RESILIENCE, COURAGE AND SOLIDARITY

STORIES FROM THE EBOLA RESPONSE

International Organization for Migration (IOM)
The UN Migration Agency

The opinions expressed in the book are those of the authors and do not necessarily reflect the views of the International Organization for Migration (IOM). The designations employed and the presentation of material throughout the book do not imply the expression of any opinion whatsoever on the part of IOM concerning the legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

PUBLISHER

INTERNATIONAL ORGANIZATION
FOR MIGRATION

17 route des Morillons
P.O. Box 17
1211 Geneva 19
Switzerland
T. +41 22 717 91 11
F. +41 22 798 61 50
hq@iom.int
www.iom.int

COVER: A NURSE PUTS ON HER PERSONAL PROTECTIVE EQUIPMENT IN SINJE, GRAND CAPE MOUNT, LIBERIA, IN JANUARY 2015. ©UNMEER/MARTINE PERRET
BOOK LAYOUT: IOM/CARLO MENDES

International Organization for Migration (IOM)

The UN Migration Agency

TABLE OF CONTENTS

THIS BOOK IS DEDICATED TO THE NUMEROUS STAFF MEMBERS WHO SERVED AT THE FRONTLINES OF IOM'S EBOLA RESPONSE AS WELL AS THOSE IN THE SUPPORTIVE ROLES WHO CONTRIBUTED TOWARDS ITS SUCCESS.

But these efforts could not have been achieved alone. IOM is grateful for the strong national and international partnerships that came together as part of the Ebola response, starting of course, with the Governments of Guinea, Liberia, Mali and Sierra Leone. This includes the support from the Armed Forces of Liberia, and Sierra Leone respectively, as well as the Ministries of Health, District Ebola Response Centres, and District Health Management Teams. In addition to working among all of the partners of the UN Mission for Emergency Ebola Response (UNMEER), IOM would like to extend special thanks to the World Health Organization, World Food Programme, UNICEF, Americares Foundation, Concern Worldwide, GOAL, Global Communities, respective Red Cross societies, and Save the Children. IOM extends its special gratitude to International Medical Corps and Médecins sans Frontières for training IOM staff to open the first Ebola Treatment Unit (ETU) and the United States Public Health Services for providing a safety and security net for operations. The funding, expertise and implementation support from United States Agency for International Development (USAID), the Centres for Disease Control and Prevention (CDC), and the United States Department of Defense (DoD) were instrumental in setting up the ETUs and supporting IOM's response throughout. IOM would also like to extend its deep appreciation for the support of partners on key aspects of the response, including the Belgian Development Cooperation, the United Kingdom Department for International Development (DFID), the Government of Japan, the UN Joint Programme on Ebola Virus Disease Preparedness in Ghana, and eHealth Africa Sierra Leone.

FOREWORD

Director General
William Lacy Swing

The Ebola outbreak in West Africa from 2013 to 2016 was one of the largest, deadliest and most complex public health emergencies of our lifetime. With over 28,000 cases — including over 11,300 tragic deaths, spanning Guinea, Liberia, Sierra Leone and Mali — the disease had devastating effects within the region and for many thousands.

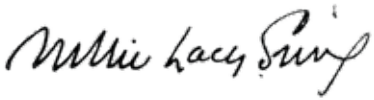
Our staff — from IOM, the UN Migration Agency — were on the frontlines of the response, at times, putting their own lives at risk. Our staff bravely stared down harm's way to focus on doing everything possible to save the lives of those affected and support the communities they belonged to.

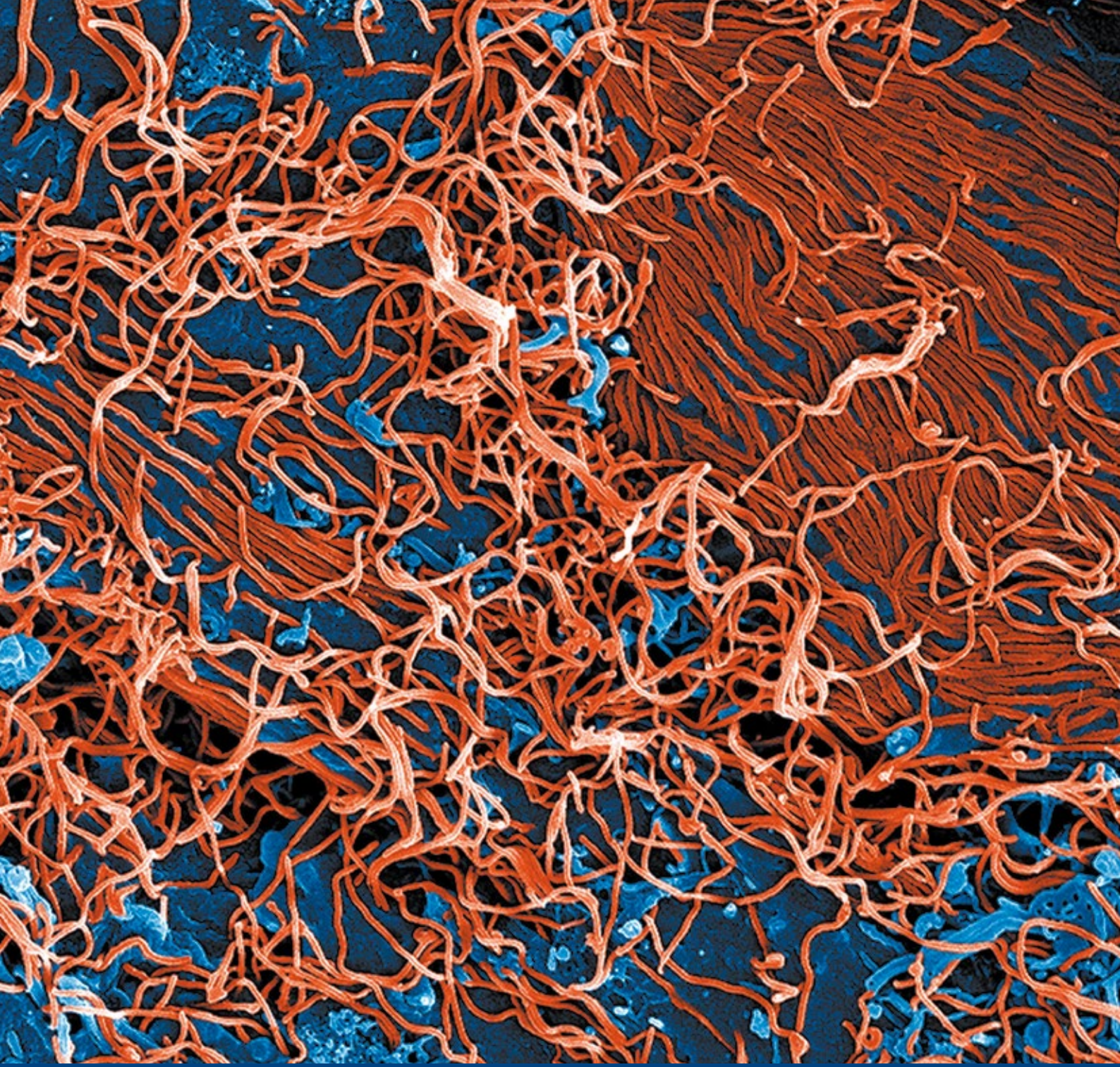
I want to thank every single IOM colleague who contributed towards the Ebola humanitarian response. From setting up and working in the Ebola Treatment Units (ETU) in Liberia; establishing Standard Operating Procedures at international airports in Sierra Leone, Guinea, Liberia and Mali; monitoring flows; rehabilitating key border points in Côte d'Ivoire; to training countless volunteers and health professionals in Sierra Leone, among many other tasks and responsibilities — your work truly made a difference.

