

1 **High subsequent mortality of Ebola virus disease survivors in Guinea: a**  
2 **nationwide retrospective cohort study.**

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25 **Abstract**

26 **Background**

27 The 2013-2016 West African Ebola outbreak left a record number of Ebola survivors, and this has been  
28 added to in subsequent outbreaks. A range of post-Ebola sequelae in survivors have been reported, but  
29 little is known about subsequent mortality of those discharged from Ebola Treatment Units (ETU).

30 **Methods**

31 The Guinean national survivors' monitoring program (SA-Ceint) contacted all survivors and recorded  
32 deaths from December 2015. Survivors were followed up until September 2016, a mean of 21 months  
33 after ETU discharge. Deaths were investigated using verbal autopsy. We calculated the age-standardised  
34 mortality ratio compared to the Guinean population, and assessed risk factors for mortality using  
35 survival analysis and Cox regression.

36 **Findings**

37 Information was retrieved on 1130/1270 Guinean Ebola virus disease survivors (follow-up rate 89%).  
38 Survivors had an over five-fold increased risk of dying, compared to the Guinean population (age-  
39 standardised mortality ratio 5.2, 95% CI 4.0-6.8), a mean of one year of follow-up after ETU discharge,  
40 with no increase in risk for the subsequent 9 months. Mortality rates were increased in all age groups  
41 and were similar for males and females. Of the 59 deaths, cause of death was tentatively attributed to  
42 renal failure for 37, usually based only on reported anuria. Cause of death was unknown for 7. Longer  
43 hospitalisation in the ETU was associated with an increased risk of late death.

44 **Interpretation**

45 The subsequent mortality rate in individuals who survived the acute phase of Ebola Virus Disease and  
46 were discharged from ETU was high. The finding that survivors that experienced longer hospitalisation  
47 had an increased risk of death, may be of help in the set-up of current and future survivors' programs  
48 and the prioritisation of funds in resource-constrained settings. The suggestion of renal failure as a  
49 potential contributor to the late deaths needs further investigation.

50 **Funding**

51 World Health Organization, International Medical Corps and the Guinean Red Cross.

52 **Keywords:** Ebola, Survivor, Resurgence, Surveillance, Guinea, Kidney, Mortality, late death

53 **Research in context**

54 **Evidence before this study**

55 Little evidence exists on the subsequent mortality rate in people surviving Ebola. Up to April, 4<sup>th</sup>, 2019,  
56 we used the following search string for a PubMed search: (Ebola OR ebolavirus) AND (survivor) AND  
57 (death OR mortality). The search yielded 68 citations. Of those, some reported post-Ebola sequelae and  
58 Ebola virus persistence in survivors' body fluids; only one study looked at late deaths among Ebola  
59 survivors, and reported 4 deaths out of 151 survivors who were followed-up for a mean time of 10  
60 months.

61 **Added value of this study**

62 This is the largest study, and the first nationwide cohort study to report subsequent mortality of people  
63 who survived Ebola virus disease (EVD). We report high mortality among Ebola survivors in Guinea,  
64 with an age-standardised mortality rate over five times that of the general population in the first year.  
65 Mortality was higher in survivors who spent longer in an Ebola treatment unit, , possibly highlighting a  
66 higher-risk group within the cohort of Ebola survivors. Renal failure was tentatively suggested as a  
67 contributor to more than half the deaths.

68 **Implications of all available evidence**

69 The increased mortality among survivors is alarming; future studies aimed at establishing whether renal  
70 failure may be a long-term effect of EVD are warranted. This study confirms the high vulnerability of  
71 Ebola survivors, particularly those with more prolonged acute disease, and suggests an underestimation  
72 of the overall EVD case fatality rate.

73

74 **Background**

75 The Ebola virus disease (EVD) epidemic in West Africa caused ~28,616 cases and ~11,310 deaths. As  
76 a result, West Africa has the biggest cohort of EVD survivors (hereafter survivors) in history – over  
77 17,000 individuals.<sup>1</sup>

