SIERRA LEONE EBOLA MISSION REPORT

MÉDICOSDELMUNDO

WE FIGHT ALL DISEASES INCLUDING INJUSTICE

DECEMBER 2015

About us

Doctors of the World is an independent association working to implement the right to health for all people, especially those living in poverty, gender inequality, social exclusion and victims of humanitarian crises.

We are a health organization committed to vulnerable and excluded populations as well as victims of natural disasters, famine, disease, armed conflict or political violence. We believe that the right of victims to be attended should prevail over any other consideration.

We are not only active in southern countries, but we also work with groups excluded from the welfare society, especially those who have difficulties in accessing the public health system.

We do not intend to create parallel support systems, but rather our aim is to allow everyone to enjoy adequate health conditions which by right belong to them.

Attending and denouncing

Besides attending people whose rights have been violated we also carry out awareness activities as a means toward social change and denounce causes that are at the origin of injustices.

Doctors of the World is an association directed by partners who participate on a voluntary basis, contributing to its economic maintenance and making strategic decisions about the actions of the organization.

WE ARE

783	people associated with Doctors of the World - Spain (315 men and 468 women)
1.400	Volunteers (363 men and 1037 women)
40.932	loyal donors (20,508 men and 20,424 women)
448	public and private collaborating entities
83	aid workers (32 men and 51 women)
417	workers in countries where International Cooperation projects are being carried out (265 men and 152 women)
185	workers in headquarter and regional offices and autonomous representations (46 men and 139 women)

**"...My tactic is
to talk to you
and to listen to you;
To build with words
an indestructible bridge..."
Mario Benedetti**

THANKS

When last November the WHO officially declared that the Ebola virus had been eradicated in Sierra Leone, many of us felt a kind of liberation. The nightmare had finally ended for thousands of people; the pain, the suffering and the fear, especially the terrible fear of infection and death. The virus left the country with 14,122 cases of people infected and 3,955 deaths. In the whole world Sierra Leone was the site where Ebola most savagely struck an almost helpless sanitarily unprotected population.

We have spent a hard year. We have lived close to the suffering of many people due to the apparent lack of health resources in one of the poorest countries in Africa. We felt the enormous impotence while the international community took their time to react. We have seen how the virus spread with such brutal force and cruelty and we have seen the virulence with which it marched forward much due to the precarious health system.

Finally, only when the Ebola virus emerged in Africa and threatened the safety of other continents, did the international community react as it should have from the beginning.

Doctors of the World had been working for ten years in Koinadugu in Sierra Leone and the Epidemic put the Organization's commitment to the people of Sierra Leone and its health system to the test. It was not an easy decision for Doctors of the World but it was understood that it was our commitment and responsibility to make every effort to mitigate the effects of this health crisis.

Thanks to funding from the British cooperation agency and the generosity of dozens of partners, associates as well as Spanish and international donors we had the good fortune of working with Doctors of the World - UK, at the treatment centre in the districts of Moyamba and Koinadugu taking a different approach.

Thanks to the Spanish coopoeration agency we were also able to work in prevention against the Epidemic in Mali and Senegal.

For an organization like ours the challenge became an opportunity to further believe in our abilities. It was not an easy road, the people and the whole organization were tested in many ways; but it has convinced us that teamwork, building networks and mutual learning can obtain tremendous results.

Therefore, when WHO declared the country free of Ebola we felt the victory for the thousands of Sierra Leoneans who suffered and worked to stop the Epidemic. To a lesser degree we also could sense the victory as being ours as well as being one for the dozens of volunteers and European donors and aid workers who offered their time and generosity. Each one did their best with what they could and knew do. Thank you all.

The health crisis is under control but Doctors of the World is an organization that works with a focus on rights. From this viewpoint inquiry as to the cause becomes essential. The virus itself counts as a necessary cause but it is not the single cause of the Ebola Epidemic. Understanding what happened is impossible without first analyzing the impoverishment of the country and their causes, that is, the social, economic and cultural factors that act as determinants of health and even worse, the situation of the much weakened health system that remains.

Doctors of the World will continue to work in Sierra Leone. We want to add our bit to strengthen the health system, lend support to cover determinant health factors and contribute to making the right to health a reality.

Thank you all very much.

Sagrario Martín
President of Doctors of the World

Growing in adversity

The Ebola Epidemic in West Africa has been a challenge for many months. Primarily it has been a challenge for the Sierra Leonean people who have survived the tragedy through their effort and suffering. It has also been a challenge for the international community, governments, international agencies and Non Governmental Organizations. Specifically, it has been a challenge for Doctors of the World, which had been working in Sierra Leone for ten years at the time of the epidemic began to spread, and which saw itself faced with the decision and commitment to adapt itself to a health crisis of major proportions and unpredictable consequences.

From the beginning, the Organization faced the Project as a great missional and management challenge. Despite initial doubts, which were fundamental to be able to assess whether or not Doctors of the World had the adequate skills to give a professional response to the emergency, we decided to work in partnership with other international partners, who were experts on matters where we were not.

Thus, after the initial discussions and debates, we decided to get involved in this project in the hands of our colleagues Doctors of the World, who were used to working with the British cooperation agency (DFID), not only as a donor but also as a partner in the Project, and also with the Norwegian government and with the French organization Solidarité, which is an expert on water and sanitation in major projects in emergency situations.

Work began with the creation of a special emergency decree, made up of professionals who were experts on Ebola and based on work dynamics in these specific situations.

This meant stepping out of our usual inertia to set up a work group that would allow us to deliver the best possible response and position ourselves on the international map of humanitarian action as a leading player capable of carrying out quality work under emergency conditions.

We faced the task responsibly throughout those months, with our focus primarily centred on the people and the health community of Sierra Leone as an example of an obstacle to be overcome. Likewise, we faced the task with our project partners, who gave us the opportunity to share knowledge plus other ways of managing things and especially learning.

The Ebola virus affected everyone in the organization in this way. It affected those who we have been involved with from the beginning in combating the epidemic in the best way possible, and those who, with more emphasis, undertook the rest of the tasks so that we could focus on this one.

Therefore, this mission has shown us that we are capable of doing well with what we set out to do, with a lot of hard work and dedication, but also with the conviction that Doctors of the World can carry out such wonders as guaranteeing for the people of Sierra Leone the right to fight against Ebola.

Elena Urdaneta
Doctors of the World General Coordinator

Lessons Learnt from the Ebola Epidemic in West Africa: A step backward on the road forward

José Félix Hoyo
Member of Doctors of the World International Operations

Lessons Learnt are comprised of a summary of the activities carried out in an intervention. They attempt to analyze both what was done well and what could have been done better. But more than this, the aim of Lessons Learnt are to analyze what should be done from now on based on the experience gained.

Doctors of the World and Sierra Leone

Doctors of the World began working in Sierra Leone in 2001. Since then, we have come a long way together. Through all these years the commitment of our organization to the communities of Sierra Leone, which goes far beyond intervention in the Ebola Epidemic, has been solid and consistent. For the Doctors-of-the-World teams, Sierra Leone is a very significant country.

Throughout these years of involvement we have conducted more than 14 different projects and worked with the local health system in many various sectors. But above all, our ultimate goal has been to improve the health system and thus allow the people of Sierra Leone to enjoy a longer life expectancy and quality of life, respecting the right to health for its citizens.

The work started in Porto Loko and later moved northward to Koinadugu. Our aim has always been to work with the most vulnerable populations, placing a special emphasis on sexual and reproductive health. In addition to our work in reinforcing primary health care capacity, Doctors of the World has been present in epidemic emergencies such as the Cholera Epidemic of 2012.

Together, Doctors of the World has managed more than 14 million Euros for Sierra Leone on 14 different projects. Unfortunately, more than half of these funds were designated to control the recent outbreak of Ebola, while the world as a whole in two years invested over 6,000 million Euros in the Epidemic.

Nevertheless, reformation of the health systems of the three most affected countries would have cost about 1,500 million Euros over a period of five years.

Recently, a new phase has been opened with the closing of the Millennium Development Goals. These Goals were met with only partial success. Not all were achieved on a regular basis and due to a complex set of reasons some regions of the world have been partially stuck in time. The large majority of disfavoured countries lie in West Africa, the Sahel and sub-Saharan Africa.

Sierra Leone has one of the lowest rates of life expectancy and one of the worst child mortality rates, where one in 9 children never reach their first birthday and one in 6 never reach the age of 5. In addition, Sierra Leone has a maternal mortality rate placing it well ahead of other countries, with one woman out of 91 dying in childbirth. Sierra Leone has one doctor for every 50,000 inhabitants and invests 9.7% of the country's budget on health, not considering private contributions, which means only about 9 Euros per person per year is spent on health care. Even if the investment of 15% of the country's budget, which was committed at the conference in Abuja in 2001, were made the figures allocated would be insufficient to be effective in the implementation of the basic package for essential health services.

In Spain for example in 2013, 5.9% of the budget was allocated for health, which corresponds to 1,309 Euros per person per year. The target figure for the minimum standard to cover a basic health care package is a little less than 90 Euros, far beyond the budget possibilities of poor countries.

Table 1: Health statistics

Life expectancy at birth (male)	45 (2012)
Life expectancy at birth (female)	46 (2012)
Malnutrition prevalence (height for age, children under 5)	44.9 (2010)
Malnutrition prevalence (weight for age, children under 5)	21.1 (2010)
Maternal mortality rate (per 100,000 live births)	1,100 (2013)
Mortality rate for infants (per 1,000 live births)	117 (2012)
Mortality rate for age 5 and under (per 1,000 live births)	182 (2012)
Access to improved sanitation[14]	13% (2012)
Access to improved water	60% (2012)
Births attended by skilled health staff	63% (2010)
Prevalence of HIV/AIDS (age 15-49)	1.5% (2012)

Source: World Bank, http://data.worldbank.org/indicator/SE.PRM.TCAQ.ZS/countries/MW-ZF-XM?display=default

With the obvious budget difficulties that are hard to get around without foreign aid and after many years of hard work, some data, such as an accelerated growth of around 7% and timid advances in health indicators, have provided some improvement in this chronically desperate situation.For example, the maternal mortality rate dropped 10% between 2010 and 2012 and a Prosperity Agenda was proposed with challenges to improve infrastructures and equipment, financing, the control of communicable and non-communicable diseases and to improve the small number of professionals in the health care sector with a set plan and clear objectives.