In a time of great need and risk, IOM responded in full force bringing specialists from around the world, as well as local expertise, to help those affected and to prevent further spreading of the disease. It took a truly remarkable amount of courage from the men and women to have worked during this time, and for that, I am incredibly grateful.

IOM recognizes your tireless efforts and the deep commitment you demonstrated in responding to this crisis. All of us at IOM thank you.

William Lacy Swing
UN Migration Director General





COLOURIZED SCANNING ELECTRON MICROGRAPH OF FILAMENTOUS EBOLA VIRUS PARTICLES (RED). © NIAID

IOM RESPONDS TO A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN

DR DAVIDE T. MOSCA
Director, Migration Health Division

"IF YOU CAN HELP, YOU HAVE TO"

The 2013-2016 Ebola outbreak in West Africa has been termed one of the largest, deadliest and most complex public health emergencies of our time. It had devastating effects — from the sheer amount of human lives lost, the suffering, fear, mental trauma, stigma, and sacrifices that many had to endure, to the economic, social, and political costs. The last outbreaks in Guinea and Liberia were declared over in June 2016—more than two and a half years after the first reported case. By then, more than 11,300 people had lost their lives, including over 500 health personnel. More than 28,600 individuals had reportedly been infected.

The rapid spread of the epidemic revealed how ill prepared the international community was to promptly recognize the health threat posed, and to mobilize a commensurate response. The outbreak also exposed the lack of adequate instruments to manage the threat in such a mobile world, including in terms of health security and protection.

The threat eventually crossed intercontinental frontiers and reached the shores of countries outside of the region.

In its resolution 2177 (2014) of 18 September 2014, the United Nations Security Council recognized that the outbreak of Ebola virus disease (EVD) in West Africa represented a threat to international peace and security. This exceptional step gave rise to an unparalleled international response. The role of IOM in the response to the outbreak was unprecedented for the Organization, as it became a major actor in the provision of humanitarian health-care responses. Hundreds of staff were deployed to the three most affected countries, namely Guinea, Liberia and Sierra Leone, and also to neighbouring countries, such as Mali, where transmission was low or rapidly contained.

Looking back, I recall the achievements, innovations, commitments and adaptation that IOM displayed. The Organization-wide response was both successful and effective. It was a response built upon the unification of core multi-disciplinary capacities within various health, emergency and migration management models, framed in what I would define as a 'nimble, clinical and public health-competent operational response'.

And yet, despite its long history responding to epidemics and pandemics such as HIV/AIDS, tuberculosis, cholera, severe acute respiratory syndrome (SARS), and the H5N1 influenza virus among others, this was the first IOM-wide response to a public health emergency of international concern (PHEIC). The Organization had yet to realize its full potential to successfully respond to a high-mortality disease outbreak such as EVD in West Africa.

To appreciate how far we came and the tremendous efforts of our colleagues in the field, it is useful to briefly review the process that shaped our response as the situation unfolded. Lessons can be gleaned from our experiences helping to build better health systems in West Africa, and for translating IOM's experiences with EVD into

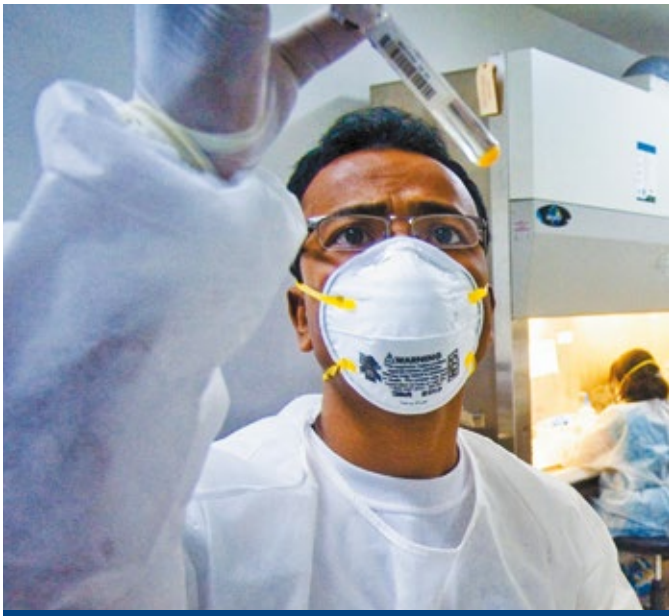
preparedness for future humanitarian crises.

IOM's EVD outbreak response started as early as July 2014 in Guinea, when Dr Lamine Kaba, the only IOM Medical Doctor in the three affected countries at the time, became a member of the Ebola Crisis Committee along with other UN agency representatives. At this point, IOM had neither a response plan nor dedicated resources. Yet, it was evident there were critical mobility dimensions in the spread of the disease. The IOM Migration Crisis Operational Framework (MCOF), which IOM Member States adopted in 2012, recognized health emergencies as grounds for an Organization wide response.

Looking at IOM's history, methods and models, most of our health responses along the pathways of migration and human mobility, including migration health assessments, tuberculosis or HIV inherently bridged global health security with the health protection of individuals. In many cases, this included measures such as quarantine, isolation and treatment of patients affected by contagious diseases, counselling, behaviour change communication, and psychosocial support — domains of intervention that were very relevant to the EVD crisis in West Africa.

At this point in the response, our thoughts on intervention focused primarily on the human mobility dimension. The first course of action was to review relevant IOM programmes with an assisted movement component, such as Refugee Resettlement and Assisted Voluntary Return and Reintegration, to ensure that our movements were taking the precautions necessary to prevent the spread of EVD. Additionally, we examined the safety of staff in the affected countries. We also explored the option of engaging communities in implementing preventive and control measures, such as working with cross-border communities and border health immigration officials. With initial seed funding mobilized by the Director General through the Regional Office in Dakar, IOM looked into enhancing information gathering on population movements, contributing to surveillance activities and need assessments, and engaging with border health and immigration sectors.

IOM MEDICAL STAFF ASSISTING INTERNALLY DISPLACED PEOPLE IN SOUTHERN SUDAN. ©IOM 2007/ MARIO SAMAJA



IOM TUBERCULOSIS LAB IN DAMAK, NEPAL A PART OF RESETTLEMENT PROGRAMME. ©IOM 2009/ KARI COLLINS

IOM WORKING ACROSS SOMALIA SUPPORTING VULNERABLE MIGRANTS. ©IOM 2011/CELESTE HIBBERT.