78 Ebola sequelae were reported by cohort studies of survivors of the 1995 Kikwit EVD outbreak, and  
79 included arthralgia, myalgia, abdominal pain, fatigue, anorexia and late ocular complications.<sup>2-4</sup> Studies  
80 from subsequent outbreaks, including the 2013-2016 outbreak in West Africa, have confirmed that many  
81 EVD survivors suffer from a broad range of sequelae, which also include hearing loss and neurological  
82 signs.<sup>5-10</sup> A large cohort study from Liberia has reported that symptoms such as urinary frequency,  
83 headache, memory loss, fatigue, joint pain and muscle pain were more frequent among survivors than  
84 controls (ie antibody-negative close contacts).<sup>11</sup> Long viral persistence in semen and other bodily fluids  
85 of survivors can occasionally cause EVD recrudescence in the individual, and EVD re-emergence in the  
86 community by infecting other people.<sup>11-15</sup>

87 Despite the extensive literature on Ebola sequelae, little information is available on deaths occurring  
88 after discharge from Ebola Treatment Units (ETU) in cohorts of EVD survivors. A study in Sierra Leone  
89 followed up 151 survivors at a mean time of 10 months after discharge from an ETU and reported the  
90 death of four of them, all within 6 weeks of discharge.<sup>16</sup>

91 Initially, survivors in Guinea were followed up mainly within research-focused cohort studies and no  
92 exhaustive national cohort was established.<sup>9,17-20</sup> The World Health Organization (WHO) advised that  
93 an intensive integrated program was necessary to address the medical and psychosocial needs of  
94 survivors as well as the risk of virus reintroduction, ideally to be integrated into existing routine health  
95 services and facilities.<sup>21</sup> Therefore, the national coordination for the fight against EVD (Coordination  
96 National pour la Lutte contre le virus Ebola, CNLEB), WHO Country office, and its partners, developed  
97 and implemented a community monitoring program for EVD survivors, called SA-Ceint (from

98 ‘Surveillance Active en ceinture’; ie cordon sanitaire), to follow survivors closely with the aim of  
99 avoiding Ebola virus reintroduction into the community.

100 Using these national level data, we estimate the standardised mortality ratio of EVD survivors in Guinea,  
101 describe the potential contributors to the deaths identified during death investigations, and report on the  
102 risk factors associated with death after ETU discharge.

103

## 104 **Methods**

### 105 *Study design and participants*

106 The names and contacts of all eligible survivors were identified from the EVD database managed by the  
107 Ministry of Health (MoH) and partners. All survivors were eligible to participate in the SA-Ceint  
108 program if they were able to show the certificate of medical clearance that they were given at discharge  
109 from the ETU. From December, 2015, the teams of the survivors’ monitoring program attempted to  
110 contact all EVD survivors, and classified them as: i) willing to participate, ii) lost to follow-up, and iii)  
111 reportedly dead. For those who were reported to have died, a field team was in charge of the death  
112 investigation. The closest member of the family completed a verbal autopsy. Verbal autopsy interviews  
113 collect a description of illness and events and a checklist of symptoms. WHO medical epidemiologists  
114 in charge of the death investigation suggested the main contributor to death based on the verbal autopsy  
115 and medical files shared by the family member, when available. Each cause of death was reviewed and  
116 validated by a panel of experts from WHO and the MoH. The survivors who responded were actively  
117 followed up from January 1<sup>st</sup> until September 30<sup>th</sup>, 2016, which corresponded to at least one year after  
118 discharge from the ETU for over 99% of survivors. All participants received a monthly allowance,  
119 including free cell phone with monthly credit, as well as other forms of support (such as rice and flour)  
120 as part of the survivor package.

### 121 *Statistical analysis*

122 For all statistical analyses, we used the official MoH Ebola virus database that was curated in  
123 collaboration with WHO and other partners. This database was used for notification purposes during  
124 the outbreak and reviewed on a weekly basis; it contained complete epidemiological information  
125 available to the MoH and information on laboratory confirmation (yes/no) for all suspected, probable  
126 and confirmed cases of EVD in Guinea.

127 The outcome of this analysis, late death, was defined as death from any cause after ETU discharge.  
128 Independent variables (age group, sex, number of days of hospitalisation, date of ETU discharge and  
129 area of residence) were recorded as at ETU discharge. Categorical variables were reported using  
130 numbers and percentages and compared by the Pearson's chi-squared test. Date of ETU discharge was  
131 divided in four categories based on the median and interquartile range dates. Duration of  
132 hospitalisation was divided in number of days above or below the median. Missing observations for  
133 this variable were included in the Cox regression models as unknown. Survival of the participants by  
134 each independent variable was compared using the log-rank test.

