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Post-Ebola Sequelae and Long-term Care: Ethical Responsibilities to Survivors Through an African Communitarian Lens

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ABSTRACT

More than a decade after the West Africa Ebola outbreak (2014–2016), thousands of survivors continue to experience long-term health, social, and ethical consequences that remain insufficiently addressed. This viewpoint examines the ethical responsibilities of governments and funders toward Ebola Virus Disease (EVD) survivors in West Africa, with particular attention to long-term care, survivor vulnerability, and post-Ebola sequelae. Beyond acute mortality, the epidemic revealed enduring inequities in global health responses and raised unresolved questions regarding responsibility once outbreaks are contained. Evidence of post-Ebola sequelae, including ocular, rheumatological, reproductive, and psychosocial complications, alongside reports of viral persistence in immune-privileged tissues, underscores the need for sustained monitoring and survivor-centered care. With more than 11,000 survivors in Liberia, Sierra Leone, and Guinea, many of them children, unresolved scientific uncertainty and inadequate long-term support raise critical ethical concerns grounded in universal human rights. Drawing on African communitarian ethics, this viewpoint argues that justice extends beyond survival to include sustained care, social reintegration, and the capability for survivors to recover dignity and thrive as productive members of their communities.

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INTRODUCTION

The 2014–2016 Ebola Virus Disease (EVD) outbreak resulted in more than 28,000 reported cases and over 11,000 deaths, primarily in Guinea, Liberia, and Sierra Leone (Centers for Disease Control and Prevention (CDC, n.d.). While global efforts eventually succeeded in interrupting transmission, the ethical and social consequences of the epidemic did not end with outbreak control. Thousands of survivors were left with long-term health complications, social stigma, and economic precarity, revealing critical gaps in global health responsibility once emergency responses recede.

Beyond its immediate mortality, the West Africa Ebola outbreak exposed enduring inequities in how global health emergencies are prioritized, managed, and ultimately resolved. International engagement surged during the height of the crisis, mobilizing humanitarian actors, research initiatives, and emergency funding. Yet once transmission declined and global attention shifted, sustained investment in survivor care, rehabilitation, and social reintegration diminished markedly. For survivors living with post-Ebola sequelae, ranging from chronic physical symptoms to psychological trauma, this withdrawal of support has had lasting consequences, underscoring a troubling pattern in which moral obligation appears to wane after containment is achieved.

This commentary focuses on these gaps by examining ethical obligations toward EVD survivors through the lens of African communitarianism. It argues that prevailing global health approaches often emphasize short-term containment over long-term care, particularly in low-resource settings, thereby neglecting those who survive epidemics but remain chronically vulnerable. Such imbalances reflect broader structural inequities in global health governance, where responsibility is frequently framed as episodic rather than sustained.

Drawing on African communitarian ethics, which emphasize relational personhood, shared responsibility, and collective well-being, this viewpoint challenges the notion that ethical duty ends with outbreak control. Instead, it advances the position that justice requires ongoing commitment to survivor-centered care, particularly for children and other vulnerable populations whose lives and futures continue to be shaped by the aftermath of epidemic disease. This viewpoint argues that justice in the aftermath of Ebola requires sustained, survivor-centered commitments grounded in African communitarian ethics, extending moral responsibility beyond outbreak containment to long-term care, social reintegration, and human dignity.

African Communitarianism as an Ethical Framework

African communitarianism emphasizes relational identity, shared responsibility, and collective well-being (Skoble, 1994; Ambe & Kombe, 2019). Across many African societies, moral value is grounded in community membership, mutual care, and

social interdependence. Within this framework, individual well-being is inseparable from community flourishing, and moral obligations extend particularly to those who are most vulnerable.

Applied to post-Ebola contexts, African communitarian ethics challenge response models that prioritize containment over recovery. Abandoning survivors after crisis resolution undermines social cohesion and violates communitarian principles that demand sustained care, solidarity, and reintegration.

Post-Ebola sequelae and ethical uncertainty

Evidence from cohort studies, including the Postebogui study in Guinea, demonstrates that many EVD survivors experience chronic sequelae affecting vision, musculoskeletal health, reproductive systems, and mental well-being (Etard et al., 2017). These conditions often persist in settings with limited access to specialized care.