MIGRANT COMMUNITY HEALTH WORKERS ON THE THAI-MYANMAR BORDER. ©IOM 2006/THIERRY FALISE

By August 2014, the cries for help from health responders soared. The transmission rate was such that, if circumstances had not changed, the spread of disease could have become unstoppable. Borders were ordered closed and communities quarantined. There was a strong push for large-scale "protective isolation" of at risk populations, due to mounting anxiety and distrust. Media and social media networks amplified peoples' fears with images and commentaries of death, suffering and stigma.

Health personnel in the affected countries were near exhaustion, overwhelmed by high mortality rates and the rapidity with which the disease spread. Many health professionals were dying due to the lack of protective gear and effective barrier nursing measures. Many healthcare services were suspended due to the risk of contagion and the few still functioning facilities were transformed into isolation wards for the sick. These were soon overwhelmed and had to refuse patients. These conditions, coupled with increasing food shortages, resulted in mounting civil unrest. In the midst of these trying circumstances, compassion and empathy were put to the test.

World Health Organization (WHO) colleagues involved in Foreign Medical Teams reached out to IOM and shared their concerns on the challenges foreseen in the quarantining of communities, including the risk of displacement and social unrest, which could further spread infection to new locations. There was a need for a surge in the deployment of health responders to the affected countries and for increased identification of cases, greater isolation and treatment capacity and enhanced monitoring of contact cases in order to control and reduce transmission.

On 8 August 2014, WHO declared the EVD epidemic a public health emergency of international concern under the International Health Regulations (IHR) and the UN Secretary General called for a system-wide response. IOM took part in the first formal engagement in EVD response at the Emergency Directors' and Global Health Cluster meetings. The main issues of concern included cross-border movements, information strategies, communication and prevention measures for airlines and airports, given that there were virtually no travel restrictions yet in place.

As both health and operational capacity were needed, on 6 September 2015, the US Agency for International Development (USAID) reached out to the IOM Director General concerning the need to scale up the number of Ebola Treatment Units (ETUs) in Liberia.

A decision needed to be made, and quickly. IOM was already engaged in four other major emergencies but with three countries in the grip of a devastating health and humanitarian crisis that could have expanded beyond control, it was natural to focus on doing everything possible to end the suffering.

On Saturday, 13 September 2015, during a final meeting, the Director General supported the proposal: IOM was in. Two days later, a surge team to set up the ETUs was en route to Monrovia. The first IOM-wide response to a public health emergency of international concern had begun.

THE WIFE OF A POTENTIAL EBOLA PATIENT BREAKS DOWN AS THE USAID-SUPPORTED CASE INVESTIGATION TEAM PLACES THE PATIENT INTO THE AMBULANCE IN FEBRUARY 2015. DEPLOYMENTS SUCH AS THIS, IN RESPONSE TO REPORTS OF NEW EBOLA CASES, HAD SEVERAL CRITICAL COMPONENTS. THE IMMEDIACY OF RESPONSE WAS KEY-MOST CONTAMINATION WOULD OCCUR BEFORE THE PATIENTS COME INTO CONTACT WITH HEALTH-CARE WORKERS. UPON ARRIVAL, THE PATIENT WOULD BE REMOVED, SURROUNDING AREAS SANITIZED, AND FAMILY MEMBERS INTERVIEWED TO DETERMINE, WHO THE PATIENT HAS HAD CONTACT WITH. USAID HAS SUPPORTED THE TRAINING, EQUIPPING, AND STAFFING OF THESE TEAMS, ENSURING THAT DEPLOYMENTS RUN SMOOTHLY AND EFFECTIVELY.

USAID GRAVEYARD AT THE EBOLA TREATMENT UNIT SUAKOKO, BONG COUNTY, LIBERIA ©USAID 2014


In Loving Memory of
MATAMU BEINDA
Sunrise: 1/1/1944
Sunset: 30/9/2014

DR DAVID NABARRO, SPECIAL ENVOY ON EBOLA, LISTENS TO AN EXPLANATION AT THE EBOLA TREATMENT UNIT (ETU) IN SINJE, LIBERIA ©UNMEER 2015/SIMON RUF

IOM STAFF CONDUCTING ASSESSMENTS IN LIBERIA © IOM 2015

TRAINING OF TRAINERS IN KOFORIDUA © IOM 2015

ON THE ROAD TO THREE EBOLA TREATMENT UNITS

ANDREW LIND
Project Coordinator

SETTING UP

When IOM committed to the clinical and operational management of three Ebola Treatment Units (ETUs) in Liberia (Bomi, Grand Cape Mount, and Grand Bassa Counties), funded by the Government of the United States of America, the project team knew they had a steep climb ahead of them.

At the time, there were only a handful of ETUs in the country, and all were either at capacity or overflowing. The IOM team visited ELWA 3, an ETU run by Médecins sans Frontières (MSF), as well as another ETU run by the International Medical Corps in Bong County. The team also visited those under construction by the World Food Programme (WFP), the World Health Organization (WHO) and the Ministry of Health in Monrovia. We did our best to build on the learning of our colleagues and prepare the way for opening ETUs in the three counties.

In consultation with medical engineers from the Armed Forces of Liberia (AFL) and the Department of Defense (DoD) of the United States of America at each site, the IOM team began the process of looking over site plans, discussing flows and structures, and finalizing material requirements for the ETUs. Each day, we would speak with one of the DoD or AFL engineers regarding the details of the ETU construction. Our medical or Water, Sanitation and Health (WASH) team would visit, make a recommendation, or learn something new, and together we would discuss possible solutions with the military engineering teams.

The partnerships paid off. IOM learned from its counterparts, and they improved each subsequent ETU. The Units required complex biosafety protocols that addressed everything from the flow of personnel and patients, to the locations of water points and various necessary chlorine solutions. The ETUs were inspected and approved by the Ministry of Health, WHO and sanitation experts.

Simultaneously, the DoD and WHO supported IOM in training more than 450 staff, and the ETUs opened one after another during November to December 2014.

OPENING

Opening our first ETU—the Tubmanburg ETU in Bomi, in just six weeks, was a proud accomplishment. As the first patients arrived, we phoned the respective military engineers knowing how important the accomplishment was for them as well. We also wrote to MSF and the International Medical Corps, thanking them for their insights and training, for helping us to overcome the learning curve so quickly.

Buchanan, in Grand Bassa, was the second ETU to open, and the Sinje ETU followed thereafter in Grand Cape Mount. The timing of the Sinje ETU opening proved critical: there was a sudden flare up in the area. Within weeks of the ETU opening, IOM, the County Health Team and partners had tracked down every case of Ebola and brought the confirmed caseload to zero. This was only possible through utter dedication and hard teamwork.

UP AND RUNNING

The ETUs worked as a referral point to support the county Ebola response. Under the supervision of the County Health Team, the ETU staff not only received, isolated and treated patients, but also reached out to communities and linked up with partners supporting various other pillars of the response.

