CDC Ebola Response Oral History Project

The Reminiscences of

Osman Barrie

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Osman Barrie

Interviewed by Samuel Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson. It is March 22nd, 2017, and I have the pleasure of sitting down with Mr. Osman Barrie here in Kambia, Sierra Leone. This interview is part of our CDC Ebola Response Oral History Project. Thank you so much, Mr. Barrie, for joining me for the interview.

Barrie: Thank you very much, Sam.

Q: Of course. Would you mind first saying, "my name is," and then saying your name?

Barrie: My name is Osman Barrie. I am the district surveillance lead for Kambia District, and I am based in Kambia Town, and I work for the Ministry of Health and Sanitation with the District Health Management Team in Kambia here.

Q: If you could summarize your Ebola experiences in just two to three sentences, what would you say?

Barrie: I would say the experience gained from Ebola in Sierra Leone, specifically Kambia, has been an experience for future development in terms of surveillance

activities. It has opened up my eyes [to epidemiology], something which everybody may actually want to be part of because it's very interesting.

[interruption]

Q: I'm back with Mr. Barrie. I'm wondering if we can talk a little bit about your life before Ebola. Can you tell me when and where you were born?

Barrie: I was born in the southern part of Sierra Leone, in a small village called Taiama, in Kori Chiefdom, Moyamba District. I [grew] up in the South, specifically in Bo, that is the second capital city of Sierra Leone. I went to my primary, secondary, and university education at Njala University, Sierra Leone, and I happened to study community health and clinical sciences.

Q: Why did you get into that? Why were you interested in that work?

Barrie: It came about as a result of one of my aunts that was very ill who went to the hospital, and a lot of things happened that never went down well with me. I was thinking, if I could have the opportunity to be part of the medical system, maybe I could change something and do something better. That was where I got my inspiration from, and as God may have it, I had support from my elder brother. After taking my WASSCE [West African Senior School Certificate Examination]—that's the GCE O Level [Graduate Certificate of Education: Ordinance Level] exams—I enrolled into the program at Njala

University. The program, when they started it in the eighties, it only had diploma-level courses. By the time I enrolled, it was at a higher diploma level. Only now, they have upgraded it to a BSc [bachelor of science] level, which I am still intending to have because it's very interesting. It has a lot to do with the community: community people, community involvement, community entry, a lot of community activities. And dealing with local-based people, you have to have the behavioral practices, the health practices I mean, of these community people, so that you can actually deliver the health services you intend to deliver. As a young man coming from a village, I think it was very inspirational to study about community, local community people. That's where I got my inspiration.

I went through the university, and I graduated in 2010. I happened to pick up a job with a local NGO [nongovernmental organization] that was dealing with community activities—that is, integrated community case management. They call it iCCM, integrated community case management, where we were visiting communities, selecting community volunteers—that is, community leaders themselves appoint somebody to be trained and be given basic treatment [supplies] for malaria, diarrhea, and pneumonia for under-five children. We were on those particular activities until 2012. Then I decided to join the Ministry because I was still not very comfortable. Even though I was dealing with the community, my clinical skills were dwindling because I was not practicing enough clinical activities.

Q: What was your role with that organization?

Barrie: To train. I was a supervisor training chiefdom health workers and training community health volunteers that would be delivering these health services in terms of treating children for malaria, pneumonia and diarrhea. It was just like that. Those basic tablets given to those children.

I said, okay, now I have learned a year-plus about the community; I want to go back to the clinical field, where I can really practice my clinical work. I happened to come back to the referral hospital in Kambia here, and I spent a year in the hospital seeing patients of different kinds, treating and referring those that need referral to the tertiary level in Freetown. From there, the District Health Management Team thought it wise that okay, I am fit to head a chiefdom.

The district political division is, from the national level, they have regional divisions—that is, we have the East, West, North and South divisions, and in each of these divisions they have districts. In each district, they also have a chiefdom-level division, which a whole chiefdom may have ten, five—as the case may be—health facilities in those chiefdoms, which is also having a local administrative structure that is headed by the paramount chief. Every chiefdom has got a paramount chief, and in those chiefdoms also, they have section divisions [where] they have section chiefs, and in each section, we have villages.

