

HUMANITARIAN ALTERNATIVES

Tale of a mission to Liberia, unlike any other

Jean-Pierre Veyrenche • Consultant for the United Nations

In his story of his field experiences Jean-Pierre Veyrenche brings us close to people by giving us the opportunity to get a feel for the atmosphere that pervaded Liberia during the height of the epidemic at a time when the country was gripped by silence and fear.

It all began for me in April 2014, while I was in Haiti during the cholera outbreak. I heard on RFI (Radio France Internationale) that Médecins Sans Frontières (MSF) had announced that the Ebola epidemic ravaging Guinea was getting beyond the control of health authorities. This chilling news was to linger in my mind. Although MSF does have a tendency to cry wolf, and understandably so, on account of its front line field position where it works closely with beneficiaries and their needs, its statements are often on target. Then, everything cascaded. Within weeks, Liberia, and Sierra Leone, in turn, were struck, just as MSF had announced, while the World Health Organization (WHO)—the UN agency responsible for global health—seemingly unconcerned, delayed the deployment of staff that brought support to the health ministries of the countries concerned.

In early August 2014, Liberia, with its several hundred cases a day, was the most distressed. Neighbourhoods were quarantined under army surveillance, while much of the expatriate community, and many NGOs (MSF aside) and non-essential UN staff were leaving the country. Some airlines even decided to stop scheduled services. A curfew was imposed from 10 p.m. to 6 a.m. All Liberian health facilities were closed. It was to this state of events that, twenty-two years after my first humanitarian mission to Liberia with Action against Hunger (ACF), I was flying, in a half-empty plane headed for Monrovia, to lead the construction of Ebola Treatment Centres (ETC) and run the WHO water and sanitation programs.

As I arrived at the airport, the tension was palpable. We were greeted by health professionals covered from head to foot in white protective suits and wearing rubber boots, gloves, masks, and goggles. Not a bit of bare skin was to be seen. Before entering the air terminal, we were required to wash our hands and have our temperature taken. The smell of chlorine was strong, almost overpowering, caused by the portable sulphur vaporizers the employees were constantly using to disinfect the ground and the soles of the visitors.

The Liberians that I had left behind in 1993 during the civil war were known for their warmth and appreciation for physical contact, especially typified by their legendary handshake that was followed by a finger snap. But today this is no more. Instead, people with anxious, sullen faces, kept their distance from each other. Fear was there, contagious and overwhelming. It was forbidden to take taxis into town due to the high risk of infection. And in any case, given the lack of ambulance services, they were mostly used to transport the massive influx of patients. My first night, I slept fully dressed, out of fear of being contaminated by the sheets and mattress. Yes, there was fear.

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What astounded me from the very first day was the small number of people in the streets. No children in sight, running and playing. The schools had been closed for weeks. Many stores were shut. The usual merchant stalls cluttering the sidewalks and crowded with people were gone. Time seemed suspended. The wailing sound of ambulance sirens was deafening. Every ten minutes, ambulances would rush by at high speed, manned by staff fully garbed in protective suits. Breaking the silence, those sirens were the sole reminders of the crisis we were enduring, unlike when interventions occurred in surroundings where buildings, roads, and the landscape bore the obvious scars of natural disasters or armed conflict. Here, everything seemed untouched. It was a disquieting feeling, knowing that danger was nevertheless present.

I promptly took up my duties, contacting the various people concerned for a meeting to assess the scope of needs and figure out who was to do what and where. Oddly, very few of us, barely a dozen, sat around the table. In any emergency situation, we usually numbered in the hundreds. But for the first time in my career in emergency relief, I was not being assailed by the traditional hordes of journalists and NGOs from all political persuasions and religious creeds. In Haiti, in the aftermath of the 2010 earthquake, there were more than 10,000 professionals representing some 1,200 humanitarian NGOs! Here instead, MSF was the only NGO present, involved in the management of an ETC with more than 100 beds that was to grow to 300, a record, so to say, for this virus that had been raging throughout several African countries since 1976. In previous outbreaks the virus had affected comparatively few people. Treatment centres at that time did not exceed thirty beds.

To take the measure of this unprecedented situation, one must be aware that Ebola patients require around-the-clock intensive care, meaning that three people, counting the nurse and the hygienist, must be assigned to each patient. But patients may arrive, ten at a time, carrying a fever and fouled by vomit and feces. They are quickly sorted out according to their symptoms and admitted to receive corresponding care. When the diagnosis leaves room for doubt, a test is run and the patient is put in an isolation ward for suspected cases. Initially, it took more than 48 hours to get test results, because there was only one laboratory. With the gradual increase in the number of laboratories, the test was made available within two hours.