For example, survivors were reintegrated back into their communities. When a patient died, we would call on the county burial team supported by Global Communities. They would work with our psychosocial team to ensure that families were safely involved, and that the deceased received a safe and dignified burial. Various partners supported contact tracing, social mobilization, and active case finding. IOM ETU team ambulances reached the furthest corners of the districts, and when there were no cases, they returned to collaborate with partners to monitor hotspots, to ensure that no case went undetected.

At any given moment, IOM had teams of medical and hygiene personnel in the field searching for possible cases, supporting county surveillance teams, training market associations to improve their infection control, or to district nurses to use computers to send better reports.

ETUs ran for 24 hours, on three rotating shifts. Staff had core functions that required training and regular drills. The hygiene requirements alone required up to 20 staff at any given time. IOM had to keep a mandatory readiness to address any flare-ups and save lives. Each county required different and flexible responses. While some still had patients and contacts to follow up with, others focussed on revitalizing the general health services. Teams juggled to conduct hygiene training in advance of re-opening schools, and Infection Control and Prevention (ICP) training for the local county nurses; to establish mobile clinics; and to run immunization campaigns.

All the while supporting the Ministry of Health on the rapid assessments required to revitalize the health system and maintain full readiness to receive new patients.

ETUs were at the frontlines of response and played a fundamental role in the overall Ebola response. In June 2016, the epidemic was officially declared over. The setup, running, and the achieved results of the ETUs, symbolize what can be achieved and sustained through dedication, partnerships, lessons and goodwill.

AS PART OF THE EBOLA RESPONSE IN SIERRA LEONE, IOM'S LEAD TRAINER, GLADYS MBABAZI, ADJUSTS A TRAINEE'S FACIAL MASK DURING A MOBILE INFECTION PREVENTION AND CONTROL TRAINING IN MAKENI IN MARCH 2015. © IOM 2015

(ABOVE AND RIGHT) THE US CENTRE FOR DISEASE CONTROL (CDC) COLLABORATED WITH PARTNERS THAT CONDUCTED IPC TRAINING AT THE NATIONAL EBOLA TRAINING ACADEMY IN FREETOWN, SIERRA LEONE, DURING THE EBOLA RESPONSE. IOM STAFF ARE SHOWN TRAINING FRONT LINE RESPONDERS THROUGH SIMULATION EXERCISES. PATIENTS USED IN THE SIMULATION EXERCISES ARE EBOLA SURVIVORS. © MARSHA VANDERFORD

AN EBOLA RESPONDER SHOWS OFF A HAND-WASHING SIGN AT THE OPENING OF THE SINJE ETU IN LIBERIA. ©IOM

DR PETER GITHUA PUTS ON HIS GLOVES BEFORE HE HEADS TO THE RED ZONE OF AN EBOLA TREATMENT UNIT (ETU) IN SINJE, GRAND CAPE MOUNT, LIBERIA, IN JANUARY 2015. THE FACILITY WAS OPERATED BY IOM IN PARTNERSHIP WITH LIBERIA'S MINISTRY OF HEALTH AND SOCIAL WELFARE AND SUPPORTED BY USAID'S OFFICE OF U.S FOREIGN DISASTER ASSISTANCE. IT OPENED WITH A CAPACITY OF 10 BEDS, BUT RAPIDLY SCALED TO PROVIDE CARE FOR AS MANY AS 50 PEOPLE. THE ETU WAS STAFFED WITH 23 MEDICAL PROFESSIONALS FROM KENYA, SOUTH AFRICA, UNITED REPUBLIC OF TANZANIA, UGANDA AND UKRAINE, AS WELL AS 114 LIBERIANS FROM GRAND CAPE MOUNT COUNTY, LIBERIA. © UNMEER/MARTINE PERRET

DR PETER GITHUA IS ASSISTED IN PUTTING ON HIS PERSONAL PROTECTIVE EQUIPMENT (PPE) BEFORE HEADING TO THE RED ZONE OF AN EBOLA TREATMENT UNIT (ETU) IN SINJE, GRAND CAPE MOUNT, LIBERIA, IN JANUARY 2015. © UNMEER/MARTINE PERRET

A NURSE PUTS ON HER PERSONAL PROTECTIVE EQUIPMENT (PPE) BEFORE HEADING TO THE RED ZONE OF AN EBOLA TREATMENT UNIT (ETU) IN SINJE, GRAND CAPE MOUNT, LIBERIA, IN JANUARY 2015. ©UNMEER/MARTINE PERRET

NURSES HEAD TOWARDS THE PATIENT WARD INSIDE THE RED ZONE OF AN EBOLA TREATMENT UNIT (ETU) IN SINJE, GRAND CAPE MOUNT, LIBERIA, IN JANUARY 2015 © UNMEER/MARTINE PERRET

BOOTS DRY AFTER BEING WASHED WITH CHLORINE WATER FOLLOWING USE INSIDE THE WARD IN SUAKOKO, BONG COUNTY, LIBERIA IN OCTOBER, 2014. THE BONG COUNTY EBOLA TREATMENT UNIT WAS RUN BY IMC WITH SUPPORT AND FUNDING FROM USAID. IT WAS DESIGNED TO ACCOMMODATE UP TO 70 PATIENTS. ©MORGANA WINGARD

HEALTH SCREENING TRAINING FOR BORDER OFFICIALS IN GRAND CAPE MOUNT COUNTY, LIBERIA. ©IOM

HEALTH SCREENING TRAINING IN GRAND CAPE MOUNT COUNTY, LIBERIA ©IOM

TRAVELLER SCREENING IN GBAH, LIBERIA ©IOM

AS PART OF EFFORTS TO REDUCE THE CROSS-BORDER TRANSMISSION OF EBOLA IN WEST AFRICA, IOM LED MONITORING AND OUTREACH EFFORTS ALONG THE GUINEA-MALI BORDER. BORDER SURVEILLANCE ALONG THE KEY POINTS OF ENTRY TO MALI WAS ESSENTIAL TO ENSURING THE COUNTRY DID NOT EXPERIENCE MANY CASES OF THE DISEASE. AT THIS CHECKPOINT IN NOUGANI, MALI, IOM WORKERS LIKE BALY KOURAME REGISTERED THE FLOW OF ALL TRAVELLERS, TOOK THEIR TEMPERATURES, SHOWED THEM PROPER HAND WASHING HYGIENE AND EDUCATED THEM ON HOW TO PROTECT THEMSELVES AGAINST EBOLA. NOUGANI, MALI, ON 5 FEBRUARY 2015. ©UNMEER

ETU WATER SANITATION AND HYGIENE IN BUCHANAN, LIBERIA. ©IOM

USAID IN COLLABORATION WITH MEDAIR, DELIVERING INTERIM CARE KITS TO FAMILIES ACROSS SIERRA LEONE © PALOMA CLOHOSSEY/USAID/OFDA 2015

A QUARANTINED FAMILY RECEIVES AN EMERGENCY INTERIM CARE KIT AS PART OF IOM'S EBOLA RESPONSE IN SIERRA LEONE. ©USAID/CLOHOSSEY

