

Communicating and convincing: a humanitarian perspective on the French response to the coronavirus epidemic

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In this paper, the two authors examine certain aspects of the French response to the epidemic in the light of the experience of *Médecins Sans Frontières* (MSF) in that field, primarily with respect to the relationship between the actors of the response and the beneficiaries.

While centuries of experience have taught humanity that there is no universal recipe for controlling an epidemic, we know that the response lies in a combination of political, social, economic, medical, and scientific action. Leaders in the field of epidemics recognise that while experience is a helpful guide, it is no guarantee. Practices have been defined to limit the number and improve the management of new cases, but their implementation requires having access to knowledge and skills that have been more empirically developed than rigorously demonstrated.

Undeniable progress has been made since the Black Death of the 14th century. Countries are far less overwhelmed today than in the past by tsunamis of cases and deaths, yet the challenge of controlling epidemics still exists. The recent examples of SARS in Southeast Asia in 2003, H1N1 flu in Europe in 2008, cholera in Haiti in 2010, Marburg virus disease in Angola in 2004, Ebola in West Africa in 2014, and Zika virus in South America in 2015-2016 are reminders that “new epidemics” are not uncommon. Environmental changes, increased global travel and trade, and precarious socio-economic conditions continue to favour the emergence of new diseases with no end in sight.

Changes and reversals: which direction should the response take?

The response to an epidemic outbreak is seldom earth-shattering, especially when a new virus appears or when an epidemic reaches unprecedented proportions (for example, the cholera and Ebola epidemics in Haiti and in West Africa respectively). When it does happen, uncertainty prevails or the response system has to navigate through it, at times in a dense fog, which at best will clear as knowledge of the pathogen progresses. Reversals and changes of tack are, therefore, unavoidable, but nevertheless have to be accounted for.

In early March 2020, the French Minister of Health, Olivier Véran, explained, with the use of graphs, that since it was impossible to control person-to-person viral transmissions, the government’s strategy was designed to assure that hospitals would have the capacity to treat Covid-19 patients. This strategy has prevailed in most other countries too and served to justify national and local decisions to enforce lockdowns. “What we want is to slow down the virus, prevent severe forms, reduce resuscitation efforts and deaths. Not only are we protecting the capacity of our hospitals, but also the lives of our citizens”, tweeted the minister on 11 October.

While the response to an epidemic undoubtedly depends on a population’s behaviour, training people to observe health guidelines has much to do with the powers of persuasion of the authorities in charge. This is even more true when the disease is novel. Yet our experience tells us that the French government’s initial assessment of the epidemic, the types of decisions made and the reasons why, and its public announcements, can be examined with the same critical eye as that directed to the population’s behaviour.

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Now armed with more knowledge about the disease's characteristics, its intensity, the mode of viral transmission, and the difficulty of imposing a protracted country-wide lockdown, French political and medical authorities have stated that the success of an adopted strategy is solely contingent on the proper and strict application of the guidelines set out. These measures have been divided into "barrier" and "behavioural", and include restricted social, family, professional, and recreational contacts, the early identification of infected people and their contacts, and the acceptance of the digital tracking of people's movements, all of which are announced in repeated public messages. Wearing a mask, initially thought to be unnecessary or even counterproductive, has gradually been made compulsory in an increasing number of places. The need to ventilate enclosed spaces was not mentioned until much later, in early October, even though it was already known that the disease was airborne. Yet in the absence of persuasive evidence, authorities are struggling to convince people of their decisions and encourage them to follow the advice. The metaphor of a war being waged, which President Macron alluded to six times in his speech on 16 March, did manage to mobilise French society. But it did not provide them with any further understanding of the strategy that had been adopted.

The overlooked value in the epidemiology of intervention

Under these circumstances, leaders can, however, rely on epidemiological research, of which population surveys conducted in real-life situations provide a tool for describing, measuring, and analysing a given outbreak and evaluating any resulting response programmes. In the context of our interventions, we apply epidemiological practices, for example, to pinpoint places and populations at risk of outbreaks such as measles in sub-Saharan Africa or cholera in Yemen, to cite two recent examples. The intention is to collect and analyse field data that could serve as a guide and help focus our efforts in reducing transmissions. However, epidemiology has been largely underexploited in France. Very few population studies have been carried out to document situations and places at risk or regional situations that would allow responses to be adapted according to time and place. To put it simply: how and where do people become infected? It seems the authorities have not adequately mobilised the French Public Health Agency to investigate this point.