135 For the survival analysis, the observation period was calculated from the date of ETU discharge,  
136 available for all survivors, to the date of death or the date of the end of the SA-Ceint program  
137 (September 30<sup>th</sup>, 2016). All deaths of survivors with unknown date of death occurred by December,  
138 31<sup>st</sup>, 2015. Therefore, we used the midpoint between ETU discharge and December 31<sup>st</sup>, 2015 as an  
139 estimate of the date of death.

140 The standardised mortality ratio (SMR) was calculated using indirect standardization. Since the risk of  
141 death associated with Ebola is likely to decrease over time, we calculated SMR for two different periods:  
142 from ETU discharge until December 31<sup>st</sup>, 2015 (the date by which all deaths with unknown dates had  
143 occurred), corresponding to a mean of 12.6 months of follow-up (range 2 days-23.8 months), and from  
144 January 1<sup>st</sup> to September 30<sup>th</sup>, 2016, a mean of 8.9 months of follow-up (range 1.1-9.0 months) The age-  
145 specific mortality rates in the Guinean population from the third General Population and Housing Census  
146 (RGPH3), National Institute for Statistics (2014),<sup>22</sup> and the number of survivors by age group in the

147 study population were used to calculate the age-specific expected deaths. These were then compared to  
148 the age-specific observed deaths to derive the SMR.

149 A multivariable proportional hazards (Cox) regression model was constructed to identify factors  
150 associated with late death. Variables giving  $p < 0.2$  in the log-rank test were included in the first model,  
151 and variables with likelihood ratio test  $p$ -value  $< 0.1$  were kept in the final model. The proportionality  
152 assumption was checked using the Schoenfeld and scaled Schoenfeld residuals' test and no violation  
153 of the final model's proportionality was found. The goodness of fit of the final model was evaluated  
154 by the Cox-Snell residuals. All tests were two sided with 95% confidence interval (CI), and analyses  
155 were performed using STATA (version 14, StataCorp, LP, TX, USA) software.

156 Analyses were repeated calculating the person-years at risk for those whose date of death was  
157 unknown in two ways: i) as if they all died the day after ETU discharge (shortest possible delay of a  
158 late death), ii) as if they all died on December 31<sup>st</sup>, 2015 (earliest date by which all deaths with  
159 unknown date of death were confirmed). A complete case analysis was also carried out including only  
160 those with known dates of death, and known duration of hospitalization.

161

#### 162 *Ethics approval and consent to participate*

163 This study is an analysis of data collected from the SA-Ceint program, which was implemented  
164 following the guidelines from the WHO Ebola response phase 3 strategic document. The SA-Ceint  
165 program was integrated in the workflow of other research projects, *i.e.* Postebogui, the JIKI trial,  
166 EBOSEX, and Ebola ça suffit vaccination trial, that were all approved by the National Committee  
167 for Ethics in Research and Health (CNERS) before their start. All the participants signed a written  
168 informed consent at the beginning of this study.

169

#### 170 *Role of the funding source*

171 The funders of the study had no role in study design, data collection, data analysis, data  
172 interpretation, or writing of the report. The corresponding author had full access to all the data in  
173 the study and had final responsibility for the decision to submit for publication.

174

## 175 **Results**

### 176 *Characteristics of study participants*

177 We aimed to enroll all survivors of the 2013-2016 EVD outbreak in Guinea (N=1270). Of these, 140  
178 were lost to follow-up (follow-up rate 89%, Figure). Fifty-five individuals were reported to have died  
179 between ETU discharge and when they were first sought for this study, and 4 more died during follow-  
180 up. The characteristics of the survivors, including those lost to follow-up, and those who subsequently  
181 died, are shown in Table 1. The baseline characteristics of those who were lost to follow-up were similar  
182 to those who were followed up except for area of residence and month of ETU discharge (Table 1).  
183 Among those for whom follow-up information was available, half (610) were female and the median  
184 age at ETU discharge was 28 years (range 1 month - 90 years). Twenty-one per cent were from Conakry  
185 (240/1130). The median number of days hospitalised was 12 (IQR 9-15), and was missing for 6% of  
186 survivors (73/1130), because date of admission was missing.

187 Because of the retrospective nature of the cohort study, for 43/59 deaths we only knew that death  
188 occurred between the date of ETU discharge and December 31<sup>st</sup>, 2015. Among the 16 survivors for  
189 whom we were able to retrieve the exact date of death, five died within a month following ETU discharge  
190 (at 2, 6, 10, 14 and 30 days), three died within the first 3 months after ETU discharge (at 53, 57 and 87  
191 days), four died 3-12 months after ETU discharge (at 5, 6, 6 and 10 months), and four more than a year  
192 after ETU discharge (at 16, 17, 19 and 21 months).