I was asked to head one of the chiefdoms as a chiefdom health supervisor, even though I was in charge of one of the [unclear] facilities in Briama Chiefdom. I was transferred to

Briama Chiefdom, overseeing the other health facilities like the maternal and child health post. I was heading the referral center in that particular chiefdom. Cases that are beyond their knowledge, they have to send them to me, and if I try also—I have limited services in my health facility, so I will transfer such cases to the district headquarters here, especially cases that need surgical interventions. We were on that till 2014, when we had a big strike of Ebola in the country. [laughs]

The chiefdom I was heading, we had five cases, five confirmed cases of Ebola. As the head of that chiefdom, I tried as much as I could with the involvement of community stakeholders, the involvement of military personnel in that chiefdom, and the youths in that chiefdom—all five cases, I was able to control, and had no secondary infection from all those imported cases.

The first case that was seen, I saw it in my health facility, that was from Freetown. Immediately, isolated the case, make [unclear] here, sample was collected. I spent three days with that case in the health facility, in that isolation. I was giving treatment to that person. Luckily enough for me, I just happened to get the training on IPC [infection prevention and control] that very week, so on my return, I had to take that case, and I was treating that patient.

Q: How were you protecting yourself with IPC?

Barrie: I was using the full PPE [personal protective equipment]. When they came, they had a supply, a massive supply of PPE before we started having Ebola in Kambia District. We were having boots, they had gloves, these overalls [people were] wearing. We had the face shield, [unclear], and face masks and the rest of it.

Q: Those were provided by whom?

Barrie: They were provided by the Ministry through other donor partners like the WHO [World Health Organization], the World Bank. Those were the partners at the initial stage that were providing the support for the Ministry. We were lucky enough to have those supplies in the district, and we took the supplies to our various facilities.

That very week, I had the first case. That case spent three days with me in the health facility. Back then, the only lab [laboratory] in the country was in Kenema [District], and the only treatment center was in Kailahun [District]. That case, after spending three days with me in the isolation unit—because I used a newly constructed toilet building, which was not used, as an isolation [unit] because the health facility was very tight. I think it was wise enough because the health facilitators died, there was no place to put patients of that nature, and I didn't want to allow that patient to be interacting with other patients in the facility. So I had no option but the patient was kept at that particular place.

After seventy-two hours, in the early hours around 5:00 am, I got a call from the lab that the patient I had was a confirmed Ebola patient. Oh, my God. [laughter] That was

something—I was alone in my room. I sat, I started thinking how I was dealing with the patient myself, trying to evaluate what I was doing. On the whole, even though I was not very—I was one hundred percent confident that I may have done the right thing, but I was still scared somehow. Notwithstanding, an ambulance went and picked [up] the patient. Of course, the family members were counseled immediately. Fortunately for the community people, the patient from Freetown came directly to the [unclear] community. That very day, they brought the patient in the evening hours. The contact with family members and the family was so slim, was very limited. The interaction was not that much.

The patient was taken to me. I immediately isolated [the patient], explained to the relatives why I had to do this. Of course, in the country, it was on the news that Ebola is a very deadly disease, and people should refer patients to health facilities immediately as they detect cases. So that community, that's what happened with them.

Q: How did they react?

Barrie: Actually, it was not as easy as someone may think, because you have your loved one, and that someone is sick. You used to take care of your loved one, and somebody is stopping you [from going] closer to your loved one. It was very, very challenging. But the community had quite a lot of confidence in me because before Ebola cases, I'd had so many engagements with the people in that community in relation to preparing their minds—if we have any case of that nature, what would happen. They saw the practical

reality of the things I was telling them, and I told them it was not out of malice, it was not out of any form of hatred, but it was because of the policy to save myself, to save the family and the community at large. Even though it was never well done with them, they accepted it and they kept to the rule.