The arguments that followed the decisions to close bars, restaurants and gyms perfectly illustrate the importance of clear explanations to be understood and accepted. As a prime example, if a restaurant is considered a high-risk environment because people of all health levels are gathered in an enclosed and possibly poorly ventilated place, and customers are not required to wear masks, there are two factors missing to assess the importance of these conditions: first, the excess risk of this exposure compared to the risk of people who never go to restaurants (and it is regrettable that French authorities referred to an American study in July, whose authors themselves recognised its limitations¹) and, second, the proportion of infections contracted at the restaurant in relation to all infections. In other words: how great is the risk and to what extent is it a national problem? Epidemiologically speaking, these two questions complement each other when seeking to identify the source of a health problem. The answers are, of course, important to provide explanations and, of course, develop a response. In France, although this approach has not been implemented thus far, its application appears even more crucial as a new lockdown is declared, after a curfew has been imposed in certain areas of the country. There is a need for people to understand and accept the scientific arguments that justify the measures that have been adopted.

Communicating and convincing

The main thrust of the response, which is admittedly difficult to implement, amounts to disseminating information and messages to explain the causes and consequences of the spread of the disease, to provide people with the means to protect themselves, and to describe the expected evolution of the

¹ Delphine Roucaute, « Les restaurants sont-ils des lieux plus à risque pour la transmission du Covid-19 ? », *Le Monde*, 2 octobre 2020, https://www.lemonde.fr/planete/article/2020/10/02/les-restaurants-sont-ils-des-lieux-plus-a-risque-pour-la-contamination-par-le-sars-cov-2_6054448_3244.html

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disease. Regardless of the content and format of these messages, one segment of the population will be unresponsive while another will be receptive. In between, success will mostly depend on the trust people have in the bearer of the message. Without any understanding of the response and the confidence it can instil, a situation can dramatically deteriorate. In Angola, when responding to an epidemic of Marburg haemorrhagic fever, MSF was accused of bleeding patients and drinking their blood. In Haiti, some fifty voodoo priests accused of spreading cholera were murdered. In Guinea, eight civilian representatives and journalists were murdered during the Ebola epidemic in 2014. And treatment centres were set on fire in the Democratic Republic of Congo (DRC) during the recent epidemic in North Kivu. It is worth noting that this violence is largely attributable to underlying political and financial conflicts, with the epidemic used as an excuse. In France, claims were made on social media that the Pasteur Institute created the coronavirus so that it could make money on the back of a vaccine. Similar claims involve Bill Gates or say the Chinese manufactured the virus in a biosafety laboratory (BSL-4 level) in Wuhan built with French funding. These types of rumours are widespread – and existed long before they ever proliferated on social media.

Successful communication is partly dependent on the accuracy and consistency of the messages delivered. Where this is not the case, information can quickly become a target of criticism and ridicule. Early on in the epidemic, France's Director-General of the Ministry of Health, Jérôme Salomon can take credit for diligently holding a daily briefing. But while the primary indicator mentioned was clearly the number of intensive care unit beds occupied by Covid-19 patients, the message got lost by spelling out information such as a number of cases that we all knew was nothing like the actual number, numbers of deaths that had long excluded those occurring in care homes, and even an inaccurate number of deaths among hospitalised patients². Not to mention that flooding the public with data is not a strategy: it is hard to garner support from graphs.

However, gaining popular support is not just a matter of clarity, it's also a matter of resources. Our experience in caring for patients with tuberculosis has long included a financial component to ensure that screening and care do not burden potential patients or their families. We have thus created incentives in a number of programmes, in the Caucasus, for example³. It is clear that in this area, the European response, and the French one in particular, has forcefully demonstrated this need. Faced with the health crisis and the need to mobilise the entire population in the response to the epidemic, economic support is necessary. The support measures developed by the government since March illustrate this need and, in contrast, explain the delay taken by humanitarians with regard to epidemics in recent years. During the Ebola crises in West Africa in 2014-2015, and in North Kivu in the DRC in 2018-2020, we lamented the lack of support programmes for patients, their families and all those who the humanitarians would have preferred to encourage to go to hospital for testing and treatment. Calling on the French to adhere to the lockdown first required making sure that they had the means to do so.

Science and politics

Medicine and science have served as a basis for some decisions, but this has led to muddled discussions on the role of politicians and scientists. Several researchers from different disciplines publicly complained about scientists having been instrumentalised, not only amidst discussions on the ongoing acquisition of knowledge of the virus and the disease, but also amidst public controversies that were "scientific" in name only. This call to mind the very French debate on hydroxychloroquine and the appearance of Didier Raoult⁴ to the public stage. The chaotic distribution of roles between politicians and scientists is not specific to France. It should be noted, moreover, that even the social sciences are not

² Rémi Dupré et Stéphane Mandard, « Coronavirus : la mortalité en réanimation beaucoup plus forte qu'annoncée en France », *Le Monde*, 27 avril 2020, https://www.lemonde.fr/planete/article/2020/04/27/coronavirus-la-mortalite-en-reanimation-beaucoup-plus-forte-qu-annoncee-en-france_6037853_3244.html

³ MSF, « Tuberculose multirésistante : Soigner les patients à domicile », 4 juillet 2011, <https://www.msf.fr/actualites/tuberculose-multiresistante-soigner-les-patients-a-domicile>