Compounding these clinical challenges is evidence of prolonged viral persistence in immune-privileged sites, such as ocular fluid and semen. Local scientific leadership in Sierra Leone has also played a critical role in advancing long-term Ebola research and survivor-focused preparedness. Researchers such as Alhaji U. N'jai have been centrally involved in Ebola and emerging infectious disease research since the 2014 outbreak, with continued engagement in survivor health, outbreak preparedness, and research capacity building, an ethically significant example of African-led responsibility and sustained commitment (N'jai, n.d.). Although the full implications of persistence and reactivation remain uncertain, this uncertainty itself raises ethical concerns regarding surveillance, risk communication, and the long-term protection of both survivors and communities. These unresolved clinical uncertainties raise ethical questions not only about surveillance and transmission risk, but about the responsibility to provide sustained care in the face of scientific uncertainty.

Survivors, Children, and Layered Vulnerability

Although the exact number is uncertain, it is clear that thousands of children survived the EVD outbreak, many as survivors, orphans, or both, and that a substantial proportion experienced significant trauma. For child survivors, vulnerability is layered and enduring. Many experienced prolonged isolation during illness, loss of caregivers, disruption to education, and persistent post

recovery stigma. Inadequate follow-up care risks long-term consequences for physical health, cognitive and emotional development, and social integration. Failure to address the needs of child survivors not only compromises individual life trajectories but also threatens intergenerational well-being, reinforcing cycles of vulnerability and inequality. From a communitarian perspective, failure to protect child survivors represents a failure of collective moral responsibility, with consequences that extend beyond the present generation.

Health Disparities and Structural Responsibility

Health disparities across Africa are often driven by preventable structural factors, including poverty, weak health systems, and limited infrastructure. The burden borne by EVD survivors reflects these broader inequities. Ethical global health practice therefore requires moving beyond emergency intervention toward sustained investment in long-term care, rehabilitation, and social support. Such disparities underscore that vulnerability is not accidental, but structurally produced, reinforcing the ethical obligation for sustained intervention.

Ethical and Socio-Political Obligations

Key ethical questions arise: Who is responsible for long-term survivor care? Do governments and international funders hold heightened obligations toward populations rendered vulnerable through global health crises? How should responsibilities be shared between national governments, regional institutions, and global actors? From a communitarian perspective, moral responsibility does not end with survival. Governments and funders have an obligation to ensure access to healthcare, psychosocial support, education, and skills development, enabling survivors to reclaim agency and participate fully in social and economic life.

CONCLUSION

More than a decade after the West Africa Ebola outbreak (2014–2016), the ethical responsibilities toward Ebola Virus Disease survivors, particularly children, remain unresolved. While emergency responses mobilized global attention, long-term care, psychosocial support, and sustained social reintegration for survivors have received far less commitment. Failure to address post-Ebola sequelae and layered vulnerability risks entrenching health disparities and perpetuating intergenerational harm within

already fragile health systems.

An African communitarian ethical framework—often articulated through the concept of Ubuntu, or the Bwatiye equivalent Bwaaraune, provides a compelling foundation for responsibility that extends beyond outbreak containment. As articulated by Thaddeus Metz, moral obligation arises from relational personhood and shared humanity, emphasizing communal harmony and the moral imperative to support vulnerable members of society (Metz, 2011; 2017). From this perspective, justice is not fulfilled by survival alone, but by sustained, survivor-centered commitments that enable recovery, social reintegration, and the restoration of dignity.

Governments, regional institutions, and funders therefore bear an ongoing obligation to invest in long-term survivor care, research on viral persistence and post-Ebola sequelae, child-focused health and educational support, and preparedness for future outbreaks. Justice in the aftermath of Ebola demands more than emergency response; it requires enduring moral responsibility grounded in African values of solidarity, shared responsibility, and collective well-being.

