to have them in the communities and by then, many were being hired to work in Ebola Treatment Units as well. By 18 September 2014, I was on a plane back to Liberia.

Three days after I arrived back in Liberia, the Situation Report for 21 September 2014 indicated 3272 cases, 1709 deaths and 85 health care workers deaths due to Ebola.

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[1] In Liberia there is a five pillar approach spelled out in an Ebola regional framework, comprising: (1) Beneficiary Communication and Social Mobilisation; (2) Contact Tracing and Surveillance; (3) Psychosocial Support; (4) Case Management; and (5) Safe and Dignified Burials (SDB) and Disinfection.

[2] All names are fictitious.

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Personal reflection

The travellers dance: how Ebola prevention measures affect day to day life

Teresa Gonzalez

While the international community remains concerned and focused on the potential spread of Ebola out of Africa, the author states that they also frequently ignore the deep psychological pain that the measures implemented to combat the disease are causing within impacted communities, as do the national authorities. She provides a snapshot of this moment in the crisis and highlights the painful impacts, dehumanising measures and makes a plea for international organisations to do more to be mindful of this pain.

Keywords: burial, Ebola, everyday life, prevention, quarantine, Sierra Leone, stigma, virus outbreak

Landing in Sierra Leone

On arrival at the airport in Sierra Leone, you are invited to wash your hands with a solution that smells strongly of chlorine. As you exit the plane onto the runway, people crowd around the arrivals door, like in many other African cities. However, in Sierra Leone, a man observes all travellers and inducts them into a new routine, one where the main message is: *'DO NOT TOUCH'.*

Waiting for their luggage, some people are already wearing gloves, masks or both. All along the way from the airport to the city travellers seem to perform a strange dance,

the '*travellers dance*', i.e. as instructed: avoid all direct contact with other people, maintain a social distance.

Do not touch anything or anybody, use your own bottle, take your temperature and do not take any risks which might result in contagion from fever causing diseases. Wash your hands, wash your hands and wash your hands. Absolutely no sex. It's difficult, but it is only temporary. You will be on site for only a few weeks and you can endure it. You must endure it.

If you are travelling with a nongovernmental organisation (NGO) and these measures are too demanding, there will be someone within your organisation who will look after you. In the event of being infected, carers from your NGO will take you to better premises (with better sanitation) where they will look after you and will try to ensure your survival.

Ebola is real

On arrival at the capital, everywhere in the city you see large billboards, which read; '*Ebola is real*' and lists preventative measures to avoid contagion. The billboards were initially supposed to be temporary, but they have remained in place much longer than anticipated. Yet, few seem to be asking the question: how do these preventative measures affect the population in these countries? What about people's everyday lives? How can anyone live without touching anything or anyone?

In the past, Ebola outbreaks had occurred in small rural communities, where patient isolation and the tracking of person-to-person contact was very effective, thereby limiting the outbreak to a few weeks or few months maximum. At first, '*treatment centres*' were built near the suspected site of the outbreak, where new patients were brought together, closely observed and investigated for potential person-to-person contact. In these centres, even psychosocial support was given once the outbreak was under control.

Measures implemented to stop the spread

In July 2014, the first case in Sierra Leone generated the *Accelerated Ebola Virus Disease Outbreak Response Plan*, intended primarily to stop transmission of the virus inside Sierra Leone, as well as between Sierra Leone and its neighbour countries. From this moment, a series of measures were implemented: the closure of schools and universities; the prohibition of rural markets; the establishment of quarantine checkpoints around affected areas; a mandatory curfew at dawn; and frequent lock-downs when an active search of patients was carried out, in order to confine them to their family homes until recognition teams arrived.

These are the same measures that had been used with Ebola outbreaks in the past to control small outbreaks, but in this case, they have been extended to the entire country and, until now, for a period of more than six months.

From an epidemiological point of view (does anyone really think that Ebola can be transmitted by a slap on the shoulder?), many of these measures have no real basis in fighting the outbreak. However, their implementation is impacting whole communities: blocking social life and generating unwanted power abuses where individuals of any community can close down a road, stop a traveller or confine them if thought to be dangerous. At the established check points located near any community, say a village or a hamlet, small youth groups are armed with infrared thermometers and can require any traveller to expose their temple for a temperature check. The thermometer has become a new weapon of power.

In October 2014, the President of Sierra Leone decided to replace the hitherto crisis coordinator, the Minister of Health, with the Minister of Defence. Immediately, quasi-command centres were created with the aim of managing everything related to Ebola, which implied virtually controlling

all aspects of communal life. One of the measures was banning traditional funerals, which meant that anyone who was dying, whatever the cause, was treated as an Ebola victim. The only authorised burial staff are those wearing a personal protective equipment (PPE) suit, who only touch the corpse to extract samples before it is placed into a plastic bag that has previously been soaked in chlorine.