⁴ Pierre-Henri Castel, « L'hydroxychloroquine : quelle(s) controverse(s) ? », AOC, 13 avril 2020, <https://aoc.media/opinion/2020/04/12/lhydroxychloroquine-quelles-controverses>

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immune to these controversies, as illustrated by the discussions following the position taken by the sociologist Laurent Muchielli, a specialist in juvenile delinquency, in support of Didier Raoult⁵. The division of roles is no stranger to power struggles, between knowledge acquisition and decision-making. While the members of the Scientific Council were appointed in March by President Macron himself, there was never any question of the Council standing in place of the government. The statements and opinions given by many doctors (few of whom have, it should be said, any experience in responding to epidemics) in the media and on social networks has contributed to confusing this divvying up of roles⁶.

Furthermore, the credibility of these doctors largely rested on the care they gave to Covid-19 patients. In this regard, they have been the illustration of the very hospital-centred approach taken to the response. An approach that broadly contributed, at least in the initial months of the epidemic, to summing up the strategy as far more a response to an influx of patients than to an epidemic and its multiple components. A similar weakness could be said to have described until recently the responses to the Ebola epidemics, characterised by insufficient attention to bringing the patients physically closer to the healthcare system. The value of relying on peripheral structures, or families, is nevertheless proven, whether responding to a cholera epidemic, or an acute nutritional crisis.

On 15 June, the President complimented the fact that the government had been able to “hold out”⁷, while others maintained that it was the health service that had “held out”. But what does “hold out” mean when 30,000 people lost their lives over a three-month period and nearly half of them had been living in confined places like care homes, where people vulnerable to the serious form of the disease were residing? Or when the virus had spread far and wide among migrants in shelters⁸ and among those living in precarious conditions? Or when hospitals had to massively reorganise their activities to the disadvantage of patients scheduled for planned services? We are well aware of the difficulty of maintaining routine care during out-of-the-ordinary periods. Epidemic disaster situations require activities to be reshuffled based on a triage system¹⁰. In this case, triage gives two results: one to the detriment of patients with chronic diseases, including cancer, or suffering from acute illnesses, heart attacks or strokes, for example, and the other to the detriment of elderly patients.

Many reports will be analysing the response to the Covid-19 epidemic. Lessons will be learned. Our experience has taught us that pitfalls arise as much from an unclear strategy as from unresolved practical and operational details, just as they can arise from a misunderstanding of the non-medical aspects of a response. Another major epidemic, the AIDS epidemic, taught us to revisit concepts, in particular, by having caregivers profoundly redefine their relationship with their patients. The same should apply to the current pandemic. That is, we should refrain from any type of moral judgment, place the decision-making process close to people in order to instil them with greater confidence, reaffirm the importance of citizen participation in the response effort, and give people the means to adhere to this.

If there is one lesson to be learned from this epidemic, it is that biomedicine, scientific research, epidemiology, and the social sciences are all tools to be used in combination. While the crisis is far from over in France and around the world, it is not too late to tackle it.

⁵ Josquin Debaz *et al.*, “Academic debates and the complexity of the hydroxychloroquine controversy”, Montréal, Centre interuniversitaire de recherche sur la science et la technologie, 2020, <https://cirst2.openum.ca/publications/academic-debates-and-the-complexity-of-the-hydroxychloroquine-controversy>

⁶ « “Covid-19 : nous ne voulons plus être gouvernés par la peur” : la tribune de chercheurs et de médecins », *Le Parisien*, 10 septembre 2020, <https://www.leparisien.fr/societe/Covid-19-nous-ne-voulons-plus-etre-gouvernes-par-la-peur-la-tribune-de-chercheurs-et-de-medecins-10-09-2020-8382387.php>

⁷ Élysée, « Adresse aux Français, 14 juin 2020 », <https://www.elysee.fr/emmanuel-macron/2020/06/14/adresse-aux-francais-14-juin-2020>

⁸ MSF, « Covid-19 : une enquête épidémiologique révèle une sur-contamination dans des lieux de regroupement de personnes en grande précarité en Île-de-France », 6 octobre 2020, <https://www.msf.fr/communiqués-presse/Covid-19-une-enquete-epidemiologique-revele-une-sur-contamination-dans-des-lieux-de-regroupement-de-personnes-en-grande>

⁹ « Épidémiologie sociale : santé, inégalité, comorbidité », *France Culture*, 3 juin 2020, <https://www.franceculture.fr/emissions/la-methode-scientifique/epidemiologie-sociale-sante-inegalite-comorbidite>

¹⁰ Jean-Hervé Bradot et Elba Rahmouni, « Le triage », CRASH, 6 avril 2020, <https://www.msf-crash.org/fr/blog/medecine-et-sante-publique/le-triage>

Translated from the French by Alan Johnson

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