### 193 *Age-specific mortality rates and age-standardised mortality ratio*

194 The mean follow-up time for the 1130 survivors was 21.2 months. The shortest follow-up among those  
195 who did not die was 5.4 months, and the longest 32.7 months. Total follow-up time was 1987.4 person-  
196 years. The mortality rate varied by age, being higher in those over 55 (Table 2). To account for  
197 background mortality the observed deaths were compared to the number of deaths expected according  
198 to the Guinea 2014 census.<sup>22</sup> There were more observed deaths than expected deaths at all ages; the ratio  
199 between observed and expected deaths varied by age, but with no consistent pattern (Table 3). It was  
200 highest at age 5-14 and lowest in the under 5s. For the period until December 2015, EVD survivors had  
201 over five times greater risk of death than the Guinean population (SMR 5.2, 95% CI 4.2-7.2, Table 3).  
202 For the period between January 1<sup>st</sup> and September 30<sup>th</sup>, 2016, the SMR was 0.6 (95% CI 0.2-1.4). Those  
203 with unknown dates of death contributed 23.0 person years at risk in the main analysis. Taking extreme  
204 values (assuming all deaths were early or all were late), the SMR for the first period hardly changed  
205 (SMR estimates = 5.4 and 5.1, respectively).

206

#### 207 *Risk factors for late death among survivors*

208 The post-ETU mortality rate was similar in males and females and in those seen at different stages of  
209 the epidemic. It was lower in Conakry than elsewhere, and was higher in those with longer stays in the  
210 ETU (Table 1). We used a Cox regression model to identify potential risk factors for death after ETU  
211 discharge. Age, area of residence and duration of stay in the ETU were independently associated with  
212 mortality (Table 4). Survivors who were hospitalised for  $\geq 12$  days during their episode of Ebola virus  
213 infection had over twice the risk of late death compared to those hospitalised less than 12 days (adjusted  
214 HR 2.62, 95% CI 1.43-4.79). Taking extreme values for the dates of death of those with unknown  
215 dates, and the complete case analysis gave similar results (Supplementary Table).

216

#### 217 *Investigations of cause of late death of Ebola virus disease survivors*

218 We could gather limited information on possible cause of death for 52/59 reported deaths. Unfortunately,  
219 due to data management challenges encountered in Guinea, we were unable to link this information to  
220 each study participant and the medical files reviewed for each death are no longer available. In over half  
221 of the late deaths (37/59), a role of renal failure was evoked by a team of medical epidemiologists who  
222 reviewed the available medical files and the verbal autopsy completed by a family member. Of those  
223 deaths, three were reported by the Centre of haemodialysis of the main hospital in Conakry, where the  
224 survivors were hospitalised when they died. Most of the rest of the purported renal failure verbal autopsy  
225 diagnoses were based on anuria declared by the family or on creatinine levels. Other conditions that  
226 were judged to have a main role in the late deaths were malaria (5) pulmonary tuberculosis (3) high  
227 blood pressure (3), septicemia (1), brain tumor (1), accident (1) and suicide (1).

## 228 **Discussion**

229 Though much is known about sequelae caused by EVD, little was known before this study about the  
230 risk of death among the Ebola virus disease survivors. Here, we report an unexpectedly high mortality  
231 among EVD survivors in Guinea. Among the risk factors we were able to investigate, we found a higher  
232 risk among survivors who had longer stays in the ETU and in older adults.

233 Bower et al. reported four late deaths among 151 survivors from Sierra Leone with a mean follow-up of  
234 10 months (2.6%).<sup>16</sup> This is consistent with our overall risk of death (5.2% with a mean follow-up of 21  
235 months). Mortality rates were not constant over time. All 4 deaths in Sierra Leone occurred within the  
236 first 6 weeks. In our study the date of death was only known for 16: half died within the first 3 months,  
237 and 11 within 10 months. Almost all the deaths (55/59) had occurred by 31<sup>st</sup> December 2015, a mean of  
238 12.6 months after ETU discharge, giving a mean mortality risk of 4.9% by this time. It is possible that  
239 the true mortality rate was higher, as mortality is likely to have been higher among those lost to follow-  
240 up.