Intervention in the Epidemic

The Ebola Epidemic in West Africa was officially declared in late March 2014. However, the first case of the disease was discovered much earlier in the small Guinean village of Meliandou in Guéckédou. The official figures of the Epidemic then spoke of 49 cases, but most likely the spread of the virus was already higher. For the first time through the triangle formed by Guéckédou, Kahilaun and Lofa the disease spread to densely populated urban areas like Conakry, Freetown and Monrovia.

More than three months passed before verification was made that the outbreak had spread extensively which would prove fatal in the long run. Early warning systems did not work simply because these systems did not exist. The international community, despite repeated calls for alarm, had an extremely slow response.

Our team in Sierra Leone, in Koinadugu, was just ending a sexual and reproductive health program, funded by the European Union. On the same weekend the Epidemic was declared the team started working on an Ebola Prevention and Learning Program. External references were scarce, even though the discovery of the disease had occurred almost 40 years earlier. Our team initiated the creation of a system for training staff and began making preparations for the possible spread of the Epidemic in Koinadugu, using our recognizable focus centred on the community, anthropological research, working with people, religious leaders and health workers.

The Epidemic spread exponentially in the months that followed, nevertheless, the international community continued to ignore calls for prevention, probably based on experience from previous epidemics that had occurred in rural environments in countries with previous outbreaks. That was in a time where "anything other than treatment has little chance for funding." Over time we realized that controlling the Epidemic had to be addressed using a multivariate approach. Unless all the fundamental pillars of the response were considered, the work would be in vain.

A lot of time was invested in preparation and we worked with our own organizational funds to maintain a preventive response. The Koinadugu district was the last to declare the Epidemic. When it all began, the mechanisms that had been created initially broke down, because with extreme caution it's difficult to cope with fear management to make fear work as an ally. Later, however, these mechanisms served to contain the large-scale spread of the Epidemic within the district. An attempt to compare just how many people were infected with how many would have been infected without such preparation is impossible to say, but indirectly inferred, the influence of preventive intervention was felt.

The proposed collaboration with Doctors of the World - UK and large scale financing emerged in September 2014.

For an organization like Doctors of the World, this marked a major challenge. The determination, extreme solidarity and the commitment of the people of Sierra Leone moved us to make a complex affirmative decision. It was impossible to say no when we could get the technical capacity required and when those in the country have been our friends for so many years. This is our humanitarian mandate. We would be there with minus zero risk. We would be there.

Players in the Intervention

So the huge task of coordination among many actors began which eventually led us to the fruit we have today. The tireless efforts, the drive of the Doctors of the World - UK and the assertiveness transmitted at our meetings during this first period proved to be key to the start of our joint intervention.

Without the financing, availability, support and invaluable assistance from UK's Department for International Development (DFID), and through the work of our partner, Doctors of the World - UK, it would have been impossible.

From Doctors of the World - Spain to both of you, thank you so very much for making us believe it was possible and for giving us the tools to achieve it. As one representative of DFID, a key donor in the intervention summarizing the human spirit behind this collaboration phrased it, "Thanks for being here, even before we thought this was going to happen."

The condition of our presence was linked to the opening of a 100-bed treatment centre in Moyamba. Opening a treatment centre with these characteristics along with an additional three isolation centres in Koinadugu was a huge logistical challenge. But that was not our only difficulty. In September 2014, the international pressure placed on workers moving to the field was almost unbearable. Mechanisms and tools for evacuation or treatment in the case of infection were going through a slow and tortuous development process. Just one error could seriously hinder the goal. One mistake could delay our operating commitment as seen in examples of other like organizations. The pressure within Spanish territory was even greater due to the first secondary infection outside of Africa.

Therefore we had to create stricter specific protocols to protect both our national and international workers and avoid errors. Thank you Doctors Without Borders for your invaluable collaboration in guiding us through the opening and operation of those protocols. Thank you Red Cross for your cooperation in Spain and for your courage in opening the Kenema Centre, heavily providing added experience to other organizations.

We chose the strictest protocols because we knew that in order to sustain a centre we would need a lot of untrained staff. Working against the clock, a system had to be created that would be extremely safe. Thank you Doctors of the World Logistics and Safety Department for doing such a thorough job so quickly.

As in all major emergencies, the responsiveness of a weak local health system was greatly overwhelmed. Hundreds of international workers were needed. The Norwegian Government signed a collaboration agreement with the DFID, even before knowing who would undertake the clinical management of the treatment centre to supply it with sufficient trained personnel. The untiring work and merit of their workers was invaluable. Thank you for carrying out the work involved in planning and execution and thank you for your strength of will and confidence in a difficult context.

The protection of workers at a treatment or isolation centre is mainly sustained by the work of the Infection Control and Prevention Team. Thank you Solidarité and Oxfam International in Moyamba and Koinadugu for being our "washing" part and to all your team for being part of this complex framework allowing us, for example, to open the centre in a record time of 11 days after delivery. Without your selfless effort we would never have achieved an infection-free centre.

Hundreds of international workers travelled to Sierra Leone to assist in various fields in the response to the Epidemic. Each and every one of them should be named for their professionalism and work. Surely without these men and women and without their effort and confidence, control of the outbreak would not have been possible.

Our thanks go out to all the organizations, municipalities and private donors who through their contributions have helped us in this intervention.

Finally, a special mention must be made for the people of Sierra Leone, the real heroes of this story, because without their work to support the health of its people we would not be at this meeting today. I would also like to say on behalf of the international community, in the part that concerns us, we're sorry.

We're sorry we were not been able to sufficiently improve the public health system over the years.

We're sorry we were not able to create a public health system sufficiently capable of controlling the virus in its early stage.

We're sorry for not being able to have worked more and better in the prevention, treatment and control of diseases that have accompanied us for decades. We're sorry for not having created vaccines and treatments and for not having invested enough in primary and public health care avoiding the suffering and predictable deaths.

Mortality of the outbreak in West Africa was close to 60%, however, where there is an early intensive symptomatic treatment, mortality drops below 20%.

The number of cases fell sharply in January 2015 from nearly 1,000 cases a week in the three affected countries to less than a hundred, with the line descending until "Ebola-zero" was reached. But the work does not end there. It's only the end of a paragraph with more to follow.

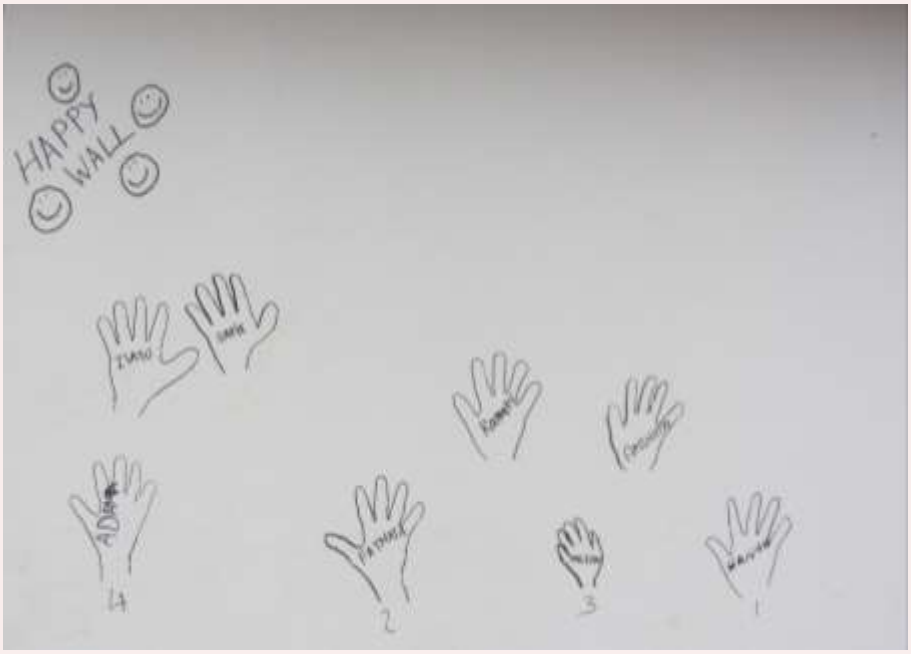
In January 2015 we were finally able to start preventive programs in our projects in Senegal and Mali with funding from AECID.

Today there is a promising vaccine that was developed in record time.

Current panorama

Today, only 50% of the country's health workers are active and 74% of the population believe that the health situation is worse than a year ago.

The virus that killed thousands of people also drove the population away from the health centres for fear of infection. There has been a dramatic reduction in the use of these services in Sierra Leone which is estimated at 70% as compared with the pre-Ebola situation. In addition there has also been a 60% decline in the rate of child immunization and currently only half of the population seeks medical care when faced with a health problem.



More than 3.5 million people are at risk due to the unmet health needs facing the country.

Of the thousands of Ebola survivors, 90% lost family members during the outbreak. On average, each survivor lost approximately five of members. 74% of households affected by the disease lost the head of the family as well as its main source of income.

Those who have survived felt stigmatized in 29% of cases, which amplifies their feeling of loneliness. Fortunately, this rejection decreases over time, so that currently only 13% still feel discriminated against. Local health workers, hygienists and social workers, who have been responsible among the population for raising awareness and for breaking down myths which have no basis in reality, have played a key role in this decrease in rejection. But the society as a whole can still be referred to as being stigmatized.

