MAN: Good morning, everyone. Today we’re just going to review the current status of the epidemiology across the … countries ….

COX: I’m overlooking the Strategic Health Operation Centre here at the World Health Organisation, and this is the nerve centre for the Ebola outbreak. They’re having their morning meeting and they’re getting updates about new cases of Ebola that are popping up each day around the world.

MAN 2: … we have big problems in Guinea-Conakry, we have today two new confirmed cases, twenty-five new suspected cases and there is ….

MUSIC

COX: Seven months after the Ebola outbreak started, the virus still has the upper hand and it’s spreading. This latest epidemic has killed far more people than all the previous outbreaks put together.
STOKES: If the international community had mobilised effectively earlier on in this epidemic, we wouldn’t be where we are here today. Basically this failure to act has had catastrophic consequences for West Africa and potentially for other countries in the region or elsewhere.

COX: Each day there’s a new twist in this epidemic, but one question has remained constant - could and should this have been stopped earlier?

SIGNATURE TUNE

YUSUF: I got the virus through my dad. My dad was sick and I did not know that it was the Ebola virus. I was tending to him at that time.

COX: Yusuf is one of the more than nine thousand people in West Africa who have been infected with Ebola, and each day this figure increases.

YUSUF: And when we went to the hospital they took his blood and the test was conducted, and when the test came out it was positive. In fact the test came out when he had died and they conducted a burial ceremony, and after his death then I started having the signs and symptoms.

COX: What were they?

YUSUF: I had constant fever, high fever, I have body pains and then after some time I started vomiting and had frequent stool.

COX: What was it like when you had all those things happening to you?

YUSUF: It was terrible, it was terrible. In fact, you see death, because the fever that it gives you, it is very, very high. The entire system of your body feels discomfort. You see death, it is really, really deadly.
COX: And it must have been difficult for you if your father had died from it as well? That must have been very hard.

YUSUF: Yes, truly speaking, I lost eight family members including my dad, and for now we only have three survivors.

COX: Though he is fortunate to have survived as seven out of ten people who’ve been infected during this outbreak have died. Yusuf is the first survivor from the Connaught, Freetown’s main hospital in Sierra Leone, where it spread after its original outbreak late last year.

MUSIC

READER IN STUDIO: December 6th 2013, two year old boy in Guinea dies after a mysterious fever.


COX: Ebola isn’t new – but this is the first time it’s been in West Africa. Previous outbreaks have tended to be in Central Africa where the virus was discovered almost forty years ago.

ACTUALITY WITH PHOTOS

COX: These are all photos here, these are from when?

PIOT: From 1976, yes, in Yambuku, yes.

COX: And how big was that outbreak in ‘76?

PIOT: There were about slightly over three hundred cases and 90% died, so close to 300 people died, that was the first known outbreak.
Professor Peter Piot is Director of the London School of Hygiene and Tropical Medicine. He was a member of that first scientific team that arrived in what was then Zaire - now the Democratic Republic of Congo.

This is the moment really we arrived, and there were three sisters, missionaries, and a Catholic priest who had locked themselves up basically in a guesthouse between the nuns and the father’s convent, and they were waiting to die. And here we arrived and they had put a cord around the, you know, the guesthouse attached to a tree and with a message in Lingala, which I don’t speak it. It said, ‘Don’t come near, we’re all going to die, leave a message here.’ And they were convinced, they were praying and that, and so I came there. I was 27 and jumped over that cord and said, ‘Hi, you know, I’m Peter Piot and we’re coming to help you,’ and they all started crying and so on. It was yeah, it was quite …

What happened to them? Did any of them survive?

All of them survived, but they had already lost four nuns died and one father died, you know, and that’s why they were convinced they were next. But it was the nuns who worked in the hospital, they all died. As is the case now in West Africa, it’s nurses and doctors are the frontline and they die, and then it was eleven out of seventeen hospital staff had died from Ebola.

In the four decades since, there have been 1,500 deaths in at least 25 Ebola outbreaks. Then, came this one.


At this stage in March 2014, the medical charity, Medecins Sans Frontieres, or Doctors without Borders, had already been working in the region for months. They have been there throughout on the front line running the treatment centres, trying to control this epidemic in West Africa.
ACTUALITY – MEDECINS SANS FRONTIERES

WOMAN: Last week we came to a village where we had around forty patients from one village. It’s unbelievable. I never have seen it before.