The lab patient was picked up. Unfortunately, the patient happened to die in the treatment unit. The family members—I can remember we had nineteen people quarantined, to be followed up, in that community. Fortunately for us, they went through twenty-one days without anybody, even a child, manifesting any signs or symptoms. After that, we said okay—the wife that was living with the man, we said maybe they may have had—because the closest person to the husband could be the wife. We said, let's observe her for another week or so. She was observed alone, followed up, and nothing happened. Even up to date, she is very okay. That was the first case.

The district was so worried about me, the District Health Management Team, thinking that maybe I may have done something wrong. The DMO [district medical officer] called me personally on the phone, trying to know how I was dealing with the patient. I told him what I did, even though I was not one hundred percent confident, but I think there was nothing to point at to say I may have become contaminated. Notwithstanding, I was advised to observe myself for a period. That I did, and nothing happened.

The second case happened at Bullom community in one village called—how is it called? Bullom community. Bullom is one of the PHUs [peripheral health units] we have. The

community people made a call to the health facility, and the nurse was competent enough to inform me. I came right there immediately. Went to the community, saw the patient, classical signs and symptoms. We had to make a call to follow up with the family members; there was no secondary infection.

In summary, all the five cases we had in Briama chiefdom within a two-month period, there was no secondary infection. We followed up all the cases, the contacts. There was no secondary infection. The district said, what is the magic? [laughter] What is the magic? I am blamed, because if other chiefdoms—when they had a case, they had a lot of secondary cases coming up. The DMO himself and some few members of the DHMT [District Health Management Team] went to me at the health facility. They asked me this question: what is the magic that I'm not having any secondary infections? The first thing I told them was, first of all, pre-engagement of community people about what you are foreseeing to happen in the future is very, very key. It's like preparing the mind of the husband that is trying to get married to a woman. Counseling, what you may [experience] during the marriage period. It's very important. Something like that I told them, that will involve a lot of community engagement here, and I have personally been moving around the community, engaging stakeholders with pictures about the disease that has erupted in the country. With that, they were having so much confidence in me, and they had seen evidence of me dealing with cases that were confirmed to be Ebola. That was the first thing I told them, that building people's confidence before a situation happens is very key. Very important. They said, alright, if that is the case, then they will implement a similar thing. That was a time a lot of proposals were sent out to partners like UNICEF

[United Nations Children's Fund], like GOAL International, the other partners in the country back then, to intensify community engagement activities.

After some period, maybe over a five to six-month period, the district thought it wise that I should leave the chiefdom and come and head the surveillance unit in the district. It was a very hard time back then. It was very difficult because cases were coming from every part of the district. Every week we were having a lot of problems with people, people hiding away from quarantined homes. People hiding with sick people, moving with sick people at night. All those things were happening. When I came on board, it was very difficult for me the first two months. First of all, when I came, I met a different structure built up now in the district headed by military personnel. Not my usual DHMT personnel, but the military guys. Which is a very good, very proactive system in times of response. We were having three meetings every day. [coughs] Excuse me. We were having three meetings every day.

The first meeting we have is the surveillance meeting. The surveillance meeting. That is to get feedback from other colleagues—the surveillance officers, epidemiologists—that may go to different areas and come back very late in the evening, which you can't have meetings then. So we have like seven o'clock in the morning, the first meeting that will last for one hour, seven to eight o'clock, so that we have feedback from the field and have a strategic plan for the teams to go out. Immediately after that first meeting, epidemiologists, some epidemiologists, surveillance officers, swabbing team members,

we go to the field to areas that need attention, areas that need surveillance activities, burial activities to be done by the burial team which was established in the country.

Then we go, me and some of the epidemiologists and some other key stakeholders, to brief the entire team. We are having a flux of partners in the district, a lot of them, a lot of people, so you need to give them information about what is happening in the district because they were supporting in terms of logistics, in terms of a lot of other things. These partners also need information, as well as the Ministry.

