Security, with assistance from the CDC, narrowed down entryways for travelers coming from the three major Ebola-affected West African countries. All passengers coming from those states had

to fly into one of five U.S. airports: JFK, Newark, Dulles, Atlanta, and Chicago (FACT 2014). These airports were already screening over 90% of the approximately 150 people arriving from Guinea, Sierra Leone, and Liberia each day (Jansen 2014). This new policy ensured that all passengers would now go through “enhanced screening” that could also include secondary screening and temperature readings, all before being allowed into the United States. Many also had to answer questionnaires about their exposure to Ebola (Sell 2016: 116). The much smaller country Dominica also implemented a screening questionnaire for West African peoples entering the nation, focusing on potential fevers and overseas exposure (Clegg 2015: 65). It is evident that screenings, quarantines, and travel bans were popular policy responses to the EVD outbreak, and not just among those who write and implement the policies. As of October 2014, eighty percent of Americans supported a quarantine for U.S. citizens returning from West Africa until it was certain they did not have Ebola. Furthermore, over half of Americans believed foreigners from West Africa should be quarantined upon arrival, while just over a quarter of Americans felt that West Africans should not be permitted to enter the United States until the epidemic was over (Dutton 2014). And Americans were just as confident in travel bans: 77 percent believed “the U.S. government should take measures, such as suspending all travel to and from the affected areas of Africa, in order to prevent the spread of Ebola to the United States” (Laing 2014). However, perhaps they should not have been so certain. Upon examining the motivations and effectiveness of screenings, quarantines, and travel bans when dealing with the spread of EVD, it becomes apparent that these policies were in fact harmful to the response.

These three types of policies had several flaws: they limited scientific discourse, negatively labeled and disincentivized health professionals involved with the EVD response, led

to the marginalization of West African peoples, and encouraged the exposed to deny it. Quantitative data measuring the success of a policy during the Ebola response does not exist; therefore, the scholarly opinions used and referenced serve as the basis for analyzing the usefulness of a given policy. Screenings, as just discussed, will first be examined. The United States, United Kingdom, France and Canada all increased airport screenings to have better chances at finding those who may have had EVD. However, the helpfulness of this policy is questionable. Due to a long incubation period for EVD — the period between when exposure occurs and when symptoms are visible — travelers could potentially not show first symptoms, such as a fever, in the screening process (Wenham 2016: 444). This truth is certainly a flaw in the process, while a benefit of screening is that it can lead to post-arrival monitoring, where those who may have had a high temperature or another symptom can then report back on their health status, allowing the government to keep track of where EVD could be spreading. While screenings could potentially be useful when integrated with monitoring, quarantines and travel bans have much more harming effects.

The American public opinion on quarantines and travel bans was quite positive, yet the implementation unfavorable on several faces, the first being social. People of West African descent who had never come in contact with Ebola were marginalized and discriminated against purely due to their ties to a country in the realm of the Ebola outbreak (Asgary 2015: 73).

Although research is not available on how often the Ebola outbreak contributed to discrimination, one example from the Bronx illustrates what may have been occurring all over the country, either through outright abuse or general negative associations that heightens prejudices against those from West Africa. A man brought his two sons to New York from

Senegal, which borders Guinea, for better educational opportunities. However, these two sons, Amadou and Pape Drame (ages 11 and 13, respectively), were bullied physically and verbally. They suffered beatings as others told them to “go back home.” The two were also called “Ebola” — which is why the younger brother is quoted as saying “My name is not Ebola, it’s Amadou.” Moreover, if the kids attempted to play basketball in the gym, their classmates told them not to touch the ball because they have Ebola and therefore need to sit down off to the side of the court. Their father asserted that this happened to lots of African children, not just his sons (Hagan 2014). Many researchers assert that these more impactful policies are rooted in fear. Rather than being rooted in science or research on policy effectiveness, quarantines and travel bans are usually implemented on an emotional ground.

Contrasting what the general consensus is about these strategies, there is little to no evidence travel bans work when attempting to contain or kill a disease. For example, if a travel ban were even 80% effective, the spread of Ebola cases would be merely delayed two to three weeks. The risk of Ebola spreading internationally is related to the spread of the virus in West Africa. Furthermore, there would be little historical evidence for the need of a travel ban; the World Health Organization put together a group to review the spread of diseases such as SARS and pandemic influenza, and the group found that restrictions and bans on travel were ineffective policies at limiting the outbreak. Projections based on observation and research asserted that “only 2.8 people per month were likely to be infected with EVD and leave [Sierra Leone, Guinea, and Liberia] by air” (Wenham 2016: 444). Rather than stopping the spread, travel bans hindered the response. The ability to respond by moving supplies and staff overseas was limited, increasing the likelihood that Ebola patients would leave Sierra Leone, Guinea, and Liberia to

find healthcare and supplies elsewhere and therefore spread the disease to other places (Nuzzo 2014: 306-307). Furthermore, health experts believed that travel bans on those coming from West Africa, as proposed in Congress and implemented all over the Western world, would discourage health care workers from traveling to help the response to EVD in Africa (Frizell 2014). So, in addition to being rooted in fear and inciting fear, the travel bans also limited how effectively an organization or population could respond to the difficulties faced in West Africa. The harsh policies on travel and quarantine may have also stimulated undesired decisions regarding travel and diagnoses. People potentially desired to travel on unmonitored routes, denied their exposure, and avoided a diagnosis, all counterproductive in monitoring the spread of EVD on a local or international scale (Asgary 2015: 241). And when it comes to quarantines to isolate potential Ebola patients, one must consider that a quarantine is based on the idea that “asymptomatic people may be infectious and may expose others to the disease.” However, while a genuine with airborne diseases such as SARS or influenza, “it is not a reasonable assumption to make in the case of Ebola” (Wahnschafft 2017: 24).

In addition to the flaws of travel bans and quarantines uncovered by science and documented research, these policies were also integrated into other international policy and had economic impacts. For example, IHR discourages policy not scientifically rooted, and the passed bill UN Resolution 2177 called on countries to avoid suspending flights or travel (Wenham 2016: 444). Perhaps more significantly, travel restrictions on goods and people inhibited the economies of Liberia, Guinea and Sierra Leone. Ebola caused billions of dollars in GDP loss and fear about the outbreak diminished trade, as expected, but policies on travel increased the losses experienced. Even from an American economic perspective, the trade and investment between

the U.S. and those three nations is noteworthy and beneficial to the U.S. economy. Firestone is just one example of a U.S. company with lots of employees in the region that has carefully and successfully controlled the spread of Ebola inside the company (Nuzzo 2014: 307). Finally, upon reflection of the implementation of these policies, it has been suggested that the allocation of resources and money in these places could have been more useful in containing Ebola if they had been sent to West Africa or distributed differently (Wenham 2016: 444-445).

Screenings, quarantines and travel bans do not reflect the entirety of policies proposed or implemented in response to the Ebola outbreak in West Africa in 2014. Others included the creation of helpful medical response teams and increased protocol for the personal protection equipment of health care workers who were with Ebola patients (FACT 2014). However, those three policies do represent popular, bolder policies utilized in an attempt to keep healthy people around the globe by containing the spread of EVD. Due to their ineffectiveness despite their popularity, health analysts must continue to research other large-scale policies in place of these to enhance the global response to an Ebola outbreak, should another imposing threat from a disease arise. It is hopeful that this research can even be used to keep more people outside of Ebola's reach in the current Ebola outbreak in the Democratic Republic of the Congo. It is imperative that scientific research on policy effectiveness be utilized in purposeful ways so that institutions, politicians and governments around the world can better serve and help the sick in need.

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