MAN: To deal with this every day, to look people in the eye, you can see they’re scared; to look over this fence right behind you now and see, look at the patients, and you know that their chances are very small, it’s horrible.

COX: But by the end of March, just a week after the first cases were confirmed in Guinea, MSF noticed that this was different to previous outbreaks.

STOKES: We have been working in Ebola outbreaks for over twenty years and this was the first time that we were seeing it spread so quickly.

COX: Christopher Stokes is head of the MSF operation in Brussels, the centre for their Ebola response.

STOKES: So we raised the alarm bell very early on in March, April, and we used one word that’s since been used ad nauseam – we called it unprecedented. We were very concerned about the risk of it spreading to urban areas and we were aware that, through our experience, Ebola had usually happened in very isolated forest areas in parts of Congo, for example, and the spread was hampered in a way by the natural terrain, the isolation of the villages, but the potential for it to spread in West Africa was much greater. And there’s a lot of trade and commerce and people move between the three countries, and that’s exactly what – unfortunately – has happened.

COX: When you were first saying this, back in March, April, what was the response you got?

STOKES: So initially West African governments downplayed the epidemic. The main reaction was some kind of denial basically of Ebola. Remember this was the first time that they had faced this disease in their countries, and this hampered, slowed down the initial response. But also international institutions didn’t respond, and even
STOKES cont: wished to downplay – particularly WHO, of course, as is now well known and on record, downplayed the scale of this early on in the epidemic.

COX: He is referring to several tweets sent by the World Health Organisation’s main spokesman, Greg Hartl, on April 1st questioning MSF’s claim that the outbreak was unprecedented – a point Greg Hartl drove home in a press briefing that day.

ARCHIVE

HARTL: Ebola already causes enough concern. We need to be very careful about how we characterise something which is, up till now, an outbreak with sporadic cases. What we are dealing with is limited geographic area and only a few let’s say chains of transmission.

STOKES: We went to see them in Geneva and told them that they were seriously mistaken and that they needed to scale up and beef up their response quite strongly and give proper advice to the states, and basically what you’ve seen is a kind of international failure of any form of coherent, organised response for the first six months of this epidemic.

MUSIC

READER IN STUDIO: May 26th, the World Health Organisation confirms Sierra Leone’s first Ebola deaths. Total confirmed Ebola deaths in West Africa: 203.

COX: Two months into the outbreak, the response was led by the WHO’s Africa office. Dan Bausch, Associate Professor of Tropical Medicine at Tulane University in the US has worked in West Africa for many years. He was in Guinea at the start of the outbreak in March and returned to the region when Ebola spread to Sierra Leone.

BAUSCH: In Sierra Leone, I remember coming and my first day going to the WHO office and thinking, where is everybody? And there was really very few people around. Not a lot of people from WHO, not a lot of people from Red Cross. It was
BAUSCH cont: very clear that we had by that time outstripped the resources of many of the international organisations that would normally deal with this sort of thing.

COX: And what difference does that make to dealing with the disease?

BAUSCH: All the difference in the world and so, you know, what we have to deal with this disease, it’s very classic public health principles of trying to find all the people who were sick with this disease, we tried to get all the names of contacts, all the people who they have had contact with during their illness and trace them for 21 days after that point of contact. So you can imagine that if you have ten cases and each of them have ten contacts, so that’s a hundred contacts. You need enough people to trace a hundred contacts per day. If you have twenty people to do that, it’s maybe do-able. If you have two people to do it, it’s very difficult, and of course then you’re not sure now where the infection is occurring, who’s a case, who’s a contact and things get out of hand, as they have in this outbreak.

MUSIC

READER IN STUDIO: July 25th, Nigerian Ministry of Health reports first death from Ebola. Total deaths now stand at 672.

DENNIS: She lasted for a week and four days. Then eventually she died.

COX: Dennis’s pregnant wife, Justina, was a nurse who helped treat an American citizen with Ebola who had travelled from Liberia to Nigeria. She contracted the virus on her first day in the job.

DENNIS: It was horrible for me. Each day I go to the house, I end up crying. There was nobody to come around, to cheer me up, to advise me. So it was so horrible for me. I was just in it alone.
COX: He had to take time off to care for Justina and he was fired from his job at an oil company.

DENNIS: The last day I saw her, her legs were swollen, one part of her tummy was also swollen, and the following day I came to the hospital and she had died.

COX: You got ill as well?