We have regressed years in the timid progress made. Mortality from common diseases soared during the Epidemic. Only malaria, a treatable disease, produced more preventable deaths than the Ebola itself. Surgical operations within the weak local capacity diminished in some areas to 20%.

Maternal and child mortality rates shot up again due to the lack of trust and assistance in control of the population at risk and the current low capacity of the health system.

The consequences of the outbreak are not yet fully quantified and it will take years to resolve. Now is the time the long work begins to create the necessary conditions so that this does not happen again.

Conclusions

The Ebola Epidemic has brought to light many of the mechanisms that did not function well, such as research, prevention, early warning and response, international health regulations, individual country preparation, the concept of global health security and governance in health emergencies.

The most crucial element to avoid falling back into these serious errors is to improve health systems.

More than anything else, the Ebola Epidemic has again shown that despite the efforts, the right to health today is even more unequal in some parts of the world and certain populations are very vulnerable. Crises are opportunities. Let's not fail to take advantage of them and move on with this sad momentum to place in the world the reality of disadvantaged countries. Our aim is to improve access to health for these populations and we will continue to work toward this goal with the collaboration of all.

If we want to, as was demonstrated in this intervention, together we can do it.

Ebola Emergency Accountability Report

Our Intervention in Moyamba and Koinadugu Districts in the Ebola Epidemic, Sierra Leone 2014-2015, and preventive activities in Mali and Senegal

Ebola Response Unit. Médicos del Mundo

The Ebola epidemic in West Africa 2014-2015

The official declaration announcing the start of the epidemic in Guinea was made at the end of March 2014, although the first contagion was in December 2013 in a very isolated rural area in the south of Guinea near the triple border with Liberia and Sierra Leone. Almost two years have gone by since then.

In the meantime, 28,571 people have been infected, more than 11,000 have died, three health systems are even more in pieces than at the start of the epidemic and three countries have been practically paralysed by fear and by the safety measures for controlling the disease.

In Sierra Leone, the first case was reported barely a month later, in March 2014. Rapidly the virus began to travel all over the country, probably because the focus was in a mining area with a lot of people coming and going, making Sierra Leone the country with most cases, reaching the figure of 14,222 contagions and 3,955 deaths.

For too many months the Ebola outbreak continued to grow exponentially, only to be met by silence and passiveness on the part of the international community, the World Health Organization (WHO) and donors, despite repeated wake-up calls by Médicos Sin Fronteras and other organisations. Efforts to control the epidemic claimed the lives of an excessively large and distressing number of local health workers who, without the means, resources or knowledge necessary about viruses, became infected by direct contact when carrying out their health duties.

On 8 August 2014, that is to say eight months after the first case, by which time there were 1,500 cases of contagion, the WHO declared, for the third time in its history, the "International Pubic Health Emergency". Of course, by then the first European citizens to become infected had been taken back to their home country in the midst of news chaos. Fear had taken hold among European citizenry and the epidemic was out of control.

As of September (coinciding with President Barak Obama's address to the United Nations), response by the threatened international community was massive. Specialised teams from all over the world were mobilised, there was a ready availability of funds, and the whole of the humanitarian sector, government, and even the armies of some countries, assumed responsibility for what was happening, giving healthcare to people who were affected and trying to control the disease. The WHO, highly criticised until then for its passiveness, tried to take on an operational leadership that it had hitherto never held, embarking on coordinating the international response and providing the governments of the countries affected with support.

Sierra Leone was declared free of Ebola on 7 November. Guinea will be (if there are no new contagions) on 28 December. And Liberia, after having been declared free of Ebola on two occasions, confronted its third outbreak in November 2015 with 3 contagions, one death and 150 people in quarantine as things stand today.

The Ebola virus maintains itself in natural reservoirs in the countries that it affects.

Médicos del Mundo in Sierra Leone

Médicos del Mundo has worked in Sierra Leone since 2001, when we opened a mission in the wake of the tragic 10-year civil war known as "The Diamond War". In the meantime we have worked in the country, a fragile state which, despite the macro-economic successes of recent years, many regard as a complex chronic emergency. We carried out Primary Healthcare, Sexual and Reproductive, Water and Sanitation projects, among others, first in the district of Port Loko (in the south west of the country) and since 2006, in Koinadugu (in the north).

Our work model in the country was a classic MDM model: projects for bolstering Primary Healthcare by strengthening the Public Health System, placing special emphasis on Sexual and Reproductive Health and promoting active participation by the community, always from a gender-based and cross-cultural approach.

In June 2014 we were bringing to an end the execution of a multi-year project funded by the European Union that consisted in providing the Koinadugu District Health Office with support to implement the Basic Package of Reproductive Health and Child Health Services that the Government of Sierra Leone had launched as part of the "Free Health Care Initiative" in 2010.

This project had had very good results, and was highly acknowledged by the Ministry of Health and other stakeholders in the sector; mainly, for having managed to get 8 rural health centres to certify the BEmONC (Basic Emergency Obstetric and Newborn Care) standard and for the in-depth community health work that had been undertaken, coordinating a network of over 500 health promotion specialists, health committees, midwives and tradi-therapists.

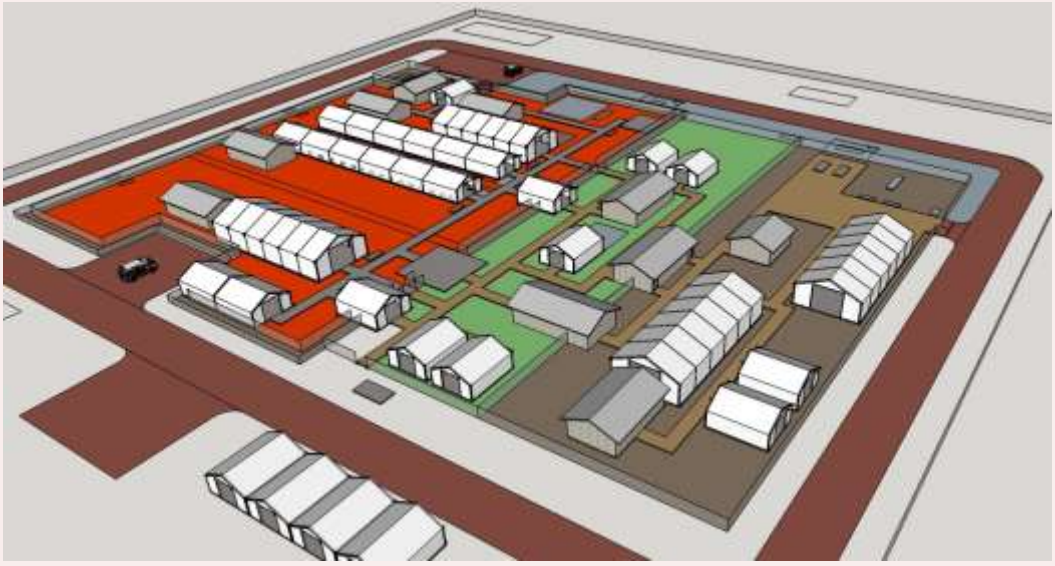
Nevertheless, we were going through serious economic difficulties to give continuity to our work in Sierra Leone, and were weighing up the possibility, after 10 years of presence, of closing the mission in the country. Contacts were being made with Doctors of the World UK to give continuity, through British cooperation, to our projects in the country.

It was then that Médicos del Mundo, faced with the situation that was unfolding in the south-east area of the country affected by cases of Ebola, began to set in motion the first Prevention and Control of the Disease and Social Mobilisation measures in Koinadugu where there had hitherto been no cases of contagion. At just the same time, when the epidemic was declared, an Ebole-prevention effort began in which health authorities, traditional authorities, health personnel took part, under the leadership of the DMO (District Medical Officer), whom we accompanied unconditionally and in a relationship of mutual trust established over the course of years, in the process of preparing the district for the arrival of cases.

The geographical setting of the district (surrounded by mountains), the climatic conditions, the scattered population and the rural context are factors that undoubtedly meant that the epidemic did not advance as rapidly as in the rest of the country. But in this preventive multifactorial casuistry we have to cite without a doubt the work of the Ministry and its counterparts as well as the involvement of the community as an added factor in containing the epidemic in its initial stages.

In September 2014, contacts began with DFID, the international cooperation agency of the British government, through Doctors of the World UK. By then, DFID had become the main international stakeholder in the response to the emergency in Sierra Leone (not only because it was the main funder, but also because of the operational resources deployed) and it had shouldered responsibility for guaranteeing Ebola virus disease treatment for 10,000 patients, which meant opening 10 Ebola Treatment Centres (ETC) country-wide, each with a capacity for 100 beds. DFID offered Medicos del Mundo/Doctors of the World the management of one of these ten ETCs and the funds for that purpose.

After several years engaged in primary healthcare and institutional strengthening, and months engaged in Prevention and Health Promotion in a district not affected (Koinadugu), we added a new intervention model of direct care for EVD- (Ebola virus disease) positive patients in a new district that we did not know: Moyamba. The other pillars for controlling the epidemic were covered by other organisations. The challenge was only just beginning.



Moyamba Ebola Treatment Centre

For Médicos del Mundo España, the decision to go to work in Moyamba providing direct care for Ebola-positive patients was not easy. Not only because of the precautions for and fears of a disease that nobody other than MSF had hitherto confronted directly and on scale; but also because of precautions as regards our operational capabilities to tackle an intervention of this nature.

Eventually, after many hours of reflection and debate, for the sake of coherence, commitment to the people of Sierra Leone and our humanitarian mandate, we took on the challenge.

It also has to be said that DFID gave us some more guarantees. Not only did British Army Royal Engineers build ETCs, neither did DFID only give us funds. They also guaranteed to supply us with disposable personal protection equipment, medicines and other supplies.

The prestigious Center for Disease Control and Prevention in Atlanta, USA, took charge of the laboratory.

The Norwegian Health Ministry had signed an agreement with the British government to provide qualified health personnel for the ETC, and the Sierra Leone Health Ministry (which until then had taken on the complete response) gave in and facilitated the presence of healthcare and non-healthcare personnel to make up the rest of the team.