So, after the seven o'clock meeting, we get this information from all the pillars: social mobilization, surveillance, swabbing teams. Then, this is information we present in the eight o'clock meeting. The eight o'clock meeting comprises all the stakeholders. When I say "stakeholders," the district Ebola coordinator; the paramount chiefs of all the chiefdoms, most of the time; the ministers; the counselors; the council; and people from the Ministry of Health and all partners. It's always a very big forum, every eight o'clock. It lasts for something like forty-five [minutes] to one hour, also. That is the time we do presentations to tell them, hey, we've had a situation in A, B, C, D community, and we have A, B, C, D quarantined homes and cases, a lot have just come in from A, B, C, D community, and we are dispatching an ambulance to this community. This update, you give to the entire team in the hall. Questions may come from [any and all sides], and also, requests for support can be made right there also because partners are there to give support, and all the support was coming. So that is how we are responding.

But the sad experience we had was in one community called Kadalo, Kadalo community that was in Tonko Limba [Chiefdom]. Kadalo community—Tonko Limba specifically is a chiefdom that is highly involved in traditional practices. When I say traditional practices, societal issues which are highly, highly secret. Most of the time, if they want to conduct secret burials, they pretend to be having societal meetings, which only [include] the ones that are part of those secret societies. That was the thing that was happening in those chiefdoms. One day—before coming to that, we were having specific surveillance teams. As God may have it, I had twenty surveillance officers in the district back then, and these twenty surveillance officers were distributed by chiefdoms. Every day, whether you have a lot or not, you will be roving in that chiefdom way around just to make sure that nothing is happening that is not being reported. Luckily enough, one of the teams bumped into a meeting, which some people were saying it was a societal meeting, which was not true, not knowing it was a burial. They wanted to conduct a secret burial. And the formation of our team back then was the surveillance officer would go alongside with the burial team, the social mobilizer, the swab collector. They would all go together, go in different cars. The swab collector and the burial team officers will stay in one car, the community engagement officer and the surveillance officer will go in one car. They were having two vehicles moving in one direction at every given time. Because when they met a case, I mean a suspected case, they were going to investigate, engage the people. If it was a death, collect swab and do a burial right there. A "safe and dignified burial," to say. So it happened, they made the burial, collected swab, swab, swab samples, which an [unclear] was not made for. The corpse was already prepared. When I say prepared: washed, dressed. Because in the event of Ebola, there was a policy which said every

death should be reported immediately, and family members should not wash the corpse or dress it. It was only the safe and dignified burial team that was allowed to bury all corpses. In that situation, that was not the case. So, the unfortunate things happened, because of the washing, preparation of that corpse, not known to them that it was an Ebola corpse.

The story goes like this during the surveillance investigation. Before we get that result, after preliminary investigations, four deaths happened retrospectively before us getting to that death. This happened because the father of the deceased, which we collected a sample for, was a traditional healer. And he was the one seeing patients who were sick. So to say: that particular chiefdom was not engaged enough in preparing the minds of traditional healers and the health practices for Ebola prevention. They were not well prepared. They were doing all their normal things. Traditional healers were treating people, and they were doing their burial as normal as they used to do. When the results came back positive, during the community engagement, giving them feedback about the outcome of the result, we heard a rumor that there was a traditional healer there who was sick. We tried to investigate to get the sick man, to no avail. They were hiding the sick man.

But one thing I learned in Ebola: most of the time, people you expect to tell you the truth are the ones that may actually mislead you. People you think you may have confidence in—oh, this person will not hide anything—are the ones that will compromise the situation and hide the truth. That was where we learned that experience from. And

anyone you are following up in a quarantined home, who every day when you go to make follow-up, pretends to be healthy—keep an eye on that person, that person is not healthy. What I meant is that we had a situation, going to a quarantined home to follow up some young guys, up to eight of them. Every day, you meet them [doing push-ups], having this physio-thing, doing some gymnastic activities. When they see you, they pretend as if they are healthy, jumping. Every day they were doing this thing, until one day, one of them could not get up.