DENNIS: Yes, before she passed on, I started having my own symptoms. I became dehydrated and I had to call the Nigeria Ebola response team, who actually came to my house and they checked my temperature and they found that my case was actually getting out of hand, so they came and picked me up and took me to the isolation centre. So just two days after I buried her, I was taken into the isolation centre.

COX: Dennis survived by getting to hospital early, where one of the doctors treating him was Simon Mardel, a hospital consultant from Manchester. He’s had years of experience dealing with Ebola and other similar haemorrhagic fevers, and it wasn’t experimental drugs that saved Dennis but something far simpler and cheaper.

MARDEL: People should hydrate orally, using oral rehydration salts, flavoured, get the volumes of fluid into them because this has always been about fluids. Drink, drink, drink - you’ve got to drink four litres at least of this fluid a day, it’s the best chance of survival.

COX: Dr Mardel was commissioned by the World Health Organisation to write a report on the outbreak in Guinea, which he completed in June, but which hasn’t been made public. File on 4 has seen the findings, which said the outbreak was unique and set out a series of recommendations. The most important was to warn people in West Africa not to take anti-inflammatory tablets like ibuprofen, as they are known to make fevers like Ebola worse. Other recommendations included telling people to use oral rehydration solution and to provide buckets – not just the bleach for people caring for relatives.
With the simple things like providing buckets, oral rehydration – have they happened?
MARDEL: No they haven’t, not on the scale that I would like, and the care and the response outbreak, it’s very often fragmented nowadays with so many people involved, so many organisations, but there is not the leadership that has that level of detail in front of it and presented to it to be able to make those decisions. That leadership has been lacking.

COX: Growing anger about the response came to a head during a meeting in June between the World Health Organisation and the steering committee of the Global Outbreak Alert and Response Network, a group of three hundred international organisations that help the WHO deal with disease outbreaks. We have spoken to a senior member of the committee who was at the meeting. He said the WHO was lambasted for its response, which was called ‘an absolute disaster’, and the point was driven home that it had to pull its finger out. A letter was then sent by the steering committee to the WHO’s Director General, and in July the headquarters in Geneva took over control of the Ebola outbreak response.

READER IN STUDIO: August 8th, the World Health Organisation declares the Ebola outbreak an international emergency. Official death toll: 961.

COX: Why do you think it took the World Health Organisation all those months to then finally declare that it was this international emergency?

PIOT: I think there’s a mix of reasons why WHO responded slowly.

COX: Professor Peter Piot, Director of the London School of Hygiene and Tropical Medicine.

PIOT: First of all it’s a very decentralised organisation and its office in Africa is really not up to the task. And I hope that this epidemic will lead to some serious reform, attracting competent people and trying to get away of political appointees and so on. That’s one point. So they should have been the frontline for that, they didn’t do their job. And then in WHO headquarters, the budget for the Haemorrhagic Fevers Division or Unit and also for the Outbreak Department was cut.
COX: But it was a massive cut of £150 million – that’s over half of its budget, and a lot of key staff left too. We’ve spoken to a former senior member of the outbreak response team who had dealt with previous Ebola outbreaks. He was scathing about the WHO’s response. There had been too much talking and not enough doing, he said, and that someone was asleep at the wheel and should be held to account. He summed up the response as ‘completely unacceptable’, adding that the decision to slash such a huge amount from the outbreak response department was like a local council getting rid of its fire service.

MUSIC

READER IN STUDIO: August 28th, the WHO warns more than 20,000 people could die from Ebola by early November. Official death toll now: 1,552.

ACTUALITY AT SHOC MEETING

COX: The daily Ebola meeting has just finished here in the Strategic Health Operation Centre in the heart of the WHO. We heard about new cases from Guinea, which people here were saying were very worrying. Also updates from Spain, Germany and the US. Clearly the organisation has ramped up its response to this. But how does it answer this criticism that this has all come months too late? Rick Brennan is one of the directors who is in charge of the response to the Ebola outbreak.

BRENNAN: We all could have done better, we all could have responded faster, but having said that, this outbreak is very different from anything we have seen before as well, so I don’t think we can beat ourselves up too hard. I think that the pace at which this outbreak picked up, its geographic spread caught everyone - even the experts - by surprise. And now we need to redouble or treble our efforts to play catch-up.

COX: You say it caught everyone by surprise, but Medecins Sans Frontieres were saying in March, April, this is an unprecedented outbreak. WHO then briefed against them and said they were causing panic and alarm.
BRENNAN: Well, when I say it caught people by surprise, I think in terms of the rate at which it escalated, the geographic spread. We’ve never had an outbreak of Ebola that’s affected more than one country. And then the fact that it’s got into an urban setting, which is different from all previous outbreaks, and that has really contributed to the spread.