We came to an agreement with the French NGO Solidarités International, an expert in water and sanitation, to complete all the WASH management of the ETC while Médicos del Mundo focused on the clinical management.

All the pieces slotted into place in record time. Médicos del Mundo would assume the leadership of a complex and powerful multidisciplinary international team capable of covering all the services that the centre called for.

Moyamba Ebola Treatment Centre started operating on 19 December 2014. With a total capacity for 100 beds, which could be opened progressively according to what the epidemiological needs called for.

Under Médicos del Mundo coordination, the staff at the centre was made up of on average 35 expatriates in 6-weekly turnovers, and around 150 workers from Sierra Leone. Altogether 106 "Ebola-suspected" people were admitted, 33 of whom proved to be laboratory-confirmed positive. There were 24 deaths and 82 people were released, with 8 re-admissions. 15 people survived, which means that the death rate from the disease in the ETC in Moyamba was 45%.

And cases appeared in Koinadugu. The Holding Centres open.

In Koinadugu we continued working on our regular programme and the EU (European Union) agreed to allow us to use part of its funds for Ebola prevention in our area of intervention, namely the whole district of Koinadugu. For a large part of the year it had remained Ebola-free, but the first case turned up at the beginning of October in the chiefdom of Nieni, an area where MDM had done a lot of work and which we knew well.

Then, the DERC (District Ebola Response Consortium) arranged for an Isolation Centre to be opened in the village of Kumala.

Initially, the Primary School of the locality was used as a Community Care Centre, that is to say that the community itself had to cope with isolating and provide basic care for Ebola suspects.

It was evident to Médicos del Mundo that the community was not prepared for this and that this format increased the risk of secondary contagions. As of the end of November, the Ministry of Health and its counterparts –Médicos del Mundo (clinical management) and Oxfam (wash management) -, transformed it into a Holding Centre, ie. an Isolation Centre .

The medical teams made up of local health personnel, the African Union, personnel from Médicos del Mundo and Oxfam took charge of screening according to the case definition, isolating probable cases of Ebola and reporting work progress to the DMO in Koinadugu.

In a Holding Centre, suspect cases are kept isolated until a case of Ebola is confirmed or ruled out by laboratory by means of a PCR (polymerase chain reaction).

In the centre, samples were taken and sent for analysis to the nearest laboratory in Makeni, 200 kilometres away. Once the results had been received, the people with positive results were referred to the ETC in the same city. The average stay by patients admitted in Kumala was 4-5 days. While they were in the Holding Centre, the patients received support treatment as if they were confirmed Ebola cases (antimalarials, antibiotics, ORS, paracetamol).

Within the same consortium funded by DFID, a new Holding Centre, the "New Kumala", was built, with the same format as a ETC and capacity for 15 beds as the school that had been functioning up until then did not fulfil the Safety conditions that were required.

Later on, a second Holding Centre was built in Kasumpe, 5 kilometres outside Kabala, the capital town of the district. The aim of that second isolation centre, with conditions similar to the one in Kumala, was to avoid suspect Ebola cases from entering the crowded Kabala Hospital and isolate them in a safe place. Kabala Hospital had been out of operation for 21 days because of inappropriate management in the admission of a positive case.

Altogether 170 people were admitted at the Holding Centres in Koinadugu, 70 of whom were positive and referred to the reference ETC to receive full treatment. There were 24 deaths of patients waiting for confirm PCR and be able to be referred. Of those deaths, 16 were caused by the confirmed virus and 8 by other causes not attributable to Ebola.

Apart from that, as had been done since June 2014, work continued on Prevention and Control of the Disease and on Health Promotion through joint planning with the DMO in which working groups were set up that developed the disease control pillars.

That programme that takes place to this day simultaneously all over the country through the Ebola Response Consortium, a partnership with the local Ministry of Health of around 15 international organisations, of which each one is an implementer in a district.

Médicos del Mundo took on this role in Koinadugu. The project had tried, since its beginnings, to improve hygiene conditions, biosafety and prevent the expansion of the disease in the 70 rural health centres of the district and in the communities of the areas most affected.

Training sessions were held with the health personnel and supervisions in secure diagnosis, differential symptoms, epidemiological surveillance, isolation of suspected cases and safe referral. Work was also done on health education with the community and on reinforcing community epidemiological surveillance and rapid alert systems. This project will continue to operate until March 2016.

Two projects with different beginnings that converge

In Moyamba, the measures put in motion in collaboration with the Ministry of Health and with other organisations present in the area gave a result surprisingly rapidly. The number of cases did not increase and remained at what would be expected of a rural community. At the same time, as the pressure of the cases imported from the west decreased (as a consequence of rolling out the intervention country-wide), the ETV in Moyamba was put on standby in April 2015.

The project was altered and new community activities were added to the excellent work done by other organisations. The first of them to be put into practice was psychosocial intervention. The Psychosocial team had had a very important role within the ETC giving support to the patients, their families and accompanying those who survived when they returned home.

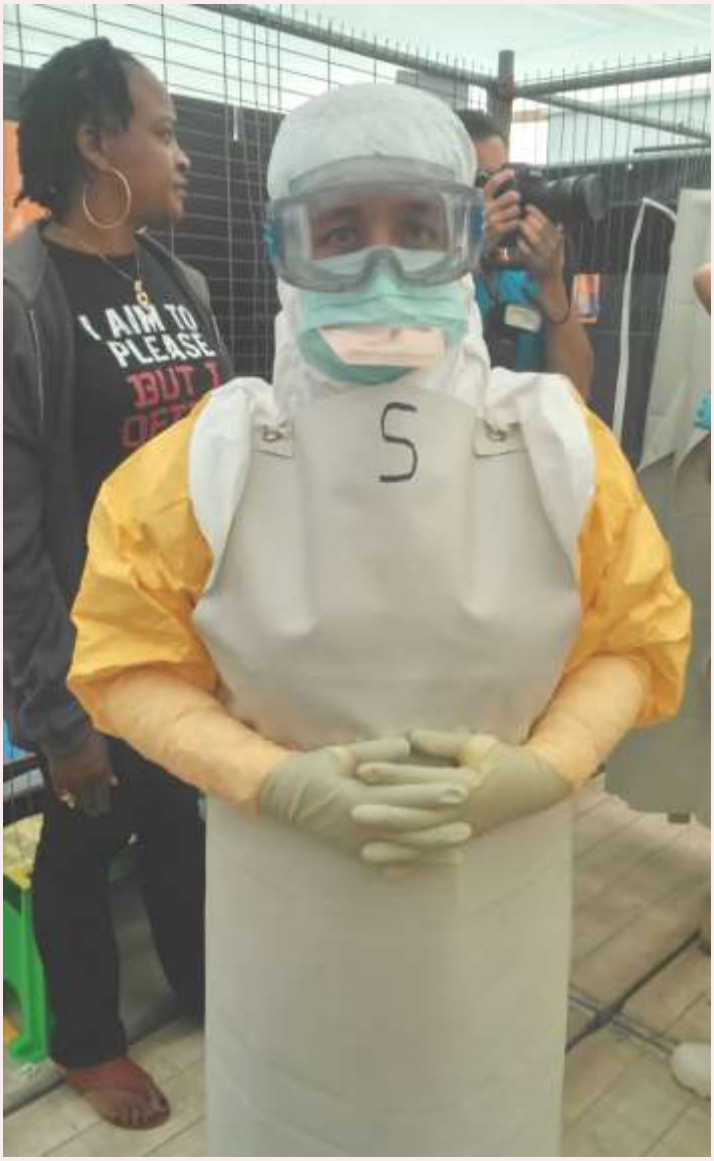
As a result, they knew us and we were accepted. Work began in the communities most affected to strengthen the social-community fabric.

Ebola was not only bringing contagions and deaths, but also fears, mistrust and discrimination. Workshops began to be held to explain the disease, banish myths and rumours, recover mutual trust within the community, and reinforce acceptance and confidence in the health teams (local and expatriate) that up to that point have been lost.

Training sessions began to be held in rural health centres as well, similar to the ones that were held in Koinadugu on Disease Prevention and Control. Training sessions were held on hygiene, differential diagnosis, clinical diagnosis and case definition, safe care for possible patients, among others, always related to Ebola specifically and infectious diseases in general. In a third phase safe care in sexual and reproductive health in an Ebola context was addressed, as well. It has to be remembered that many pregnant women were not cared for by the health personnel, as the risk of contagion increased because there are so many fluids during childbirth.

The vaccination campaigns were supported. Since Ebola was declared, vaccination was deemed a drastically interrupted risk practice. For almost a year, no vaccinations were administered. The real impact that this could have had on child morbi-mortality is not known, but there proved to be a dramatic increase in the child mortality recorded, with probably worse real data than those notified.

Three weeks after the ETC was put on standby, the centre resumed operations, this time with the functions of an isolation or Holding Centre, with exactly the same characteristics as the centres we operated in Koinadugu. During this second phase, 43 suspected cases were admitted at Moyamba Holding Centre, all of which were negative.



Support was given to the Moyamba District authorities in the “Back to School” campaign for getting girls and boys to go back to having classes in the schools safely. Hygiene measures were put in place; teachers and pupils were given training, and work was undertaken with the psycho-social team on how to manage education during Ebola. One of the effects of the epidemic was the increase in sexual abuse and child sexual exploitation, leaving the girls, mainly, in a situation of particular helplessness in these situations.

Finally, we had technical means at our disposal and some resources to support the district authorities, the District Ebola Response Committee and the District Health Medical Team, in coordinating the response at district level.

For their part, in Koinadugu, halfway through the year we added psycho-social actions to the operations in the Holding Centres and the Prevention and community mobilisation activities, and institutional support to the DERC and DHMT (District Health Medical Team).