Recently, the Minister of Defence, now head of NERC (National Response Centre for Ebola), said at a press conference that they will *'stop using the carrot and replace it with the stick'*, meaning they were now threatening the use of force against anyone violating preventative measures. As an additional measure, Christmas celebrations, such as family gatherings and other meetings or festivals that usually accompany the holiday, were banned.

Internationally, while the response has also included the need to isolate the sick, the safety of health workers has had priority above all else. When a potential Ebola victim is detected, the immediate action is to isolate them, carry out the test and, if found to be positive, send them to a treatment centre. At the same time, in order to avoid transmission, a health worker will try to track the victim's person-to-person contacts and will monitor them for 21 days. The primary steps, which are to: contain, isolate, quarantine, locate those suspected of infection and relocate those affected, are carried out well in general. In fact, almost obsessively. However, little or no psychosocial work is done within the communities in quarantine, with either the affected and/or their relatives.

Psychosocial impacts

Let us think for a moment what it might mean to a rural community, like many in Sierra Leone, when a sick person is forced to move to a care centre with no other options. In most cases, these centres will be located far from their home community, their mother tongue might not be spoken and the possibility of contact with relatives, friends or acquaintances are zero to very rare during their stay. They will remain in these conditions until they heal, or until the Ebola test (Polymerase Chain Reaction) result is negative. While at the centre they are attended by carers who appear dehumanised in their PPE suits, as if they are alien astronauts, and who touch them as little as possible, even if the patient is a small child. Let us also consider the distress of family and friends at being treated as *'suspected'* and confined to their homes, at the same time having their family members away from them in the care centre, knowing little or nothing about them until an outcome has been reached: either survival or death. In the case of death, imagine the distress and the pain of not even knowing where they will be buried.

Adding to this distress are the rumours that spread continuously between communities: *'Ebola does not exist, it's an excuse to take blood from Africans and send it to other countries. Foreigners are the ones who bring Ebola, or perhaps people from another rural community near or far away. In treatment centres, patients are starved to death and they do not let you see your sick relatives. If they die, they never know nor will tell you where they are buried'.*

While the international community is very concerned about the potential spread of Ebola and is making a great human and material effort to contain it, they [we] do not seem to bother much about the pain that this disease and the measures implemented to combat it are causing among affected communities. If international associations do care about this pain, and they should, then they should also show it more clearly.

Surviving fear and stigma

When the first survivors returned to Kabala, the capital of Koinadugu, the district where we are working, an unexpected event took place: they were not happy. Some survivors

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had received some sort of compensatory kit consisting of a mattress, a 20 kg sack of rice and some clothes. Others received nothing. All had lost relatives or friends, some their entire family. As well as trying to cope with all of the loss, they are also now expected by UNICEF to contribute to the fight by caring for children orphaned by Ebola. The problem is that these children have been so stigmatised, no person nor community wants to care for them. Many of the people who come forward to receive Ebola survivors congratulate them not with joy on their faces, but with an immense weariness.

Recently, I heard of an entire, small rural community in Koinadugu that had fled and sought refuge in the jungle, leaving the village completely deserted. They had abandoned their homes after a sample taken from a corpse was found to be positive. Who could be surprised when there is so little attention paid to increasing awareness and understanding of the disease, the measures taken to combat it and to counteract the endless rumours?

Meanwhile, back in Europe you would think rationality and scientific evidence would dominate, but you also find the *'travellers dance'* occurring here. If you are returning from an area labelled a risk region, such as Sierra Leone, you cannot go back to your regular job and have to remain under observation for three weeks, taking your temperature morning and afternoon with recommended moderate confinement to prevent febrile illness. When you ask expert epidemiologists, they confirm that Ebola can only spread at the time of massive viraemia,[1] but you had better do the 21 day quarantine *'just in case'*.

[1] Viraemia is a medical condition where viruses enter the bloodstream, thereby gaining access to the rest of the body.

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Mental illness and health in Sierra Leone affected by Ebola: lessons for health workers

Peter Hughes

Sierra Leone is currently going through the worst Ebola epidemic on record, creating anxiety and anxiety related, somatic symptoms. Additionally, increased psychiatric morbidity could be expected as a result of the adverse social and psychological consequences of the epidemic, exposing the country's weak, poorly resourced mental health services and highlighting the need for psychosocial interventions and development of psychiatric interventions. Countrywide, there are 20 psychiatric nurses and 150 community health workers trained in the mental health Gap Action Programme and Psychological First Aid. However, in order to strengthen their capacity to deliver psychosocial and psychiatric interventions and to create a potential resource for psychiatric interventions during a major humanitarian crisis, ongoing training and supervision will be essential.