IOM JOINT ASSESSMENT IN PORT LOKO WHARF, SIERRA LEONE ©IOM

IOM SET UP A MOBILE CLINIC TO PROVIDE BASIC HEALTHCARE SERVICES TO A POPULATION OF ABOUT 1400 PEOPLE IN GBAIGBON AND NEIGHBOURING COMMUNITIES IN BOMI COUNTY, LIBERIA, WHO WOULD OTHERWISE BE UNABLE TO REACH A HEALTH-CARE FACILITY. A TEAM OF ONE DOCTOR, THREE NURSES, AND TWO AMBULANCE DRIVERS, WHO HELPED IN SCREENING THE PATIENTS, TREATED CLOSE TO 100 PERSONS ON THE SITE, WITH SOME MORE SEVERE CASES BEING PROVIDED FIRST AID AND THEN TAKEN TO BOMI HOSPITAL. DR NISAR UL KHAK, MEDICAL COORDINATOR FOR THE IOM EBOLA TREATMENT UNIT IN TUBMANBURG, SAID, "UNMEER HELPS IN COORDINATING THE AGENCIES AND NGOS WHO ARE WILLING TO SUPPORT THE MOBILE CLINIC." GBAIGBON, BOMI COUNTY, LIBERIA, IN MARCH 2015. ©UNMEER/SIMON RUF

IOM MOBILE CLINIC IN GBAIGBON, LIBERIA, 2015. ©UNMEER/SIMON RUF

MOBILE CLINIC IN ZAMEYAN TOWN, LIBERIA. ©IOM (TOP AND BOTTOM)

A NURSE GIVING MEDICINE TO PATIENTS IN A MOBILE CLINIC IN ZAMEYAN TOWN, LIBERIA. ©IOM

SIAH TAMBA PUTS ON A LIGHT PERSONAL PROTECTIVE EQUIPMENT. SHE IS AN EBOLA SURVIVOR WHO WORKED AT THE ETU IN SINJE, GRAND CAPE MOUNT, LIBERIA, AFTER LOSING HER MOTHER, SISTER AND DAUGHTER IN JANUARY 2015. ©UNMEER/MARTINE PERRET

SURVIVING EBOLA TO SERVE OTHERS

TEJINIE GOLAFALEY
Tubmanburg ETU Hygienist
and IOM Bomi Psychosocial Assistant

SEPTEMBER 2014

When Ebola came to Liberia, one of my friends became very sick and kept making hiccup sounds. He said to me, "Tejinie, I have been very sick and everyone is saying that I need an herbalist." I thought, "This can't be Ebola. This man is my friend and I don't believe in Ebola." I carried him to an herbalist, who gave him medicine. I also lent him my jacket, which I later wore. A few days later, since members of our community said they wanted him to leave the locality, we enlisted some friends and planned an escape route for him. We were scared of the rumours about Ebola and ETUs. We carried him back to his hometown. Two nights later, he died in his house. If I had not arrived late to the funeral, I would have bathed his body as part of the traditional burial.

Three days later, I started feeling like I had malaria: I had a headache and I was trembling. I called my sister, who is a nurse. By the time I arrived at her home in Monrovia, my skin was hurting. She asked if I had taken part in a burial or had contact with a sick person. I lied. She tried treating me at her house but I was not getting better. She asked me again: "are you sure you did not touch a sick person? Can I take you to the Ebola centre?" I was still afraid of going to an ETU. Instead, one of my brothers helped me get back to the rural village, where I lived. Two days after I left my sister's home, she came down with the virus and was taken to hospital for treatment.

On the way to the village, we approached a checkpoint with soldiers. My brother stopped the car and said to another passenger, "If we take my brother to the checkpoint they will take us to the ETU so that they can kill him". We decided to bypass the checkpoint and took a longer route to reach my village. Although, the outbreak had just started, news had already spread that when a person gets sick they should be taken to a treatment centre. People were afraid to be near me. I heard that they were going to call an ambulance from Tubmanburg to come for me. So a bit later, at around two o'clock in the morning, I took my jacket and left my house. I could only walk a short distance before resting again. The news of my escape had reached the neighbouring community and by the time I arrived, they were already waiting to take me to the treatment centre.

I had heard that health workers were killing people and I did not want to be among the victims. I hid in the bush but I could hear them saying, "this guy is sick and cannot have gone far". I was so thirsty and desperately needed a drink, so I eventually said, "you can take me and join the people to kill me". The man I spoke to was too scared to touch me so he and his friends called an ambulance. I was finally taken to the hospital.

When I arrived at the centre, I refused to go inside and nobody could touch me because they were not wearing personal protective equipment (PPE). They were saying "we are not saying that you have Ebola. We just want to see if you have the virus and help you."

"I SAID TO MYSELF THAT IF I GET WELL, I WILL TRY MY BEST TO HELP ANYONE WHO FALLS SICK."

The first psychosocial support I received was from the ambulance driver, who was waiting outside the treatment centre. "My man you're going to get well. Don't worry we are going to treat you as a patient," he said. At that moment, I said to myself that if I get well, I will try my best to help anyone who falls sick. Health workers were giving us different medicines but the psychosocial support team would talk to us and encourage us to live. Once a guy from the UN peace mission passed by the ETU and asked us if there was anything that we needed. Later that day, he brought us a radio to keep us company.

One day, we heard over the radio that the Government of the United States was planning to send troops to build ETUs. It was like I was in heaven because I believed they would help us stop the virus. But then we heard that people in Monrovia were already receiving help and we worried that they would never make it to Bomi. Some of the patients began to cry, saying no one has time for people in the rural areas.

When the County Health Officer said that IOM had come and they would take care of Bomi, I said, "If I get well, I will do everything I can to help."

My first test results were positive, the second time were indeterminate and finally I was Ebola free.

"YOU SEE ME HERE BUT I AM A SURVIVOR. I SURVIVED EBOLA AND YOU NEED TO KEEP COURAGE SO YOU CAN SURVIVE TOO."

After I was well again, and after extensive training, I started working as a hygienist at IOM's ETU. I used this opportunity to talk to my brothers and sisters who were sick. I was not part of the psychosocial support staff but when we would dress up and go in, I would tell them, "you see me here but I am a survivor. I survived Ebola and you need to keep courage so you can survive too." When the hygienists were getting ready for a round, they started saying, "Tejinie you need to go and give your friends courage". I would say, "no problem", because I knew they will be more encouraged seeing a survivor.

The main thing that impressed me and made me very happy with the IOM team was how well they took care of the patients. When a new patient would come in, people would go to bathe them, give them clothes to wear and the doctors would go check on them. We were constantly going in to see the patients. If the patient called they would urgently send the doctors along with cleaners and sprayers on the hygienist team. Later I decided I wanted to join the psychosocial support team and talk to patients instead of being a hygienist. I began counseling survivors and promoted positive messages about Ebola survivors to help end the stigma and to help them reintegrate back into their communities.

GETTING FULLY EQUIPPED TO TREAT EBOLA PATIENTS

JAMES GITHEGI
Foreign Medical Team Physician,
Tubmanburg ETU

I started working with IOM as part of the first group of medical responders. At the time, it was all over the news that medical personnel were among the victims. Having no prior experience treating Ebola patients, I had a lot of initial internal fears. I had to learn as much as possible about patient management and protecting myself from infection, while still doing the job with a human touch.