A situation study was conducted in both districts on the situation of the people who had survived the disease from the clinical, psychological and social viewpoint. The studies had a lot of impact at national level and on the basis of them the WHO and the Ministry of Health put in motion a Comprehensive Care Programme for Survivors.

Médicos del Mundo played a very important role in this respect, and was the reference organisation in both districts.

Mobile clinics for caring for survivors were set up. Support was given to the national programme for screening Uveitis, a degenerative ophthalmological disease highly prevalent among Ebola survivors that can lead rapidly to blindness.

A system of referrals to Connaught Hospital in Freetown, a reference centre for survivors with complications, was created. And the provision of psychological care to survivors, relatives and relatives of non-survivors continued, working on their integration and acceptance in their communities and undertaking advocacy concerning their living conditions.

To summarise, in Moyamba, MDM started in a new district with a care project included in the framework of global intervention and little by little it integrated into the other non-hospital activities.

In Koinadugu, MDM, which had been working for several years in the district, embarked on its intervention in Ebola from prevention and health promotion in primary care and at community level but the appearance of cases led to the response being extended with the clinical management of patients in Holding Centres.

We reached the end of the Ebola epidemic with two identical projects in both districts that combine a series of care actions with others of institutional strengthening and community empowerment.

The response to Ebola in Sierra Leone in its 4 Phases

Throughout the epidemic, actions at national level were divided into 4 phases: acute emergency, 0 Ebola, early recovery (currently) and recovery (a period of two years until the end of 2017).

Probably, one of the greatest successes of MDM-DoTW in the response to Ebola was our flexibility and capacity to adapt to each phase of the emergency in accordance with the conditions of the context, different in both districts, according to the epidemiological evolution and to the needs for action from a public health viewpoint.

Another deciding factor was that since the start of the emergency, we had and have a clear idea about where we want get to. During the acute emergency phase, we had a clear idea of the objective: to provide healthcare to the affected persons and control the disease.

The second “0 Ebola ” phase was the moment of greatest uncertainty. Whereas in Koinadugu and Moyamba we had had no cases for months, other districts continued to report contagions. Clinical support was given to the ETC in Port Loko.

The national policies were to carry on working exclusively on controlling the disease. At operational level, this meant maintaining some Ebola-context actions and measures, without any cases in our districts, but being witness to how the health system had collapsed and could not solve the population’s most basic health needs.

Currently, now in the early recovery phase, we are starting work on re-establishing the basic health services, maintaining active and efficient epidemiological surveillance measures. It’s a matter of creating a response and isolation system against infectious diseases with epidemic potential, whether it be Ebola or any other disease that requires compulsory communication (it has to be remembered that Sierra Leone is endemic in cholera- and lassa fever-endemic).

The health indicators of Sierra Leone show a backward movement to post-war levels, 10 years back. Just to give an example, maternal mortality is the highest in the world, being estimated at a ratio of 1360 maternal deaths per 100,000 live births. Since the epidemic was declared, we knew that its impact on the health systems would be very high, and that once Ebola had passed we would have to work very hard to regain the efforts of the past, and re-establish health services, at the best of times shaky and insufficient.

It has been clear in our minds since before the emergency that the role that we want to have in this recovery phase is that of strengthening the public health system in Moyamba, Koinadugu and other districts if necessary over the next few years.

It is our way of carrying out humanitarian action, responding in the emergency, transiting the continuum towards development and making a mark on the structural causes that create vulnerability. And this is our operational aim in Sierra Leone and our commitment to the population and its authorities.

MDM approaches, our added value to response in the country

Although the mission was framed in a very specific emergency as was Ebola, and the response required, above all in the care components, a vertical intervention under very strict safety conditions, the approaches that constitute the distinguishing marks of MDM in humanitarian action were taken into account at all times.

From the human-rights approach, supporting the Ministries of Health to guarantee the conditions that ensure people's right to health forms part of our mandate.

In Koinadugu, we already had a position very close to the health authorities in the district and we have worked closely at all times. In Moyamba, we were a new player and we worked to create this space of trust. In order to fall in line, we shared information, favoured the empowerment of the DMO and strengthened his leadership so that he can work on promoting and defending the right to health of the population.

In this framework of institutional reinforcement, particularly important pieces of work were undertaken such as the Health Needs Assessment which was led by DoTW, both in Moyamba and in Koinadugu.

With this assessment, the District Health Offices could make the impact that Ebola had had on the health network visible, with data based on the facts. Its conclusions were not only useful for getting to know of the public health emergency that has taken place in the shadow of Ebola, but also for impact as regards donors, multilateral agencies, government, among others, both on our part, and on the part of the Director of District Health who made the report his own.

We collaborated very closely with the local authorities. An effort was made to involve, ask and explain to the community everything that had to do with our activities in order to rely on their participation.

A large number of activities were carried out In both districts: group discussions, ceremonies, always with a view to breaking down the acceptance barriers that the personal protection teams had. Special attention was devoted to certain activities, such as burials or work with survivors.

Very specific nuances were taken into account as well, such as the confidentiality of patients. Those who survived the disease, who found themselves in positions of great vulnerability, discrimination and instrumentalisation, were given special support.

We strived to reinforce their dignity, recognition, integration and access to indispensable aids for their maintenance. The fact that we have contributed to the Association of Survivors of the District of Moyambe being set up in Moyamba is proof of that.

We incorporated the psycho-social approach in among the centre's care services. A team was put together, made up of local personnel trained and coordinated by an expatriate psychologist. To start with, the functions of this team were to provide patients and their families with psycho-social support; and to monitor how the expatriate teams felt, in an environment of great stress and uncertainty.

This was the gene of what was to become the Psych-social Team and of our psycho-social work in the communities.

As for the gender approach, although Ebola is known to have had a fairly balanced impact among infected men and women (45% - 55% according to Unicef), it has been detected that mortality was considerable higher among the women because, as we explained at the beginning of this document, their role as carers and the persons responsible for the household meant that they were admitted to healthcare later with the disease in a more advanced state (giving priority to their family's health and in the last instance to their own).

Unfortunately, in more vulnerable groups such as Ebola-infected pregnant women, mortality had a dramatic reach, there is talk of 90%, owing to the fact that childbirth healthcare was deemed a risk practice.

For a large part of the year, childbirth situations were no longer dealt with, particularly the complicated situations, at health centres and hospitals.

The first ETC for pregnant women with Ebola was only opened at the beginning of this year.

Currently we are conducting an Evaluation of Gender in the Response to Ebola with a view to assessing sensibility to gender in the management of cases, the action protocols and in the design and functioning of the ETC in Moyamba.

As regards the crosscultural approach, we have also tried to make the "Ebola" facilities, both the ETC and the holding centres, culturally acceptable as far as possible, considering the safety measures that the intervention required.

We took into account how people passed from traditional medicine to scientific medicine, working with tradi-therapists, and we had special respect for the funeral practices of the population, seeking mechanisms for adapting them to public health needs. To achieve our aims, particular care was taken over sensitisation messages.

Preventive activities in Mali and Senegal

The first cases of Ebola were announced on 29 August 2014 in Senegal and on 17 October 2014 in Mali. After that, new cases were reported and some deaths in the two countries. This is the context in which, relying on the support of the WHO, the United States' Center for Disease Control and Prevention (CDC) and a large number of international stakeholders, the National Contingency Plans for the response to the epidemic were updated, and training actions were then put into practice for health personnel and communication actions for the populations. Despite all these efforts, the geographical situation both in Mali and in Senegal placed both countries in a highly vulnerable position as regards the spread of Ebola.

Médicos del Mundo had been working in the Districts of Bafoulabé and Kenieba (Malí) and Sédhiou (Senegal) for more than 8 years in the context of strengthening the public health systems to improve primary care and the Sexual and Reproductive Health programmes.

The "Prevention of the Ebola epidemic in the Kayes region in Mali and in the south of Senegal" project that was put in motion, funded by the AECID, in December 2014 and for a period of 6 months, was set out with an approach that was fundamentally preventive and of preparation for the response, with a view to providing the population and the public health services with the means to prevent possible cases of Ebola.

Through these two plans of action, it was hoped that the population would have enough information on how to avoid contagion and that health services professionals would have the basic skills and material means necessary to carry out early case-detection tasks, and appropriate epidemiological monitoring and disinfection in the places of origin, etc.

As usual, this project was worked on in partnership with the Malian and the Senegalese Ministry of Health through two health districts in Mali (Bafoulabé and Kénieba) and two in Senegal (Sédhiou and Kédougou).

The Ebola Mission in numbers

9 M€

9 MILLION € WERE EXECUTED IN SIERRA LEONE

+600.000 € IN MALI Y SENEGAL

+ 600.000

PEOPLE HAVE BENEFITED FROM OUR PROGRAMMES IN SIERRA LEONE

+57.000 IN MALI Y SENEGAL

103

EBOLA-POSITIVE PATIENTS WERE TREATED

450

HUMANITARIAN WORKERS

150 INTERNATIONAL WORKERS

300 LOCAL WORKERS

+300

SCREENINGS WERE PERFORMED

695

LOCAL WORKERS WERE TRAINED IN HEALTH

5

BASES

The Ebola Mission in numbers

Clinical DATA: Patients admitted in MDM ETC and HCs

	Moyamba ETC 24/12/2014 31/03/2015	MOYAMBA HC 22/04/2015 08/11/2015	TOTAL NUMBERS Moyamba	OLD KUMALA HC 31/10/2014 31/03/2015	NEW KUMALA HC 25/04/2015 01/11/2015	KASUMPE HC 03/04/2015 02/11/2015	TOTAL NUMBERS Koinadugu
Total Admissions	106	43	149	139	5	26	170
Total Deaths	24	0	24	18	2	6	26
Total Discharges	82	43	125	69	3	20	92
EVD confirmed	33	0	33	70	0	0	70
EVD survivors	15	N/A	15	N/A	N/A	N/A	N/A