COX: But the responses I’ve had, I was talking to someone who was very senior here until recently, who said the response was completely unacceptable and it was hard to believe how you’d responded. That’s quite damning, isn’t it?

BRENNAN: That’s tough. You know, I will say that, you know, in retrospect there are a number of things that we could have done better. I think we could have perhaps engaged the governments more, sooner. I think that we could have brought communities on board more effectively sooner and I think we could have brought on board a broader range of partners a little bit better.

COX: What about the cuts to the outbreak response department – over $200 million had come out of the budget? Has that made much of a difference, do you think?

BRENNAN: Well, I mean, when you lose capacity, when you lose experts, it’s obviously going to have an impact in your ability to respond in a timely manner. So there has been a reduction in capacity, I think that’s been acknowledged. We’re looking seriously at how we restructure moving forward, but again, I mean, I think that our donors, our member states have to be, you know, looking at that as well. There is a lot of reflection on that and a recognition that there have to be improvements in our procedures and in our capacities.

COX: It’s not just the World Health Organisation that needs to change. It’s funded by the 190 states in the UN and, during the financial crisis, donor countries decided to significantly reduce the WHO’s budget. Dr Jeremy Farrar, director of the global medical foundation, the Wellcome Trust, says the outbreak has called into question the way that member states support the WHO.
FARRAR: You’ve got to bear in mind that the World Health Organisation is a secretariat of the member states, and if the member states don’t contribute, if we don’t fund the World Health Organisation sufficiently, we will get a substandard organisation.

COX: And all of those countries are supposed to have health systems that can cope with public health emergencies, but many of the poorest nations in West Africa say they simply don’t have the money to do it. Britain has given tens of millions of pounds to help with this, but last year the UK Government reduced its aid to Liberia and Sierra Leone by almost 20%. A report earlier this month from the Commons International Development Committee said these cuts had hampered the fight against Ebola – a view shared by Jeremy Farrar from the Wellcome Trust.

FARRAR: We will spend huge amounts of money now in Sierra Leone, Liberia and Guinea. We would have spent less if we’d invested in the health systems before they collapsed. You’ll always spend money when you play catch up, so this will cost us a lot more and it’ll cost the countries in West Africa a lot more because we’ve neglected that area.

COX: But even when they do get money, they don’t necessarily spend it. The European Union, for example, has given £45 million to improve Liberia’s health system, but in the last two years just £2.5 million of that reached Liberia’s health department. Lewis Brown is the country’s Information Minister. What about the criticism of your government, that actually you didn’t do enough and you weren’t quick enough to deal with it, because there are certain things that you could have done, even with your stretched health system?

BROWN: Well, we’d like to hear what we could have done better or properly. We’ll be glad to listen when this is all over. The folks lying down as we speak and those who have been projected to contract this, I’m not sure that’s the kind of argument they are ready to listen to right now. What we are ready to do is to figure out how we get more treatment centres open, how close can we get treatment centres to those who are afflicted and need the help desperately, as well as how we can continue to ramp up public
BROWN cont: awareness. If we can operate on these two tracks, quite clearly we should be able to get a hold on this. We’ll save the Monday morning quarterbacking for when the game is over.

COX: Well one of the criticisms is that the EU gave $60 million to the health sector there and that only $4 million of it had actually gone to the health ministry in the last two years.

BROWN: Well, I don’t have that information. What I do know is that we’ve had a broken down, extremely collapsed health sector. When you appreciate that our country, as a result of the years of devastation and conflict, actually experienced the greatest collapse in the productive sector of any economy since World War II. 90% collapse. And we were still able to record the greatest rate of change in infant mortality. We had reduced the incidence of malaria from 66% to 28%. But even that level of change would not be able to deal with this epidemic. That is why it is extremely important that we get all the help we can get and we get it now.

MUSIC


COX: Ebola has been a death sentence for 70% of those infected, but a tiny handful of people have benefited from experimental treatments such as the drug ZMapp. It’s one of a number of treatments whose development is being accelerated. But it has been around for some time, as I discovered from Charles Arntzen, a Professor of Molecular Biology at Arizona State University in America, who helped to develop ZMapp.