"Being a bystander to suffering is not an option." Jim Greenbaum (Greenbaum Foundation)

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Table 1: Participants' Socio-demographic characteristics

Gender	**Frequency**	**Percent**
Female	16	88.89%
Male	2	11.1%
Age		
18years-30years	2	11.1%
31years-40years	10	55.6%
41years – 50years	5	27.8%
>50 years	1	5.5%
Designation/cadre		
Reproductive health(RH/HIV counsellor)	10	55.5%
SECHN/HIV Counsellor	7	38.9%
OTHER CADRES(CHO,CHA,MCH AIDE,NURSING AIDE)	0	5.5%
Length of service		
>5years	11	61.11%
3years	3	16.67%
4years	2	11.11%
5years	2	11.11%
Type of health facility		
Community Health Centre	13	72.22%
District Health Management Team/HIV Program	1	5.56%
Secondary hospital	3	16.67%
Tertiary hospital	1	5.56%
Highest level of education		
Certificate	13	72.22%
Diploma	5	27.8%
Degree	0	0%
Masters/Phd	0	100%
Pin-coded staff?		
Yes	1	5.56%
No	17	94.44%

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Table 2

Simplicity				
Indicators	**Score**	**maximum score**	**Score percent**	**Rank**
Instructions and guidelines for completing the HIV Surveillance system and reporting forms are easy to understand	5	60	8.3	Good
The system has standard case definitions and algorithms for HIV/AIDS	5	60	8.3	Good
The case definition/algorithm for HIV is easy to use and understanding the functionality of the HIV Surveillance system is easy	4	60	6.7	Good
Report forms are available. And surveillance data is easily managed	4	60	6.7	Good
Forms for reporting HIV surveillance data are easy to complete.	3	60	5.0	Average
The system has partners/organizations supporting the facility, district, and National	3	60	5.0	Good
Data collection is not time-consuming and only takes one hour to do so	3	60	5.0	Average
Transmitting data to the central level is easy	3	60	5.0	Good
Follow-up of cases is easy	3	60	5.0	
ARV drugs and HIV/AIDS test kits are available in a health facility to confirm diagnosis	3	60	5.0	Poor
Staff received training and training courses are performed frequently	4	60	6.7	Average
The system is responsive to suggestions.	4	60	6.7	Good
Implementation status (Overall Score)	44	60	73.3	73.3%(Good)

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Table 3

Flexibility

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Indicators	Score	maximum score	Score percent	Rank
The system is flexible and is part of the Integrated disease surveillance system (IDSR)	5	25	20	Good
The system can accommodate changes in case definition	3	25	12	Good
The existing surveillance reporting system is well adapted to reporting all HIV surveillance in this region. The system can accommodate any changes in reporting method	2	25	8	Good
The system can integrate the surveillance of other disease/HIV surveillance and response within the existing Surveillance system easily adapts to changes in technology (e.g. paper-based to electronic-based reporting)	5	25	20	Good
The system can accommodate data changes with minimum cost and efforts	5	25	20	Good
Implementation status (Overall Score)	20	25	80	80%(Good)

Table 4

Acceptability				
Indicators	**Score**	**Maximum score**	**Score percent**	**Rank**
Fellow health personnel in this facility show interest in HIV surveillance activities / Willing to continue to participate in the HIV/AIDS surveillance system	5	25	20	Good

The system appreciates effort of staff for doing the job effectively. My contributions and inputs to the existing HIV Surveillance system are considered valuable.	4	25	16	Good
I am satisfied with my involvement in the HIV surveillance activities in this facility	5	25	20	Good
The existing HIV surveillance system protects users' privacy and confidentiality / The system acceptable to users	5	25	20	Good
All actions regarding HIV surveillance are adequately supported by the health facility management and Suggestions/comments about improving the system are considered by the program	5	25	20	Good
Implementation status (Overall Score)	24	25	96	96%(Good)

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Table 5

Stability				
Indicators	**Score**	**Maximum score**	**Score percent**	**Rank**
The system is stable after sponsors withdraw their support	2	40	5	Poor
The system does require time to manage the data	3	40	7.5	Good
The system was not interrupted during the COVID-19 pandemic	3	40	7.5	Good
The system has dedicated staff for data collection,, Analysis and Reporting	4	40	10	Poor

The system data is manually collected and submitted to a higher level/The existing HIV Surveillance system has always been reliable when reporting HIV surveillance data.	5	40	12.5	Good
The system protects patient privacy/ data confidentiality	4	40	10	Good
The system receives feedback from a higher level after reports are submitted	3	40	7.5	Good
Resources provided for HIV surveillance and response activities in this region/facility are sufficient/ There was no stockout of test kits/ARV drugs in the facility/	2	40	5	Average
Implementation status(Overall Score)	26	40	65	65%(Average)

Table 6

Representativeness				
Indicators	**Score**	**Maximum Score**	**Score percent**	**Rank**
The system capture all pregnant women attending the facility	3	30	10	Good
Surveillance/DHIS data covers public facilities including government and NGOs providing HIV services	3	30	10	
Private, NGO and Faith based NGO do not report HIV surveillance data to DHMT/National AIDS control program	2	30	6.7	