241 For the first year of follow-up, the mortality rate we measured was over five times that expected in the  
242 Guinean population, having adjusted for age. For the subsequent 9 months, the SMR among survivors

243 was not significantly higher than in the general population. This is in line with observations from a  
244 cohort study that recruited Liberian survivors on average a year after ETU discharge, and found no  
245 increased risk of death compared to controls.<sup>11</sup> The data we used for the comparison of mortality rates  
246 were representative of the Guinean population and came from the report on mortality of the latest  
247 available census (2014). This census was undertaken by the Guinean National Institute for Statistics  
248 under the technical assistance of experts of the United Nations Population Fund, and published in 2017.<sup>22</sup>  
249 A limitation of the census was that the number of deaths were not based on death records but  
250 extrapolated from the questionnaire given to the census study participants.

251 Although poorer sections of the population, who would have higher background mortality rates, may  
252 have been more affected by Ebola, and so over-represented, this is unlikely to explain such a large  
253 increase in early mortality and is not supported by the mortality rates in 2016 . The lower risk of death  
254 among survivors residing in Conakry may be due to easier access to health care in the city, compared to  
255 non-urban areas. Limitations include that for most deaths date of death was missing, and that verbal  
256 autopsy and clinical data used to determine possible cause of death are no longer available. However,  
257 the distribution of deaths over time, and the possibility that renal failure contributed to over 60% of the  
258 deaths may suggest that the majority were linked to Ebola sequelae.

259 While evidence of the role of renal failure is weak for most patients, it is biologically plausible. EBOV  
260 is often detected in urine samples during the acute phase of the disease because it can infect the kidney,  
261 <sup>23</sup> and EVD patients may develop acute kidney injury. <sup>24,25</sup> Acute kidney injury may lead to longer term  
262 renal failure and increased mortality rates even after initial apparent recovery.<sup>26,27</sup>

263 This analysis used the data collected by the SA-Ceint program, so variables to investigate were limited  
264 to those collected for the program. No information about sequelae or exposure to drugs was available,  
265 so we could not further assess whether treatment was associated with adverse outcome, as tentatively  
266 observed by Etard *et al.* <sup>9</sup> The SA-Ceint program had an almost 90% follow-up rate among the survivors,  
267 which is a remarkable achievement. Of note, Guinea has many fewer survivors than Sierra Leone (over

268 10,000) and Liberia (almost 6,000), possibly explaining why the implementation of a nationwide follow-  
269 up program with such a high follow-up rate may have been possible.

270 However, Guinean health authorities encountered challenges in coordinating such a rapidly  
271 implemented program within a health system that was ravaged by the epidemic. An example is that  
272 although the main contributor to death for EVD survivors was investigated and available for most  
273 deaths, we do not know on which data it was based, and the information to link it to the MoH database  
274 could not be retrieved.

275 This study reveals that post-Ebola sequelae include an increased mortality rate. This demonstrates that  
276 survivors' monitoring programs should be strengthened and should not exclusively focus on body fluid  
277 testing. Moreover, this study gives preliminary evidence that survivors hospitalised for longer periods  
278 may be particularly at risk and should be targeted, and, perhaps, that renal function should be monitored.  
279 Guidelines on how to implement such programs, to be followed by Ministries of Health of affected  
280 countries, are being constantly updated by a pool of Ebola experts coordinated by WHO.

281 Future research should focus on the long-term effect of Ebola virus infection, including on the potential  
282 role of kidney function; illness duration and viral persistence in body fluids should be considered as  
283 potential risk factors in future epidemiological studies.

284 In conclusion, we have shown a five-fold higher age-adjusted mortality rate among EVD survivors  
285 during the first year of follow-up, compared to the Guinean population. This study should be replicated  
286 in Sierra Leone and Liberia, and steps taken to understand, and, if possible, prevent these late deaths.

287

288 **Author contributions**

289 B.D., M.H.D., A.M., I.S.F., K.Y.N., N.M., A.B.D., M.K.K., A.B., M.O.B., R.P., J.R.G., L.S. and M.K.  
290 designed and performed the study. S.M., B.B. and S.C. managed the data. A.O.B and M.S.B provided  
291 documentation for cases hospitalised in the Nephrology department. M.K. and S.S. performed the  
292 appraisal of the program. L.S. and J.R.G. performed the statistical analyses. M.K., P.F., S.V.G., J.R.G.  
293 and L.S. wrote the manuscript. All authors reviewed the final draft. The corresponding author had  
294 full access to all the data in the study and had final responsibility for the decision to submit for  
295 publication.

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