ARNTZEN: It was shortly after our major 9/11 event in the US and there was money available through the US Army to begin to develop preventive technology in the event of a bioterrorism attack. Now one of the agents that they were very interested in was the Ebola virus.
COX: How worried were they, the army, that Ebola could be turned into a weapon?

ARNTZEN: You know, it’s hard to say whether the army was chiefly concerned about Ebola as a weapon, although we had good evidence that the Russians had weaponised or attempted to weaponise Ebola and other viruses way back, twenty years ago. So perhaps they were very concerned about the threat, but the army also has to be concerned about where their troops are called out to go, and whether they would be protected.

COX: You started the development in 2002. You get it to the stage where you’ve tested it in animals. Could we have got to this stage sooner, where we do have drugs that might work, that could be the key?

ARNTZEN: Well, I think it’s always easy to say we could have gotten here earlier. In general our group and others have been constrained by the funding that we have available. The big drug research efforts we have in the US are driven by self-interest, political interest, tax payer interest. They are the ones who provide the funds and they want solutions to problems that affect Americans, like Alzheimer’s or cancer or whatever. So in a sense it’s not surprising that in the US at least, the military has been a major factor in pushing funding in this area of research. I guess I’m just very, very happy that we made it to the point where we are today, where we see, I’d say rather clearly, the vision of a good therapeutic that should be very important for tens of thousands of people in West Africa.

MUSIC


EXTRACT OF SPEECH, OBAMA

OBAMA: We’re going to create an air bridge to get health workers and medical supplies into West Africa faster.
READER IN STUDIO: September 16th, President Obama announces three thousand military personnel to be sent to West Africa. Death toll: 2,461.

READER 2 IN STUDIO: September 30th, first case of Ebola in the US is announced. Death toll: 3,338.

COX: As the virus spreads to other countries and with treatments - when they finally arrive - in short supply, many of the experts we spoke to believe the only way to contain the current outbreak is with a vaccine to stop people getting Ebola in the first place.

ACTUALITY WITH VOLUNTEER

OWEN: The day after the vaccine, I felt a bit, like I had flu-ey sort of symptoms, but since then I’ve been absolutely fine.

WOMAN: No problems …

COX: Nick Owen is one of the volunteers who have been injected with a test vaccine and he is back at the Jenner Institute in Oxford for a check-up.

OWEN: It’s a horrific virus. I think it’s a really small sacrifice to make, to potentially help prevent epidemics like this from happening again.

COX: The drug he has been given is being developed by the pharmaceutical giant, GlaxoSmithKline. It’s one of several companies trying to develop a vaccine. It normally takes ten years to do this, moving it through animal and human clinical trials and onto mass production. But the severity of this outbreak means that GSK is trying to compress this into just twelve months. Dr Ripley Ballou is in charge of the project at GSK’s vaccine research unit, just outside of Brussels.

BALLOU: I mean, I was alarmed as far back as March, when we first read about this epidemic being in West Africa, that there could be something quite unusual here.
COX: And did you try and get things moving with the vaccine, even at that early stage with WHO?

BALLOU: Well, we started internally discussing this, and we had a very concrete discussion about what we could do, what it would take to be able to accelerate the project, and the reality is, is that it took time for people’s thoughts to gel around this. We did discuss with the WHO and they were very appreciative that we were sharing our information with them. They felt that, if you go back now to the spring, there really was no vaccine policy. No one anticipated that we would need a vaccine. So both internally and, I think at the WHO, we felt that the best approach was to watch very closely, to begin to prepare, but not to pull the trigger until it was obvious that we would need to do something. I think in retrospect we should have pulled that trigger earlier. But it is what it is and we are working very closely with WHO. There shouldn’t be any finger pointing around this. I mean, this is a tremendous international effort to try to respond to an unprecedented problem.

COX: But didn’t they then come back in the summer and say, okay, we do need a vaccine?

BALLOU: They did. They came to us in August and said, what can you do to accelerate this?

COX: We asked the World Health Organisation about this, but they didn’t respond. In the next phase of the trial, GSK hope to have 20,000 doses ready for testing on health workers by the beginning of next year. But what about the millions of people in West Africa at risk of the disease?

BALLOU: To have a vaccine that people can use, you have to have the vaccine registered and it has to be manufactured at a scale that is consistent with the intended use. And that is going to be well into next year, if not the year beyond, before we have that kind of level of manufacturing and the actual data that’s necessary. You’re right, a vaccine is going to come too late for this epidemic. But what we can do during this epidemic is to gather the data that the vaccine works, and if it does work, then to be able to be prepared
BALLOU cont: so that we don’t have to go through this again in five years, or whenever the next epidemic is going to break out.