I arrived from Nairobi at 4:00 a.m. and by 6:00 a.m., I had set off with other foreign medical staff to join a large group of Liberian health workers for cold training (pre-training) with the World Health Organization (WHO) and Ministry of Health and Social Welfare. At the time, I was afraid of sitting in a hall with 150 people and making physical contact with them. As we sat so closely at small desks, I started worrying that if I touch someone, I could fall from the disease before I even arrive at a real ETU. I remember refusing to eat at the training for the first two days, because I was not sure about the risk. However, after I saw those conducting the training eating, I relaxed. I also learnt that to catch the disease the other person must already be displaying symptoms. This put me at ease and I was then able to freely interact with other trainees.

The cold training ran for two weeks. We were taught about the signs and symptoms of the disease, how to protect ourselves, how to put on and take off protective gear, and the right attitude to have while working in an ETU. We had to practice carefully taking off the gear because contaminated material could be splashed around, posing the greatest risk for staff to contract the disease. We discussed the psychological aspects of working in an ETU, how to have the resources to cope with the challenges, and to assist patients going through the sickness.

At the end of the two weeks, we got our clearance and proceeded to the "hot training", meaning training directly with affected patients. This took place at an ETU run by the International Medical Corps (IMC) in Bong County. Despite receiving the cold training, once we entered the ETU, it really struck us that we were now on the frontline. Walking into the ward for the first time was an unforgettable moment. We put on the full personal protective equipment (PPE), second-guessing whether we got all the procedures right. We double checked to confirm that our faces were covered and that we put on our gloves in the right order. During the hot training, we were taught precautionary measures when dealing with patients. This helped us to shake off excess fears, showing us that when necessary it is ok to touch the patient. It acclimatized us to working in an ETU. For the first few ward rounds, we would simply trail and observe the IMC clinicians as they did the treatment and prescribed medication. We were not yet allowed to touch the patients or handle wastes. By the end of the fourth day, I remember doing my first risky procedure - fixing a cannula for a confirmed Ebola patient. We quickly realized that some of the fears we had were excessive and unjustified. We took part in ambulance operations, sometimes joining the daily trips to communities to pick up patients to be brought to the ETU. Overall, it prepared us for work we would do at the ETU in Tubmanburg, the first of three ETUs to be run by IOM.

When we arrived at the Tubmanburg ETU, we had a week of dry runs under supervision. We used the buddy system where a colleague observes whether or not you are following the correct procedures or missing any steps. That week, we practiced donning and doffing the PPE, the hand washing that was required after handling each patient, and going into the actual wards to treat different patients. This was useful for us because it helped us get used to the extreme heat. With PPE on, there would be almost no ventilation into the body and the environment itself would be very hot. You would easily sweat so by the time you got out of the PPE, your rubber boots would be almost halfway full of sweat.

Then came the day when we transferred the first patients from the community care centre (CCC), a holding centre about half a kilometer away, to the ETU. A team gathered the patients from the centre. We initially had three patients. When we went in to see them, they told us they were grateful to have more space, air conditioning, frequent meals and round the clock medical attention.

> "... THEY APPRECIATED IT MORE WHEN WE, THE MEDICAL STAFF, WERE CLOSER TO THEM, INQUIRED HOW THEY WERE DOING AND DID SOME PHYSICAL CHECKUPS."

The training helped reduce my apprehensions. I was always cautious but as time went by, I became more comfortable and confident. I would try to have reasonable contact with the patients and they appreciated it more when we, the medical staff, were closer to them, inquired how they were doing and did some physical checkups. We found that this improved their experience, helped them cope better with their time at the ETU and probably contributed to their survival.

A TEAM OF LAB TECHNICIANS HANDLES A SAMPLE FOR PCR EBOLA TESTING IN A BIO SAFETY LEVEL 3 GLOVE BOX IN AN EBOLA TEST LABORATORY IN JANUARY 2015. WORKING IN PAIRS ALLOWS ONE PERSON TO FOCUS ON HANDLING THE SAMPLES WHILE THE OTHER PERSON CHECKS THE PROCESS. THE LABORATORY WAS DONATED BY THE DUTCH GOVERNMENT TO IOM AND WAS LOCATED NEAR THE ETU OPERATED BY THE IOM IN SINJE, GRAND CAPE MOUNT COUNTY. IT SERVES THE ETU AND THE WHOLE COUNTY. ©UNMEER/MARTINE PERRET

SOCIAL MOBILIZATION BILLBOARD IN LIBERIA. ©IOM

ON THE FRONTLINE AT THE COMMUNITY CARE CENTRE AND THE EBOLA TREATMENT UNIT

WUBU A MILLER
Foreign Medical Team Physician,
Tubmanburg ETU

NOVEMBER 2014

I first started working at the community care centre (CCC) in Tubmanburg in March 2014.

When our County Health Services Administrator got infected with the Ebola virus, he was taken to Monrovia for treatment. He died. Afterwards we learned that his entire family died. So at that time our County Health Officer decided to advocate for us to have a CCC so we could extend care to our patients. It was very dangerous for the sick to live in the community, so initially the CCC was meant to keep the sick for 24 hours while we called Monrovia to pick them up.

When they built the CCC, people rejected working there because they did not want to risk their lives. Even more, if your parents or friends got to know that you are working in an Ebola unit, they would stay away from you. However, because we saw our people dying, we decided to take the risk and work in the CCC. We started working there using the nursing knowledge that we had, with the help of the doctors and other people around us giving us courage.

As I cared for people in the CCC, I started liking it. When the opportunity came for us to go for training, I was on board. IOM offered positions to some of those working at the CCC because we already had the experience of working with Ebola patients. In October, they took us to Monrovia for a World Health Organization (WHO) training and we started working in the Ebola Treatment Unit (ETU) in November.

After the training, we were aware of the best practices for caring for Ebola patients, how to give them medication and using new materials. At the ETU we took all the standard precautions for infection prevention and control. We were able to detect cases. We started doing a triage of patients and when one came, we knew all the cardinal signs so for us to become infected would have been difficult. Before this experience, we had neglected many infection prevention and control (IPC) rules, including personal hygiene that they taught us like washing hands. Even today, proper hand washing is part of us and what we do.

MOTHER AND DAUGHTER SURVIVORS IN AN ETU IN LIBERIA IN 2015. ©USAID

REUNITING MOTHER AND CHILD: SINJE ETU'S FIRST PATIENTS AND SURVIVORS

ELIZABETH KIRIRI
Foreign Medical Team Physician,
Sinje Ebola Treatment Unit

DECEMBER 2014

I vividly remember the first patient admitted to the Sinje Ebola Treatment Unit (ETU) — she was no ordinary patient. Baby C was a seventeen months old girl, who was brought to the ETU by the County Health Team ambulance on 31 December 2014. It was exactly two days after the ETU had opened to patients. We were told that she had developed a fever after being under quarantine for six days. Her mother had tested positive for Ebola and was at an ETU in Monrovia.