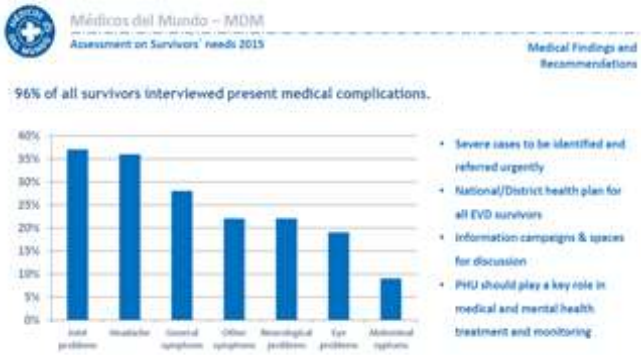
Outreach Activities: IPC and Surivors clinics

Training on the new national guidelines on Infection Prevention Control (IPC):	
Health staff; health staff volunteers; cleaners, screeners	576
TBA	62
CHOs	22
DHMT	25
Partners	10
Total number of people trained	**695**

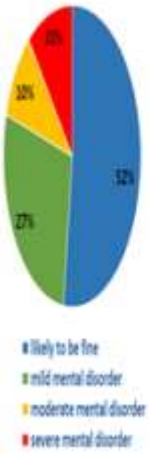
Survivor Clinic in Moyamba and Koinadugu District:

Clinical assessment and follow up of EVD survivor

- Moyamba 96 survivors
- Koinadugu 43 survivors



Mental Health and Psycho Social Support during EVD outbreak



EVD main impacts mentioned by survivors

- ✓ 47% - Multiple loss of family members
- ✓ 42% - Loss of Livelihoods
- ✓ 15% - Psychological feelings and status (discouragement, bad feelings, abnormal behavior, unhappiness and trauma)
- ✓ 9% - Medical complications
- ✓ Only two survivors (2 %) gave positive answers EVD impact

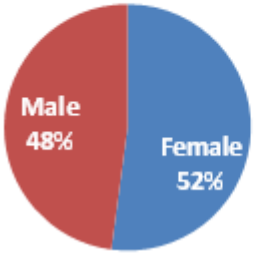
Personal, medical, social and economic impact

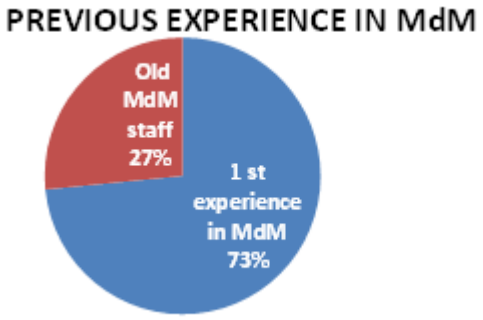
- loss of family members
- loss of livelihoods
- medical complications
- lack of autonomy/incapacity to provide for families: psychological problems

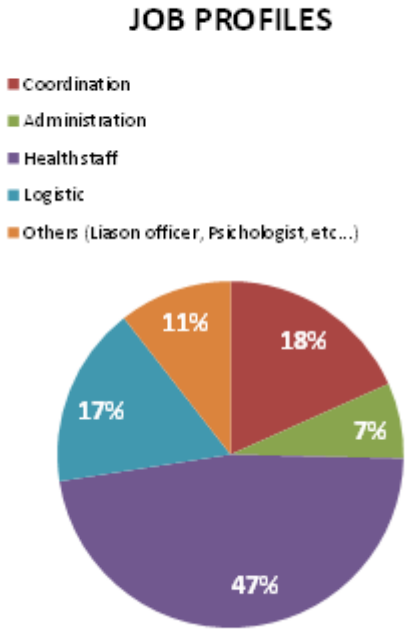
All survivors having declared stigma are mainly from Fakunya, Kailyamba, Kori.

The Ebola Mission in numbers

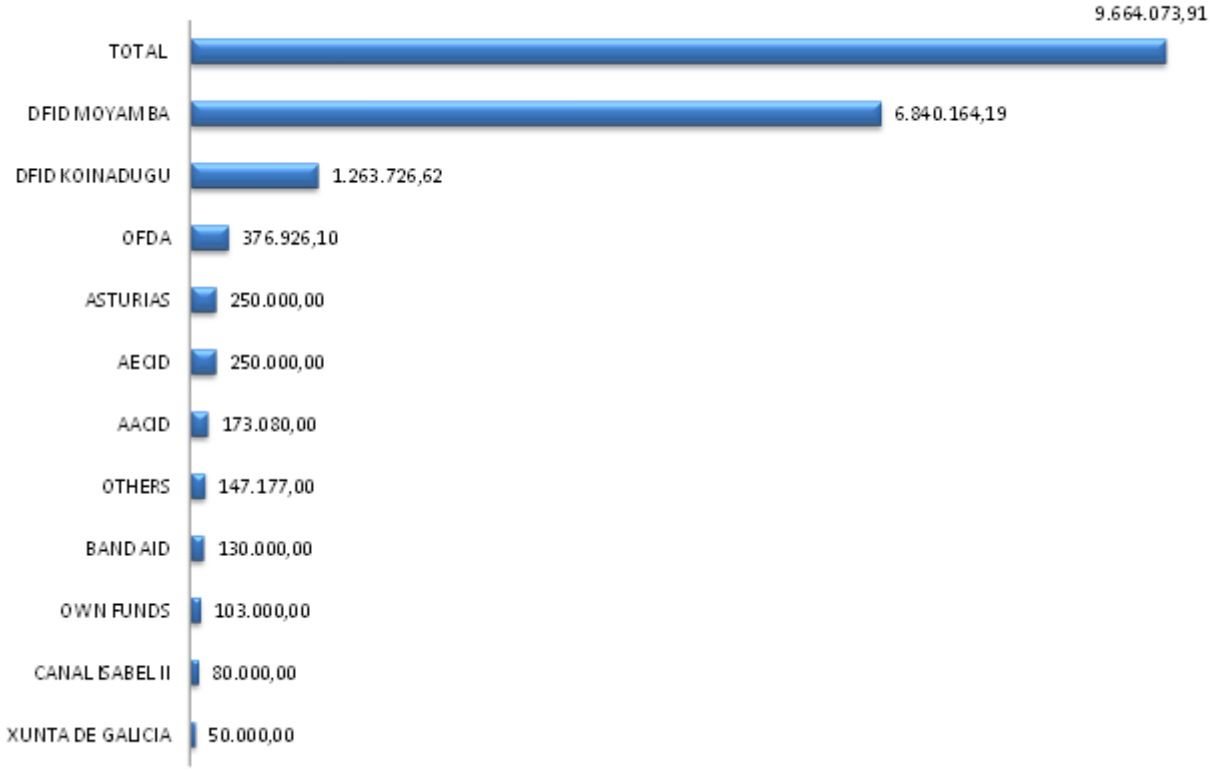
Human Resources: International Staff 142 expatriates







Funding: Contributions by donors



The Ebola Mission in numbers

Accountability: how funds have been spent?

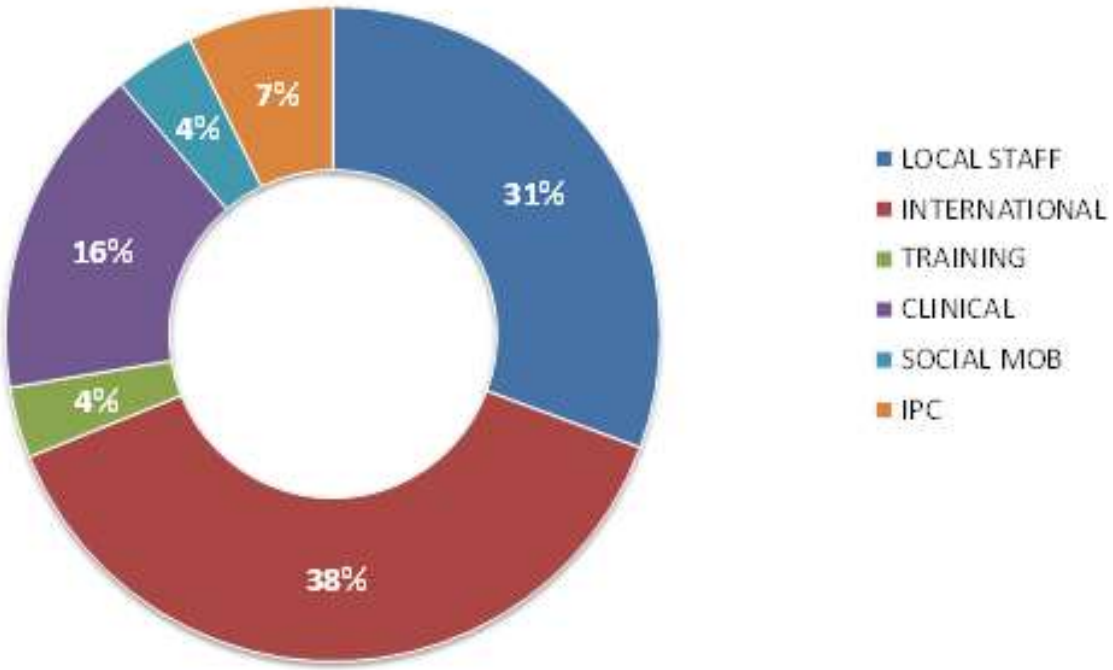
1)Operational Costs:

- International Staff
- Local staff
- Clinical actions
- Trainings
- IPC
- Social Mob

2)Running Costs

- Fleet Managment
- IT
- Rent (guest, house-office. Etc)
- Supplies
- Fuel
- Others

Accountability: Operational Cost



The Ebola Mission in numbers

The response to Ebola represented one of the greatest interventions in emergencies in the history of Médicos del Mundo. More than 9 million euros were executed in Sierra Leone in a year (between all the bases, all the projects and the 3 partners) and more than 600,000 euros in Mali and Senegal. More than 150 international humanitarian workers and 300 local workers passed through our centres, 103 Ebola-positive patients were treated, and more than 300 screenings were performed. Training and prevention and IPC (infection prevention and control) actions were carried out in more than 150 health posts. Monitoring is being carried out on the almost 150 survivors that there are between both districts. More than 600,000 people have benefited directly or indirectly from our programmes in Sierra Leone, which represents 10% of the population of Sierra Leone, and 57,000 more in Mali and Senegal.