Following the announcement by the UN's representative for the Ebola crisis that WHO was to build five 100-bed ETCs, I was given the responsibility of that monumental task. The job represented a true challenge for this organisation that traditionally has no operational role, but rather one of lending advice and providing support to country health policies. No plan had been set out for ETCs of that size. They had to be created from scratch, conceived with the idea of how patients and staff would evolve in their new space, and in line with epidemic prevention guidelines, which called for "green" and "red" zones to be set up according to the risk of contamination. Showers, toilets and plumbing had to be fitted according to the respective concentrations of chlorine passing through them that would vary according to the various tasks being undertaken (scrubbing of floors, disposal of bodies, disinfection of toilets and showers, washing of hands, etc.). An architect had to plan this arrangement before the tens of categories of craftsmen could begin work on the construction of the centres.

The first building was rapidly completed in response to the extreme urgency. This was coping with pressure. The President of the Republic of Liberia, accompanied by the Ambassador of the United States, came to meet me in person. She had wanted the centre opened in 48 hours! I had to explain that such haste ran the risk of exposing health teams and the surrounding population to danger, if the minimum infection control requirements were not met. I managed to convince her that I needed another ten days, even though 150 people were already working night and day

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on the construction site. The surrounding situation was even more of a motivating factor. Going by a former hospital, I saw several corpses lying in front of the entrance. The Liberian Red Cross, in charge of collecting bodies and planning burials and secure cremations, was overwhelmed by the job, having to handle more than 60 bodies a day, in addition to the disinfection of affected households. It was only the next day that it could go to the former hospital.

We opened our first treatment centre one Sunday evening. It had a capacity of 100 beds, and employed more than 350 people. The following Wednesday, 250 patients had already been admitted. The nursing staff was swamped, not having had time to acclimatize itself to the various established protocols and guidelines. The risk of contamination was great for these health professionals working several hours a day in dry suits under stressful conditions in unbearably high temperatures and levels of humidity.

The simultaneous construction of the six other centres was to be a challenge in a country where, during the rainy season, an impressive six metres of water fall in the space of three months. Work was naturally delayed when several inches of water flooded the worksites. One day, on one of them, our teams found a body that was to lie there for several days in a state of decomposition before we could resume work. Each centre, once built, ended up taking between 12 and 15 bodies daily.

In September, some NGOs returned to check out the situation, trying to see what they could do, since few, if any, had had any kind of experience in managing Ebola. They were hesitating, committing few volunteers willing to work under unstable conditions. The US government even announced that it would deploy more than 3,000 soldiers to build facilities and train health workers. The hope of the Liberian population was being renewed. The people, since the beginning of the crisis, had had to cope with the death of several hundred members of the health profession, thus prompting the shutdown of all government health facilities. As well, this had triggered the departure of NGOs mostly engaged in development programs, as they were totally unprepared to handle such an emergency, underlining the inaction of UN agencies present in the country. Unfortunately, US troops would do no better, thus bringing further disappointment. It would take them several months to build treatment centres, of which finally more than 65% would never take in a single patient, now that the peak of the epidemic had subsided. The last centre was completed in late February 2015, just as Liberia was tallying its final Ebola patients. The United Nations, meanwhile, had set up the well-intended UN Mission for Ebola Emergency Response (UNMEER) that was to pool human and material resources from various UN agencies. But UNMEER would only have added another layer of bureaucracy that would have hindered rather than facilitated the job.

Faced with such disappointments, Liberians showed tremendous resilience. I returned to Liberia in February 2015. Upon my arrival, hearing the sounds of children in the schools gave me joy and delight. City traffic was once again congested, small fruit stalls and the others selling their trifles had reappeared on the sidewalks. Fear was behind us. In March 2015, we then went through a transition phase, decontaminating and dismantling the Ebola centres. Each hospital was to be equipped with an adapted clearing centre, an isolation ward, and trained staff. Life was reawakening.

Translated from the French by Alain Johnson

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Biography • Jean-Pierre Veyrenche

Jean-Pierre Veyrenche graduated from the Science University of Avignon in Engineering and Water Management. Since his first humanitarian mission in Liberia with ACF in 1992, he has gained extensive experience in emergency response both to natural disasters and to conflicts, as well as in project development in Africa, Asia, Latin America, and the Middle East in the area of implementation, monitoring, and management of water resources and of complex projects affecting displaced persons and refugees in rural and urban environments. For the last two years, he has pursued his career providing his expertise and advice as an international consultant for the United Nations. For five years, he also worked as an educational coordinator and technical instructor at the Bioforce Institute in Lyon on a training course he launched that is now recognized for the Master's I degree. He currently teaches for the project management and coordination program of the School of Business and Development 3A in Lyon and in Paris.)

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