Being our first patient, we were definitely nervous despite having completed the cold training in Monrovia and an extra week in the Bong County ETU. Nevertheless, it was clear how determined we were to make sure the baby was comfortable and received the best treatment. The nurses went into the ward to care for her on an hourly basis because she was so young and on her own. The full protective gear was so hot and dehydrating that a shift of nurses could not stay with her for longer than one hour.

Luckily, three days after baby C was admitted, Siah Tamba an Ebola survivor, who was also one of our expert patient trainers during the cold training in Monrovia, came to visit us at the ETU. We gladly grabbed the opportunity to recommend her to work at the ETU so she could take care of her. Siah joined the ETU nursing team and, as a survivor, she was able to care for baby C around the clock only wearing light personal protective equipment (PPE), which was more comfortable.

The medical team knew that the baby's psychological well-being and her chances of recovery would improve with her own mother's presence. The Medical Coordinator in Sinje called the IOM Medical Coordinator in Monrovia to initiate the process of reuniting mother and child. However, we were faced with a challenge because her mother was not stable and in no shape to be transferred to Sinje, a two-hour drive from Monrovia. By that time, the baby's condition was worsening but we were all determined to make sure she survived the disease. On the sixth day, we got word from the ETU in Monrovia that her mother was now stable and could be transferred to the Sinje ETU. That evening, the team got everything ready to pick her up the next day. One week after baby C was admitted, the ambulance team of two nurses, two sprayers and a psychosocial officer, returned from the ETU in Monrovia with her mother and we all breathed a sigh of relief.

It was joy and jubilation at Sinje ETU when mother and child were finally reunited. To our delight, after her mother arrived, she started showing signs of improvement and changed her eating. She had rice for breakfast, lunch and dinner. This made us all happy since initially she was unable to eat and at one point we contemplated using a feeding tube on her because she would not take anything by mouth.

After three days at the ETU, baby C's mother was in stable condition but her test results were indeterminate. She continued taking care of her baby until 17 January 2015 when her test results were negative and she became the first survivor at the Sinje ETU. Three days later, baby C's results were also negative. By 20 January, both mother and child were discharged from the ETU amid singing and jubilation from all of us at the ETU.

The two survivors returned to their family in Camp 3 village. A survivor follow-up team from the Sinje ETU would visit them regularly to provide psychosocial and medical support. That April, with zero cases in Grand Cape Mount County, the focus on outreach activities, including the mobile clinics, was increased. Through the mobile clinics a medical team would travel out to a remote village and provide free health care. With three mobile clinics carried out in Camp 3, we had the opportunity to meet them again. Both mother and child survivor are doing well in their community and Baby C's mother returned to school after her treatment.

MOTHER AND SON SURVIVORS REINTEGRATION IN SINJE, LIBERIA. ©IOM 2015

EBOLA SURVIVOR, PATRICK POOPEI OF LIBERIA, SHOWS OFF HIS NEW BIKE, OCTOBER, 2014. © MORGANA WINGARD

EBOLA SURVIVORS AT THE EBOLA TREATMENT UNIT IN HASTINGS, NEAR FREETOWN, SIERRA LEONE, WELCOMED SECRETARY-GENERAL BAN KI-MOON DURING HIS VISIT TO SIERRA LEONE, GUINEA, LIBERIA AND MALI, FOUR COUNTRIES MOST AFFECTED BY THE EBOLA VIRUS DISEASE OUTBREAK IN WEST AFRICA, AS WELL AS TO GHANA, WHERE THE HEADQUARTERS OF THE UN MISSION FOR EBOLA EMERGENCY RESPONSE (UNMEER) WAS LOCATED IN DECEMBER 2014. HE WAS ACCOMPANIED ON THE TRIP BY MARGARET CHAN, DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION (WHO); DAVID NABARRO, SPECIAL ENVOY OF THE SECRETARY-GENERAL ON EBOLA; AND ANTHONY BANBURY, SPECIAL REPRESENTATIVE OF THE SECRETARY-GENERAL AND HEAD OF UNMEER. ©UNMEER/MARTINE PERRET

EBOLA: FADING MEMORIES…

(POEM)

ABIGAIL YASMIN KANDEH
IOM, Freetown, Sierra Leone

OCTOBER 2014

It seems only like yesterday that I was sitting down in the comfort of my living room in the United States watching vivid, captivating pictures scroll like crashing waves across the television screen. Memories of utter helplessness and paralysing fear gripped my mind. Awe and dread were quickly replaced by a "tugging" of my heart, redirecting my attention across the Atlantic ocean to my ancestral home of Sierra Leone and the alarming plight of humanity. The fine focus settled on courageous health-care workers united in one accord, toiling tirelessly and relentlessly, in less than ideal conditions to stem the cascade of Ebola's tsunami effect. My heart was moored like a rope to the little children orphaned by this scourge surviving all odds, looking into the future with wide eyes of hope. That was my defining moment. It was at this iota in time, the decision was made to take that step of faith out of my comfort zone, return home to avail of my time, talents and energies to serve and help make a difference to humanity. Providentially, IOM created that unique opportunity for me to train healthcare workers both nationwide and internationally. Under the kind auspices of IOM, a panel of Ebola Survivors from different backgrounds was borne. The stories and experiences of these unsung heroes will remain indelibly etched in my memory- deeds of courage, attitudes of resilience and bonds of solidarity…

INTERVIEW WITH

KALLIE TURAY

Senior monitor, Health and Humanitarian Border Management, Bombali

"I BELIEVE I SERVE MY COUNTRY AND HHBM KEEPS ME ON MY TOES TO DO MORE AND LEARN MORE."

JULY 2015

At the time of the interview, Kallie Turay was a senior monitor with the Health and Humanitarian Border Management (HHBM) project at the Tomparay checkpoint, about six hours north of Makeni, Bombali District, Sierra Leone.

Prior to joining IOM, Kallie had been lecturing on knowledge sharing at the University of Makeni for two years and had a diverse career in print media and development communications. He worked as a consultant with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) on intergenerational dialogue in Kailahun and Kono, as a journalist in Freetown, and with the Network Movement for Justice and Development, a local NGO, conducting advocacy and outreach communications.

One day several years ago, Kallie happened to catch a news story on IOM. In the polished manner of a practiced public speaker, he describes the experience as "profoundly important" and began keeping an eye out for possible job openings while digging deeper into IOM activities the world over that "resonated with my shared humanitarian concerns," he says. "I believe I serve my country and HHBM keeps me on my toes to do more and learn more."

Moving to Tomparay, a small village, to work at a vehicle checkpoint was "a big change with no water or electricity supply and with no phone signal or internet you feel really disconnected" but he says with a smile, "I have no regrets about the move. We built a great team, we shared everything and complemented one another's efforts on the ground."

Kallie sees the need for HHBM activities to continue well past the current Ebola outbreak, "Sierra Leone has very porous borders. Ebola and other infectious diseases, counter trafficking, smuggling and other illegal activities can all be impacted on by our work on border management. HHBM enhances preparedness and resilience. It's like an early warning system."