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The system is collecting sufficient information regarding pregnant women seeking HIV care this include age and sex of cases along with their residential areas at private, NGO and Faith based clinics	3	30	10	Poor
Implementation status (Overall Score)	11	30	36.7	36.0% (Poor)

Table 7

Usefulness				
Indicators	**Score**	**maximum score**	**Score percent**	**Rank**
HIV surveillance and response within the Surveillance system has enabled achievement of the surveillance objectives in the past one year in this district(Provide estimates of the HIV magnitude, incidence, prevalence, and mortality)	4	35	11.4	Good
Transmitting information to the next level had access to reporting tools motor vehicles, motorcycles, and cellphones	2	35	5.7	Good
HIV surveillance data has informed program implementation for prevention and control of the disease in the past one year in this district & Action taken by authorities to improve the performance of the HIV surveillance system	4	35	11.4	Good
Data Analysis done and feedback given to the responsible people	2	35	5.7	Good
Data collection and reporting done weekly and monthly by health facility staff	3	35	8.6	Good
Data generated on HIV testing, supply of HIV test kits and drug supply is used for resource planning, care and control by partners for informed decision making	4	35	11.4	Good

The system is useful and data are used to assess the impact of interventions	4	35	11.4	Good
Implementation status/Overall Score)	23	35	65.7	65.7%(Average)

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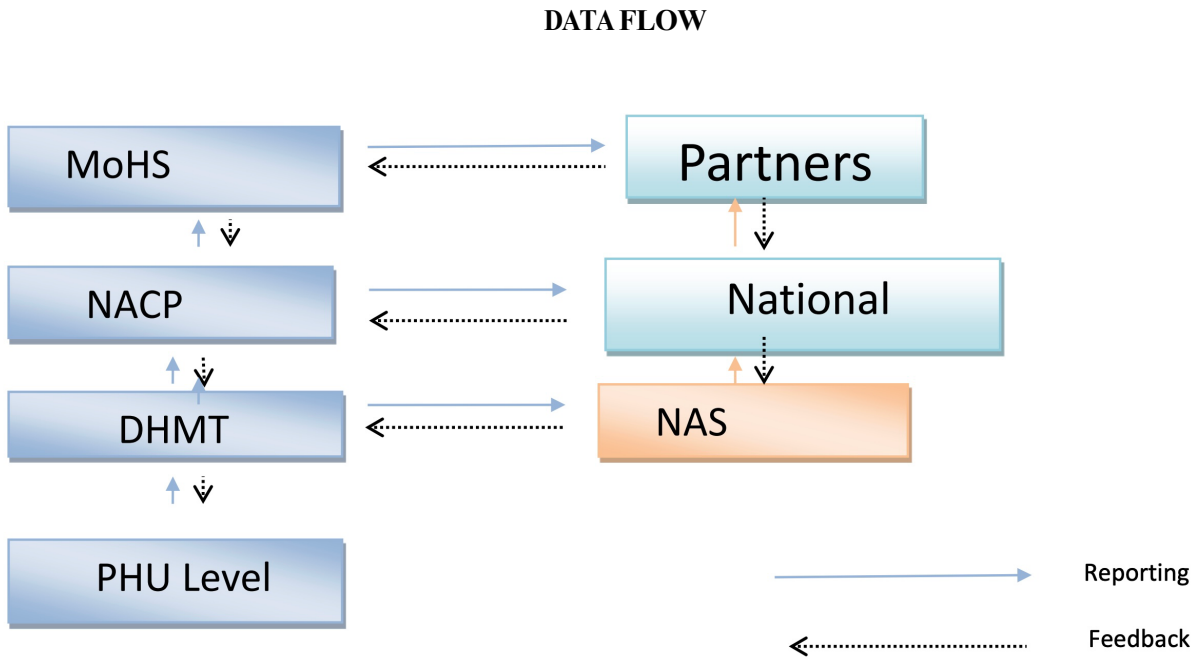

Figure 1: Trend of HIV cases among pregnant women seeking ANC/PMTCT services in Western area Urban, 2022

(Adapted from the consolidated guidelines for HIV prevention, diagnosis, treatment and care in Sierra Leone)

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