Moyamba

All this effort would not have been possible without the support of:

DFID/UK AID, the Government of the United Kingdom-OFDA/ USAID-AECID /MAEC-BILBAO City Council-OVIEDO City Council-The Regional Government of GALICIA-CAJA NAVARRA-IRÚN Town Council-HUESCA Town Council-BAN AID Fundantion-The PRINCIPALITY OF ASTURIAS-PERALTA Town Council-AACID / The Regional Government of ANDALUSIA-CANAL ISABEL II-ZARAGOZA City Council-CASTRILLON Town Council-SIERO Town Council-AVILES Town Council-LANGREO Town Council-FUNDACION OLYMPUS

Or without the close collaboration of:

The Ministry of Health – The Government of Sierra Leone.-The National Ebola Response Committee-The Ministry of Health of Norway.-IHP International Humanitarian Partners-The Ministry of Health Kingdom of Spain - Community of Madrid Regional Department of Health.

Doctors of the World UK - Médecins du Monde France - Médecins du Monde Canada Medecins du Monde International - World Health Organization – The Ebola Response Consortium International Rescue Committee -Solidarités International - Oxfam GB - Médicos sin Fronteras - Cruz Roja Española - CICR – BRAC - Universidad Tecnológica de Madrid Instituto de Salud Carlos III Escuela Nacional de Sanidad

And thanks to all the members, collaborators and volunteers of Médicos del Mundo.

TESTIMONIALS FROM HEALTH PERSONNEL

When one decides to leave his job and his day-to-day fret-free comfortable life-style and exchange it in order to live in a country surrounded by disease in an emergency situation, it's because this person sees things as they really are. Decisions, in this situation, were made without hesitation. As of ten years ago they started taking trips to Sierra Leone to fight for the eradication of the Ebola virus and to fulfill the commitment made to the people of Sierra Leone to fight for their right to health. In return, they received harsh conditions and faced the real risk of infection at any time not to mention all the suffering around them. But that is their job, their work. They are health personnel convinced that their lives in Sierra Leone would be their chance to change things, to stand up to this outlandish virus.

Below we have recorded their experiences, with their lights and their shadows, and the added suffering of not being able to touch their co-workers for weeks so as to avoid being infected in any way. However, through the pain they have learned to see life with optimism. Their fight against Ebola has been a vital learning lesson for them and one they would return to if necessary. Nobody else can give us their first-hand account.

AIRAM VADILLO

Psychologist and nurse

Airam Vadillo has worked as a psychologist in Koinadugu in the Ebola Emergency Response Project since last July, to end later this

What was your field experience like?

When I arrived in the Koinadugu district (in the northern part of the country) the virus was already controlled with no new cases appearing. All that was left were the consequences of the disease. In the psychosocial department we conducted a study on the needs of the virus survivors and the families affected by the outbreak.

While we celebrate the end of the Ebola Epidemic, the consequences of it and what it left behind are still very current. Among the work remaining, in family members affected by the outbreak we found that mourning for the loss of their loved ones had not been properly closed or normalized due to several reasons. The pain at the loss is practically overshadowed by the lack of basic needs for food and a roof to sleep under. In addition, the funerals that were held were not held according to their customs. Under protocol to prevent contagion, the Burial Team had to bury those killed by the virus making it impossible for family members to be near the burial.

We also found disintegration, orphanhood and new family responsibilities painting a bleak picture of family life. Finally, there is stigma and discrimination that has also built up around Ebola survivors.

Currently we are holdng group sessions to work on manageing their emotions, identifying common problems and finding solutions. Also in the next few weeks we will be holding a series of funeral ceremonies in order to close the mourning for their loss and to give their loved ones the farewell they deserve.

What has been your best and worst experience?

The best thing was the eagerness of the national staff to work for and in favour of their community, their courage and their effort. The real heroes are not only those who survived Ebola, but also the Sierra Leonean medical staff. The work of the expatriots would make no sense if it wasn't for them.

The worst thing is treatment in Sierra Leone. This country has been abused for many years, its bloody civil war and the cruel and despotic diamond business along with the corruption makes a country that doesn't deserve this kind of treatment. The virus ravaged a country that was already suffocated and diminished.

What was a typical day like?

There were no typical days.

… the hardest thing?

The hardest thing was the difficulty of gaining access to the villages affected by the virus, because reaching them is really difficult.

One nice thing to know is that the psychosocial work with survivors and families affected by the outbreak makes sense. Despite being a work with a very short term, we were able to leave seeds for a change.

However, the most rewarding part is to have the certainty that Sierra Leone, despite the undeserved treatment it receives, has a very great people with a tremendous desire to change the country's direction.

These people are the tireless Sierra Leoneans, the national staff that any expatriate would be glad to work with and for. I am fortunate to have got to know the local workers who live out every day with the hope of seeing their beloved Sierra Leone with a promising future, that is, the future they deserve.

BEATRIZ SALAS MARTÍN

Specialist in Family and Community Medicine. Rural Emergency Medicine. Doctors of the World Aragon volunteer in patient consultation care for those without access to health care, as medical coordinator.

Beatriz worked for two months in Koinadugu.

What convinced you to go?

Ebola had become a challenge. In Spain it was a complete unknown and panic reigned among nearby health services. My commitment to Doctors of the World in Zaragoza made me apply for the mission and I immediately received an answer. I didn't spend a lot of time thinking about it and any doubts I had were dispelled as I talked with Nico Dotta the head of Human Resources at that time.

What was your experience during the time you worked there?

Very positive. The team that I lived with and the experiences as a trainer of the local workers were very rewarding. The enthusiasm with which they wanted to fight Ebola was fantastic. The ranchers, farmers and farm workers who came in to be trained as hygienists to fight Ebola and become the true heroes of the largest outbreak of Ebola in history. Training them there was a real privilege.

What is the best and the worst experience you brought back?

The best thing were my colleagues and the experiences shared with other aid workers in the organization. We worked a lot with the local workers in Koinadugu, all hired by Doctors of the World, some since a long time ago and some just for the Epìdemic. The possibility of being able to integrate into their society and be in their day-to-day and be accepted with such enthusiasm was a fantastic highlight.

The worse was getting used to the lack of physical contact with other people and not missing it. Also the hypocrisy of the North/South disagreement. The enormous amount of money we had to eradicate the Epidemic when the international community finally reacted, which came rather late. The impotence of not being able to use it to improve the basic health system.

What was a typical day like during your stay?

We used to be woken up at five o'clock in the morning with the singing of the Iman, then sleep until 6:45 with intermittent awakenings since the bed or cot was usually not very comfortable. We had our breakfast and at 7:30 we'd go to the Isolation Centre. In Kasumpe we slept in a house in Kabala, almost half hour from Kasumple. In Kumala we would walk from the Base Camp. Then we'd spend the whole day in the Isolation Centre taking turns with our other colleagues. At first, the Centre was not open and we devoted ourselves exclusively to training. At mid-stay, Kasumpe opened up and we continued to train staff (nurses and hygienists) until they were able to attend patients themselves. The hardest thing was to teach the people how to keep appropriate nursing records, control the coming and going of each person and coordinate the morning, afternoon and evening shifts.

There were a lot of days when we would arrive home or at the Base Camp after dark. We would dine late at about ten o'clock, and usually we still had to complete records and statistics and there were also protocols or training presentations that needed to be changed. An hour or two of work on the computer after a 16-hour day was just physically rough.

After dinner we would try to sip a beer sitting under the starry sky of Kabala, listen to music, watch a movie or chat with the others telling stories from other missions.

What was the hardest part of the job? And the most rewarding?

The hardest thing was starting up the Centre at Kasumpe and getting used to the staff. Coordinating work with Oxfam was sometimes difficult because they didn't have enough staff and this led to delays. Even looking for water was difficult since it was the height of the dry season when wells were dry. There were days ee even considered shutting down the Centre because we had no access to water. This was hard. We had to hire cistern trucks to go to some nearby river in order to fill our water tanks. Many times, the chlorination of the water was not done in the tanks, but in pails of water, as the influx of patients was not massive, but the scarcity of water was overwhelming.

Working at night in the Isolation Centre was also not easy. Life in the Kumala Base Camp, at first, when there were only tents, was also hard. It was very hot inside those tents all day. You could only stand to be there during the night and the fatigue and tiredness would seize you.The lack of communication when the internet wasn't working was frustrating. Calls could only be made by satellite phone, with its five-second delay. Medical liability at the Base Camp was on Doctors of the World and when any aid worker in our organization or some other had isolation criteria, the day become harder. The improvised med-evacuations were a tremendous challenge, which ultimately were carried out successfully, but in the meantime, the nervousness was palpable.

The evacuation of a mission colleague was definitely the hardest. Having to isolate him and leave him in Kerry Town, the place where all aid workers with symptoms of a possible Ebola infection were recieved, ...in a hostile environment, for 48 hours, no mobile, no communication and knowing how hard conditions are in these types of field hospitals..., it was really something terribly difficult.A tremendous gratification comes over you when once you come out of being in such conditions. The harder it is to reach your goal, the better it is, so I can say that this mission has been the most rewarding I have ever participated in.

RAQUEL CODESIDO TOURIÑO

32 years old, Nurse and MA in Humanitarian Aid

Rachel worked in Koinadugu for six weeks and two in Freetown in 2015.

What convinced you to go to Sierra Leone?

I think my way of thinking and understanding humanitarian aid fits with the principles of Doctors of the World. That was my main reason. It seemed to me to be the best organization where I could make my contribution in response to Ebola. As a nurse, I was always clear to me that helping others suited my principle of life. As a volunteer, working responsibly and preventing causes that bought harm, Doctors of the World was the best organization to be with to be able to participate in a response of this magnitude and help those who were suffering the most at that time.