COX: The treatments and vaccines are unlikely to solve this outbreak and the frustration for experts like Dr Jeremy Farrar, from the Wellcome Trust, is that many of these have been around for years, but money wasn’t spent moving them from animal through to human clinical trials. He says that can’t be allowed to happen again.

FARRAR: It is easy to, for instance, see big pharma as the problem here, but we’re all the problem here. Ebola will commonly come back, but you can control it with public health measures. There isn’t - and there never will be - a commercial market there. This is where I think governments, the public money and philanthropy like the Wellcome Trust and industry to an extent is going to have to work a different paradigm for how we develop vaccines and drugs for these epidemic diseases, which are quite rare, may never happen and for which there is no commercial market. We’re going to have to find a better system for both developing them and testing them and then manufacturing and having them in stockpiles, so we can use them when needed. We don’t have that system in place today. And so I think one of the most important lessons that we must learn is that when we develop vaccines and drugs for these rare epidemic diseases, but which can be devastating, that we at least take them through to human phase one safety data, so that when an epidemic occurs, we have a system for deployment immediately. That has to be perhaps the number one lesson that we take away from this epidemic.

COX: We don’t just leave them on the shelf?

FARRAR: We don’t just leave them on the shelf. We absolutely need that safety data.

MUSIC

READER IN STUDIO: October 5\textsuperscript{th}, Sierra Leone has its highest death toll in a day, with 120 dead. Total outbreak death toll: 3,439.
READER 2 IN STUDIO: October 6th, Spanish nurse becomes the first person to be infected with Ebola outside of West Africa.


COX: After a sluggish start, the World Health Organisation is now fully engaged, but with no drugs or vaccine, it’s left to the initiative of West Africans and the courage of health workers to try and stop the inexorable spread of Ebola.

BRENNAN: We’re not waiting around for the development of a vaccine or one of these other experimental therapies being shown to be effective. We can’t afford that.

COX: Rick Brennan, Director of Emergency Response at the WHO, says even now, after all the dire warnings, they are still well short of what they need to get on top of the disease.

BRENNAN: At present, we believe we need fifty Ebola treatment centres across the three main affected countries. Now most of these will be purpose-built, in-patient, field hospitals, if you like. Currently, of the fifty that we believe we need, we have sixteen operational. Now of the other 34 that will be established, we only have partners identified for another nine, so in the next few weeks we’ll have 25 of these up and running. So to run a field hospital for Ebola treatment, you need doctors, nurses, hygienists, cleaners, cooks, administrators, logisticians and so on, so we are asking the international community to mobilise resources to staff these facilities.

COX: So you need another 25 hospitals and for them to be staffed and you haven’t had that commitment as yet?

BRENNAN: Correct, yes.
COX: But we have known for months, haven’t we? For months we’ve been told. You declared it an emergency in August. We’re now into October and still we’re nowhere near the amount of things you need.

BRENNAN: Correct. So everyone could have moved faster.

COX: And however fast they are moving now, they’ll always be playing catch up because the virus has taken hold and is moving beyond West Africa.

MUSIC

READER IN STUDIO: October 12th, an American nurse becomes the first person to contract Ebola in the US. Latest death toll: 4,024.

COX: The WHO says it is now the worst health emergency of the modern era. After all the promises, help is finally arriving. Britain has set up a hospital in Sierra Leone and sent military staff to run it. MSF were there at the beginning and have been a constant presence in the field hospitals in Guinea, Liberia and Sierra Leone. So how long does Thomas Neirle, President of MSF in Geneva, think this Ebola outbreak will last? The answer is one you probably don’t want to hear.

NEIRLE: The outbreak will certainly carry on for many months. I think we estimate, at least in our planning and budgeting, that the outbreak will last until the end of 2015 or early 2016, which is another eighteen months.

COX: That long?

NEIRLE: That long. But as the situation is today, we really have to plan for the long term. And I think the world has to be shaken, heavily shaken, in order to develop mechanisms which will help to save lives all over the world, not only in Europe, not only in the United States, not only in emerging countries, but as well in the poorest countries of this world.
October 20th, the World Health Organisation declares the Ebola outbreak in Nigeria over, but still out of control in Guinea, Liberia and Sierra Leone. Latest official death toll: 4,555.

And counting.