On IOM, Kallie is unequivocal in his opinion. "In Bombali, it is no exaggeration to say IOM is very visible and has attracted a lot of highly qualified individuals who have performed exceedingly well on its behalf. The organization has become so admired that people are literally climbing over one another to work for IOM."

Kallie believes that IOM is worth working for because it recognizes and encourages staff to grow. As a result of his own hard work and dedicated efforts Kallie has recently been promoted to Acting Sub-office Head and National Project Officer in Kamakwie.

INTERVIEW WITH

CAROLINE CHRISTIANA DAMBA

Tomparay, Tambaka chiefdom, Bombali

JULY 2015

At the time of the interview, Caroline Damba, 26, was working in IOM as a health screening monitor in Bombali District, Sierra Leone. She had been working with local communities for several years. As the communications focal person with the Attitude and Behavioral Change (ABC) Secretariat in Makeni, she was heavily involved in sensitizing local community members on a wide range of issues ranging from health and hygiene to law and order. She brought guest speakers on to radio programmes and to town hall style meetings. An 'Agent of Change' club was set up at a number of local schools to ensure messages were disseminated at all levels.

The Ebola epidemic reinforced Caroline's determination to make a difference in the lives of Sierra Leoneans. In November 2014, during the peak of the outbreak, Caroline began working on a 15-person District Ebola Response Centre (DERC) monitoring team. As Bombali was one of the districts with the highest transmission rates in the country, Caroline's team was responsible for making daily visits to Ebola treatment facilities, holding centres and Community Care Centres (CCC) to report on constraints and challenges.

Caroline is very passionate about field work and sees it as a learning experience that has opened her mind to new cultures and relationships. "IOM is all about aiding vulnerable communities. We are making sure Bombali stays safe by monitoring travellers on the road."

As an IOM monitor, she and her six teammates were welcomed by the local community in Tomparay, Tambaka chiefdom where IOM managed a Vehicle Checkpoint (VCP) as a part of its wider Health and Humanitarian Border Management (HHBM) intervention in Bombali. With the Bombali sub-office located at Kamakwie, IOM staff were deployed with members from the District Health Management Team, Republic of Sierra Leone Armed Forces (RSLAF) troops and Sierra Leone Police at the international border crossing with Guinea at Sanya, Kainaday VCP south of Kamakwie, as well as two ferry ports, every day while the border crossings were open.

Tomparay sits at a major transit route. It links Kambia's Bramaia chiefdom, Tamabaka chiefdom capital Samaya town, and the road north to Sanya and Guinea. On average, 550 travellers passed the VCP weekly. However, the number was lower when Kambia put in place the curfew and closed the markets until Ebola was brought under control. Kambia residents would seek medical care at the large clinic in Samaya town, and this could result in health incidents in Tomparay.

Caroline is firm when she says, "I am working with IOM to come to the aid of Sierra Leoneans. We need to help one another to overcome Ebola and move our country forward."

"WE NEED TO HELP ONE ANOTHER TO OVERCOME EBOLA AND MOVE OUR COUNTRY FORWARD."

INTERVIEW WITH

QUINETTE BANGURAS

Senior monitor, Health and Humanitarian Border Management, Kambia

AUGUST 2015

In 2014, Quinette Bangura would never have imagined she would be managing a team of seven health-screening monitors for IOM in Kambia District. She was a third year student at Zenith University in Accra, Ghana, studying business management and accounting. She had heard of IOM before, but border management and health screening were concepts that had never crossed her mind until an impromptu trip home to Freetown.

"I came home for holidays and I was looking for practical management experience to complement my studies." Although Quinette's grandparents are originally from Kambia she grew up in Freetown with her family.

At the time of the interview, she had been spending the past three months with her team between Gbalamuya and Mange checkpoints conducting health screening and data collection in partnership with the District Health Management Team, Sierra Leonean Armed Forces (RSLAF) and Sierra Leone Police personnel in support of Operation Northern Push.

"I ALWAYS FIND MY WAY THROUGH."

"Health and Humanitarian Border Management (HHBM) is fascinating. It is really surprising to learn that the Guinea-Kambia border is a transit point for travellers from all across West Africa. We have had people come from as far as Senegal, Banjul [Gambia], Mali and Burkina Faso."

Recently IOM Guinea has also begun HHBM activities on their side of the international border. "IOM is a family. We learn from our Guinea counterparts and they learn from us."

When asked about her greatest challenge as a senior monitor she answered said: "Talking to people, to total strangers to get information is the most challenging aspect of my job but it's a great experience."

Quinette has diligently continued her studies in Accra online in the evenings while working to ensure her country stays safe from Ebola. Despite the difficulties she faces every day in Kambia, she says with a smile, "I always find my way through."

INTERVIEW WITH

MANSO KAMARA

Senior monitor, Health and Humanitarian Border Management, Kambia

JUNE 2015

Manso Kamara, 36, who hails originally from Kamakwie, Bombali District, Sierra Leone, worked with IOM Kambia as a senior monitor with IOM's Health and Humanitarian Border Management (HHBM) project. Just prior, Manso, a social worker by training, was working on a project to implement behavioral change at Peripheral Health Units (PHUs) in Kambia with Catholic Relief Services.

At the time of interview, Mansa was managing a team of nine monitors working in shifts beginning at 6:30 a.m. and rotating between Mange checkpoint, Port Loko District, and the Gbalamuya international border crossing with Guinea, which is in Kambia. Both districts were Ebola hotspots. In a bid to end the outbreak, the Government imposed strict security protocols including a curfew as part of its 21 day surge operation known as Operational Northern Push.

Manso said candidly, "our objective is to help the country go through this process to eradicate the menace of Ebola." IOM monitors in collaboration with the military, the police and District Health Management Team staff were responsible for ensuring that each vehicle stops at checkpoints, and that all passengers exit their vehicles so that proper health screening could take place, including hand-washing with chlorine solution, temperature checks and observation for Ebola symptoms.

> "OUR OBJECTIVE IS TO HELP THE COUNTRY GO THROUGH THIS PROCESS TO ERADICATE THE MENACE OF EBOLA."

Manso notes that "the vast majority of travellers expected and complied with the health screening process. However, high level dignitaries, the military and Guineans who entered Sierra Leone who did not have the same training and awareness on Ebola were more reluctant."

Manso's wife, who lived in Kenema with their three children, is the gender focal point for the Sierra Leone Police in the area. On a recent visit to Kambia, she told her husband "your checkpoint is different [in reference to Mange]. This is the difference IOM is making. Instructing everyone to come down from their vehicles and go through the process correctly no matter who it is. They are convincing people to change their behavior for the better."

FIRST EBOLA SURVIVOR TREATED AT SINJE ETU, LIBERIA. ©IOM 2015

SURVIVORS HANDPRINT CLOSING CEREMONY IN TUBMANBURG LIBERA. ©IOM 2015

PHOTO EXHIBIT AT AN ETU CLOSING CEREMONY IN TUBMANBURG,LIBERIA. ©IOM 2015

International Organization for Migration (IOM)

The UN Migration Agency