What was your experience like?

The nature of the work I did was very different in the two places I worked. In Koinadugu, as Coordinator of Infection Prevention and Control, I gave training to hospital staff and we carried out assessments of the PHUs as well as social mobilization activities related to prevention. In Freetown, however, my position was less technical, I worked as liaison advisor, and my job was to give Doctors-of-the-World presence at decision making meetings nationwide.

¿ What is the best and the worst experience you brought back?

The best was everything related to Ebola, from handling national responses to ones at the district level, the coordination of partnerships and consortia and getting to know some great people who I hope will remain in my life.

The worst thing? I can't say what the worst thing was. Perhaps it was the impossibility of human contact and the constant oppressive sense of the rules imposed on you, which in fact, were there to protect your own safety and that of those working with you.

What was the hardest thing for you and the most rewarding?

In Koinadugu it was sometimes difficult to understand the reason for our presence in the hospital. In Freetown, the endless hours of meetings could be really tough at times. What was the most rewarding? The results. To see the people pay enthusiastic attention to what you were explaining who later realized that what you were saying made sense, not only for Ebola, but for many other infectious diseases. In Freetown, it was our colleagues, having the opportunity first hand to get to know the participants involved in the response from its beginning and see that even though they were tired, there was hope in their eyes as they thought of the day they could declare that Epidemic had ended.

JAVIER TENA RUBIO

Doctor. **Javier Tena worked in the Moyamba ETC between January and February 2015 (six weeks).**

Why did you go to Moyamba?

I got started in the humanitarian world 12 years ago. The previous outbreak of Ebola which I was involved in was in Angola, also with Doctors of the World, but with a different post which focused on health promotion and distribution of products to help contain the epidemic.

On this occasion I was provided with an opportunity to work as a medical doctor, but also to focus on public health, on a well-known type of emergency, but taking another approach professionally speaking.

Although I had planned to take some holidays after a grueling mission, the suffering this Epidemic caused would just not let me sit back with my arms crossed and wait for a more convenient mission.

What was your experience like?

The combination of emotions and feelings that came together so quickly was infinite. In just six weeks I saw a country torn by other previous epidemics and the consequences of war. I saw remote and forgotten villages, but I also saw the echoes of international efforts to improve some life in the country in the past. What was remarkable was the manner in which a whole country faced an unknown enemy to overcome taboos and still continue making progress.

What did you learn from it all?

I learned once again to try to relativize everyday problems and prioritize what was really worth worrying about for my life. But mainly I learned to value life through those who had lost it but refused to give up hope.

What was a typical work day like?

Early in my mission, I worked as a doctor in the ETC. Then, as the Epidemic evolved, that is regressed, I had the maravulous opportunity to support the psychosocial team as they accompanied survivors back to their villages to reinforce health messages to their communities. I also participated in an assessment of health needs for future emergency response projects.

What was the most difficult work in Moyamba? And the most rewarding?

Before I went. I had tried to mentally prepare myself for watching patients die. What I was not prepared for was seeing patients survive who had just lost much of their family overnight and seeing them having to start all over again from scratch. Thinking about what would happen to those survivors next was the hardest thing.

On the other hand, it was very gratifying to see survivors return to their communities when they had been given up for dead and not only not be stigmatized, but see their return celebrated in such a moving way. The memory of the women dancing, laughing and crying all at the same time still brings tears to my eyes.

I think the most gratifying of all was to recieve a video from Raúl, the Country Coordinator during my stay, with the news of the end of the Epidemic ...only a few days ago.

CONCHA BONET

Pediatrician

Concha Bonet worked in Koinadugu for six weeks in 2015 as coordinator of two Ebola centres.

What convinced you to go to Sierra Leone?

Being able to practice medicine in the largest Epidemic in recent decades (even though tuberculosis, AIDS and malaria kill more people).

What is the best and the worst experience you brought back?

The best was local workers (like Dr. Moses), the Camp and the enthusiasm thrown out by those in the BRAC (Mr. Mawolo) and the young expatriates. Undoubtedly, the project coordinator, Jesús Cruz, and the Country Coordinating Raúl. The engineer Ian, from Oxfam. People of incredible stature both personally and professionally. The worst was the lack of space for yourself and always being surrounded by so many people.

What did you learn?

To resolve conflicts. To treat Ebola. To adapt to hard situations. To be tolerant, patient know and to wait for things to mature by themselves.

What was a typical day like on your job?

Routine in the sense of keeping centres and people in operation. Thanks to Jesús Cruz I learned a lot about project management and to have more patience than usual. I had to facilitate relationships between many players and help the younger people to take on new challenges every day. I also learned a lot from them.

What was the hardest and most rewarding thing about your experience?

The hardest part was having to deal with some expatriate who didn't understand what the limits were who put himself and the team at risk. Also due to security measures, not abandoning patients that had a solution. The most rewarding thing was the team. To see the local workers flourish in their tasks. Working with all types of nationalities, classes and professions in harmony. Being able to help in something and especially following in the footsteps of great people who launched such a Project.

Thanks: Sagrario Martín, Elena Urdaneta, José Félix Hoyo, Nico Dotta, Unidad de respuesta al ébola, Feli Ibañez, Ángelo Pirola, Airam Vadillo, Beatriz Salas Martín, Raquel Codesido Touriño, Javier Tena Rubio, Concha Bonet

Edition: LOLA DELGADO

MÉDICOS DEL MUNDO
SEDE CENTRAL
Conde de Vilches 15. 28028 Madrid / Tel. 915 436 033
informacion@medicosdelmundo.org
www.medicosdelmundo.org

MÉDICOS DEL MUNDO ANDALUCÍA
Sede autonómica de Sevilla
Bajos del Puente Cristo de la Expiración s/n. 41001 Sevilla / Tel. 954 908 288
sevilla@medicosdelmundo.org
Representación en Almería
Juan de la Encina 2, bajo 4. 04006 Almería / Tel. 950 252 432
almeria@medicosdelmundo.org
Representación en Málaga
Cruz Verde 16. 29013 Málaga / Tel. 952 252 377
malaga@medicosdelmundo.org

MÉDICOS DEL MUNDO ARAGÓN
Sede autonómica de Zaragoza
San Blas 60. 50003 Zaragoza / Tel. 976 404 940
aragon@medicosdelmundo.org
Representación en Huesca
Plaza San Pedro 5, 1º C. 22001 Huesca / Tel. 974 229 210
huesca@medicosdelmundo.org

MÉDICOS DEL MUNDO ASTURIAS
Sede autonómica de Oviedo
Plaza Barthe Aza 6, bajo. 33009 Oviedo / Tel. 985 207 815
asturias@medicosdelmundo.org

MÉDICOS DEL MUNDO CANARIAS
Sede autonómica de Las Palmas de Gran Canaria
León y Castillo 69, 1ª planta, oficina 4º. 35003 Las Palmas de Gran Canaria / Tel. 928 367 100
canarias@medicosdelmundo.org
Representación en Tenerife
Juan Pablo II 12, bajo. 38004 Santa Cruz de Tenerife / Tel. 922 24 8 936
tenerife@medicosdelmundo.org
Representación en Lanzarote
Canalejas 2, 1º J. 35500 Arrecife de Lanzarote / Tel. 928 805 555
lanzarote@medicosdelmundo.org

MÉDICOS DEL MUNDO CASTILLA-LA MANCHA
Sede autonómica de Toledo
Alemania 1, 4º A. 45005 Toledo / Tel. 925 222 312
castillamancha@medicosdelmundo.org
Representación en Albacete / La Casa de la Solidaridad
C/ Alcalde Conangla 70. 02002 Albacete / Tel. 609 744 791
albacete@medicosdelmundo.org

MÉDICOS DEL MUNDO COMUNIDAD DE MADRID
Sede autonómica de Madrid
Juan Montalvo 6. 28040 Madrid / Tel. 913 156 094
madrid.ca@medicosdelmundo.org

MÉDICOS DEL MUNDO COMUNIDAD VALENCIANA
Sede autonómica de Valencia
Carniceros 14, bajo izda. 46001 Valencia / Tel. 963 916 767
valencia@medicosdelmundo.org
Representación en Alicante
Romeu Palazuelos 8, bajo. 03013 Alicante / Tel. 965 259 630
alicante@medicosdelmundo.org

MÉDICOS DEL MUNDO NAVARRA
Sede autonómica de Pamplona
Aralar 42, bajo. 31004 Pamplona / Tel. 948 207 340
navarra@medicosdelmundo.org

MÉDICOS DO MUNDO GALICIA
Sede autonómica de Santiago de Compostela
Rua Galeras 13, 2ª, oficinas 6 y 7. 15705 Santiago de Compostela (A Coruña) / Tel. 981 578 182
galicia@medicosdelmundo.org
Representación en Vigo
Illas Baleares 15, bajo. 36203 Vigo (Pontevedra) / Tel. 986 484 301
vigo@medicosdelmundo.org

METGES DEL MÓN CATALUNYA
Sede autonómica de Barcelona
Legalitat 15, baixos. 08024 Barcelona / Tel. 932 892 715
catalunya@medicosdelmundo.org

METGES DEL MÓN ILLES BALEARS
Sede autonómica de Palma de Mallorca
Ricardo Ankerman 1, bajos. 07006 Palma de Mallorca / Tel. 971 751 342
illesbalears@medicosdelmundo.org

MUNDUKO MEDIKUAK EUSKADI
Sede autonómica de Bilbao
Bailén 1. 48003 Bilbao / Tel. 944 790 322
euskadi@medicosdelmundo.org

MÉDICOS DEL MUNDO

MÉDICOSDEL**MUNDO**

WE FIGHT ALL DISEASES INCLUDING INJUSTICE

902 286 286 | www.medicosdelmundo.org