

## Sierra Leone

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## Sierra Leone January 2015

On the morning of December 29<sup>th</sup> 2014, instead of making my way to work in the Public Health Department (HSE East) based in Dr Steevens, I headed for Dublin airport. Shortly after mid-night having passed through Heathrow and Casablanca airports I landed to the balmy air of Freetown capital of Sierra Leone. The journey from the airport into town augured well – a magical ferry trip across the bay under a moonlit sky with just a gentle breeze. My month's assignment as an Epidemiologist, with WHO as part of the Ebola response, was underway.

Ebola in Sierra Leone hit a country of 6 million people who had endured a protracted civil war (1991-2002), which prior to Ebola had the world's 5<sup>th</sup> highest maternal mortality rate and 11<sup>th</sup> highest infant mortality rate, a country where only 20% of the urban population and 1% of the rural population had piped home drinking water. The majority of the rural population relied on surface water. Such factors had a major impact - health services access, water for personal hygiene, decontamination, quarantine etc in the context of control and prevention of Ebola.

Following briefing I was assigned to Tonkolili (capital Magburaka) one of the 14 districts of Sierra Leone. Tonkolili is located in the centre of the country. It shares boundaries with 7 other districts most of which had ongoing Ebola transmission in January 2015. It is a rural area of 385,322 population with relatively little infrastructure in terms of water, roads, telecommunication etc. I joined the Tonkolili WHO team which consisted of 3 other colleagues (1 Sierra Leonian, 1 Nigerian, 1 Ugandan). Our focus was on breaking the cycle of Ebola transmission. The objectives specified in my contract were to:

- Strengthen support for District Response with emphasis on surveillance and epidemiology.
- Support Ebola surveillance system which inform intervention planning by quality data analysis, interpretation and review.
- Support on-going process evaluation and quality assessment of interventions especially:
  - Alerts/Cases:
    - By ensuring investigation of all cases,
    - By identifying and recommending prevention and control interventions
    - By identifying and seeking remedies to barriers in the implementation of recommended interventions
  - Strengthening Contact Tracing
  - Strengthening Decontamination
  - By identifying and contributing to training and refresher needs of HCWs
- Support data reporting to national level and feedback to the community
- Support the District Response effort through fostering positive relationships with all agencies involved in the district response.

How often does it happen when you get into post that the objectives of your contract seem aspirational or not relevant to the situation on the ground? This was not the case here. These objectives ruled my life, seven days a week for four weeks from the 1<sup>st</sup> informal meeting at 7.30am each day to the last at 7pm each day.

Every day there were three set meetings – 8am, 9am and 5.30am. The 8am meeting was a WHO meeting with the case (alert) investigators. This was held outdoors in the grounds of a college closed because of Ebola. Approximately 15-18 alerts were received by the District Co-ordinating Center daily. These in turn were passed to case investigators who followed up within 24 hours. These alerts were a) all deaths in the district regardless of cause or b) any illness meeting specific criteria. For each alert, the investigators completed a detailed questionnaire plus lists of contacts – in other words they were investigated as if they were cases of Ebola. We, the WHO team went through each of these, identifying unclear information and using it as on the spot training. For their efforts investigators received a daily allowance. Prior to being taken on as case investigator, each attended a 3 day District training course. As one course occurred in January, delivering the epidemiological module was my task.

The next daily meeting was that of the surveillance team at 9am. The initial focus each day was on laboratory results – positive, negative, outstanding -and new suspect or confirmed cases. However, as all other aspects of surveillance were also addressed, this meeting was attended by the myriad of agencies (12+) who had a role in surveillance. Issues about communication, swabs, transport, decontamination, burials, contact tracing, quarantine etc were aired and either solutions found or follow-up discussions scheduled – usually within 24 hours.

Between 10am and 5.30pm my routine varied. Most days I spent time in villages with local leaders, contact tracers and contacts identifying solutions to their challenges eg confining people to houses which hadn't been decontaminated, confining people to houses when they had to go to the bush for toileting, confining people to houses and expecting other villagers to bring them a daily supply of water, usually from river beds in the absence of buckets, expecting people in quarantined houses to wash their hands in the absence of soap, expecting contact tracers, village leaders, villagers to call an ambulance if somebody got sick in the absence of phone coverage, expecting speedy evacuation of sick people from villages when it could take an ambulance over 2 hours to make journey one way on dirt roads etc, etc. Time not spent in villages was on the whole spent meeting with other agencies putting in place solutions to identified problems. Generally solutions were found and implemented within hours/days.

The 5.30pm daily meeting was held outdoors at the District Co-ordination Centre which was run by the army. This was attended by all agencies involved with any aspect of Ebola in the district. Each meeting started with presentation by the army of that day's status of Ebola in the district. The information was concise and precise! It encompassed lab samples, cases, whether suspect or confirmed, and their location, discharges, burials, numbers (adults, children), households, villages in quarantine or discharged from quarantine, food delivery etc. This was followed by a representative from each of the pillars (District/National Ebola response was organised into a number of Pillars) providing a brief update on their issues/challenges. As wandering off the topic or talking other than via the Chair, quickly led a reprimand this meeting ended by 6.30pm. The rest of the evening was spent – after washing and eating – writing reports for circulation prior to next morning's surveillance

meeting on any village made that day, checking day's lab results, responding to National requests and just chatting with colleagues.

By January in Tonkolili, more than 1500 alerts had been fully investigated and entered on the National database. Of these over 600 were cases, of whom approximately 36% had died. From these more than 3,000 people were quarantined. Among the cases were more 20 of our HCWs of whom 75% had died. This in a population of 385,222 - the equivalent of the combined population of Carlow, Kilkenny, Wexford and Waterford.

I felt privileged to be in S Leone. My abiding memories are mixed. I cannot forget the eyes of a severely malnourished child in a village which no longer got food relief as food supplies were only for those quarantined due to Ebola, the almost daily alerts of maternal/neonatal deaths as access to any health service other than for Ebola was almost non-existent, the isolation of a young husband in quarantine sitting alone outside his hut where his wife and newborn 1<sup>st</sup> child had died from Ebola. On the other-hand were the repeated thanks from villagers for coming to help, the trojan work of S Leonian colleagues and other volunteers especially those from other parts of Africa and last but not least the sheer job satisfaction.

In addition to my colleagues in S Leone, I thank WHO, HSE, especially my Public Health colleagues, family and friends who enabled my going.