Bowen and colleagues’ study, with 508 randomised patients, is one of the largest impetigo studies done so far. Our Cochrane review included 68 randomised trials, with an average of only 82 patients per study, and only one of the included studies had randomised more than 500 patients with impetigo. Additionally, this new study is one of the few randomised impetigo trials done in a tropical setting for the benefit of an underprivileged population. Adherence to the prescribed treatment regimens, and follow-up to day 7 with very low attrition, are also commendable.

Cure rates were compared with those in the study done in Mali by Faye and colleagues, because Mali is a country where impetigo is also endemic and severe. However, the prevalence of disease might be less important for cure rates than for the risk of reinfection and development of complications.

A question not addressed by Bowen and colleagues’ study is whether successful treatment of severe impetigo reduces the risk of developing severe complications such as glomerulonephritis and sepsis, as is often believed to be the case, since this reduction in development of secondary complications is an important motive for treatment.

In conclusion, we believe that Bowen and colleagues’ new study in a resource-poor area makes a valuable contribution to the body of evidence about treatment of an important but under-investigated disease. The option of simple, palatable, pain-free, practical treatment of severe impetigo with co-trimoxazole is a welcome result for Indigenous children living in remote communities in Australia, and provides clinicians and patients with a simple regimen for treatment of impetigo in tropical regions where S. pyogenes is the main causative agent.

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We declare no competing interests.

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Ebola and human rights in west Africa

The fear caused by the Ebola outbreak in west Africa, which is projected to infect some 20,000 people, is understandable. However, the disproportionate measures recently adopted in some of the affected countries are a cause for concern. Some 25 years ago, Jonathan Mann, then Director of WHO’s Global Programme on AIDS, warned world leaders alarmed at the relentless spread of HIV:

“Fear and ignorance about AIDS continue to lead to tragedies: for individuals, families and entire societies... [T]hreatening infected persons with exclusion—or worse—will drive the problem ‘underground’, wreaking havoc with educational efforts and testing strategies. Therefore, how societies treat AIDS virus-infected people will not only test fundamental values, but will likely make the difference between success and failure of AIDS control strategies at the national level.”

Of course, Ebola is not AIDS. Yet two main points in Mann’s warning should inform the response to the present outbreak of Ebola.

First, we must focus on what works for the prevention and treatment of Ebola and avoid disproportionate and coercive measures against communities and individuals.
affected by the virus. Isolation of individuals suspected or confirmed to be infected with Ebola, where necessary and least intrusive, for the purpose of observation, treatment, and avoiding onward transmission is in line with the principles of necessity and proportionality in limiting human rights provided under international law, and reaffirmed in the International Health Regulations. However, some measures adopted in Guinea, Liberia, and Sierra Leone, the three west African countries worst affected by Ebola, go beyond these principles. On Aug 1, 2014, these three countries announced the enforcement of a mass quarantine in vast forest areas around their common borders that are considered the epicentre of the outbreak. The measure was implemented despite evidence that the virus had already passed outside of the quarantined zones. A few days later, Liberian authorities imposed a 10-day quarantine over West Point, the country’s largest slum, with soldiers enforcing the blockade of its some 75 000 inhabitants. On Sept 6, Sierra Leone announced a nationwide mass quarantine between Sept 19 and Sept 21 to allow health workers to find hidden patients across the country.

The unabated spread of Ebola in these countries, despite such coercive measures, suggests that they are not effective in responding to an outbreak that has already spread out of specific areas or population groups. Such measures, rather, violate the rights to liberty and security. In some countries, restrictions to freedom of movement are leading to further human rights violations and humanitarian crises, since people in quarantined zones cannot always access food, health care, or other services. Rightly, the African Union urged member states “to respect the principle of free movement, and to ensure that all restrictions are in line with recommendations from the relevant international organisations.”

Second, we must engage communities and build trust between those affected and health-care workers. The fact that people exposed to, or infected with, Ebola are reported to be hiding from health-care services indicates that suspicion and misinformation are rife in certain areas. In some places, outreach efforts to engage community leaders and to educate the public about the disease remain insufficient.

Residents of West Point, Liberia, wait in a holding area for a consignment of food on Aug 22, 2014

The Ebola outbreak in west Africa is too serious for needed resources to be used for the enforcement of disproportionate and counterproductive measures. The international community and WHO must call for evidence-informed responses that engage communities rather than alienate them. Admittedly, the global response to the present Ebola outbreak has been sluggish. Medical, logistical, material, human, and financial resources must be swiftly mobilised to combat this outbreak, and to support the countries affected in their efforts to build effective health systems after the emergency. Plans by the UN Secretary-General to convene a high-level event on Ebola during the 69th UN General Assembly are laudable. But these efforts should embrace the tested lessons of proportionality, trust-building, and respect for human rights from previous effective responses to infectious diseases.
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