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Global health security agenda and the U.S. CDC Ebola response in Liberia – An Epidemiologist's experience in Liberia

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The US CDC Ebola Virus Disease (EVD) response is the largest and longest in its outbreak response history with over 3000 employees being deployed to the Emergency Operations Center in Atlanta or in West Africa. Currently there are over 25, 000 confirmed, probable or suspect cases in the three affected West African countries (Liberia, Guinea, and Sierra Leone). Lofa County Liberia was the epicenter for EVD in the spring of 2014 when it spilled over from Guinea. Currently, Lofa County has not had a case of EVD in over 130 days but there were over 350 cases of EVD between March and November 2014. Dr. Stauffer will discuss her experiences in Liberia where she has been deployed twice, as it relates to active case finding, contact tracing, infection prevention and control assessments and management, safe burials, land border crossing evaluations, laboratory capacity building, as well as the communication issues and psychosocial impacts surround EVD. The history of the Global Health Security Agenda (GHSA) will also be discussed as it relates to EVD in West Africa and the roadmap forward in West Africa. GHSA targets of preventing avoidable catastrophes, detecting threats early, and responding rapidly and effectively to infectious diseases will be presented as they relate to EVD.

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What have we learnt about co-operation workers to comply with infection control practices and can we improve co-operation in during outbreaks?

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During large community outbreaks healthcare workers (HCWs) are integral to the treatment and infection control process. We have learnt from the sudden acute respiratory syndrome (SAR) and the current Ebola virus outbreak that HCWs occupationally acquired outbreak infections even when infection prevention equipment is available. Why is this? Modeling factors associated with behavior change is complex. Our model identified the influence of knowledge, attitudes, effort, social normative behavior within our community and pressure from peers on compliance with basic infection prevention practices. Using the model in a low resourced healthcare setting we identified similar barriers predictive of non-compliance. To assist HCWs to comply with basic infection prevention protocols, programs worldwide have attempted to address most of the predictive influences for non-compliant behavior. HCWs more aware of infection prevention policies and practices, they know when and how to hand hygiene, their perception about the effort to comply has been removed by providing alcohol based hand rub at point-of-care, social norms about hand hygiene are slowly changing, and they understand that their peers expect them to comply and assist hospitals to be accredited for infection control standards. With these barriers addressed HCWs should be complying at 100% of the time for the most basic infection control practice - hand hygiene. Yet, when we overtly audit HCWs' compliance they never reach 100%! So what is missing? I will present work we are undertaking to address systems failures within a healthcare system, how we are addressing co-operation of clinical teams and replace outdated views about role modeling to tip behavior change and save HCWs' and patients' lives.

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