[interruption]

Q: Okay. So I think you had just been talking about those guys who, every time you checked up on them, were being super physically active and doing push-ups and all this kind of thing.

Barrie: Yeah. So actually, those guys—that was another experience we had, that if you have followed up contacts in a quarantined home, who that pretends to be very active, keep a close eye on them; they may not be very active. There is a reason why they are pretending to be healthy. We observed these guys closely. One day, one of them could not come out. That person was removed from the quarantine because he manifested some fever, not knowing all the rest were having self-medication in the home, with all the pieces of advice given to them in the quarantined home that when you feel any unusual feeling, you should report immediately so that you can be taken care of. That was [our advice]. They were treating themselves in the home until one of them actually could not

pick up his head the other day. We had to take the person out. He told us based on the confidence we built with him in the treatment facility, he told us that all those other colleagues were really not well because they were all taking drugs. We had to go back there. It took us two days counseling them for us to take them out. The last day, we went and took seven of them out of the house, all of them who were pretending to be tested. We took them to the isolation facility in the treatment unit. We decided to take samples from all of them. We tested all seven of them, all six were confirmed Ebola positive and only one was negative for Ebola. That was another very good experience we had. From quarantined homes, if you are following up people, contacts for Ebola or any hemorrhagic fever disease—in the quarantined home, if you are following up people and somebody is pretending to be super active, keep a close eye and do further investigation on that person. That was a very good point we learned.

Now, back to this Kadalo community. We had to do day-to-day engagement in that community until the confidence of the people were built and they started talking. We got the traditional healer who was sick, we took him out, he was confirmed Ebola-[positive], he died. We had a contact line listed, following up, following them up. They were getting sick every day. We were taking them out and they were dying. Then, we came back to the panel and asked, why are people dying, even when we are taking them out of the quarantined homes? We did further investigation and found out that when you are in a quarantined home and you start manifesting symptoms and you suppress it by taking medication, self-medication, by the time the team realizes, your system is already down. That was another point of message development for people in quarantined homes, as

well. That if you are there, the moment you feel even a headache or even sleeplessness, you should report it immediately and we should investigate you further so that you can be taken care of in a treatment unit. We started getting survivors after the development of that message.

A lot of things happened, really, in that village. We ended up quarantining the entire village. A very small village with about twenty houses. We had over eleven confirmed Ebola cases house-to-house. The first two quarantined houses, people were using backdoor entering to support their loved ones even when they were not in quarantine, feeding them, providing medication and other stuff, so they were carrying the virus from one home to the other house. We ended up quarantining the entire community, and we followed them up. Luckily enough, we had some survivors, about three of them from that community.

Q: How many people were in that community to start with?

Barrie: The population roughly in that community was something like about four hundred. Around four hundred people in that community.

Q: And how many of them got Ebola?

Barrie: We had eleven confirmed Ebola cases, but a situation happened where a lot of them escaped the quarantine. We could have had more Ebola cases from that community,

but some [escaped] quarantine. We even discovered one of them in the bush, we met the skeleton in the bush, which is another story, that woman. When she escaped from the quarantine, naturally she was very short like a dwarf, a very short woman, and they said she was a traditional healer and she was so powerful that she could disappear, she could be standing there and disappear. When she escaped the quarantine, that is what they told us, that she may have used her magical powers to disappear. We were really not very comfortable, but we had no other option. We were still looking for her until, after the quarantine, WHO offered the community people—donated some funds for anyone who discovered even her skeleton, that person would get that reward. The entire community went in to search. They went to one swamp land and they saw the skeleton, the plastic torch light she was having, and by description, you see her bones were very short, very short, short things, just like her, and the clothes she was having on and everything, that was discovered. Now, it came to the mind of people again about eating bush animals. Which animal could have fed on that carcass, on the woman's carcass? We started worrying also about that area. We had a lot of thoughts during this Ebola, which even up to now we are not very sure, we are not very sure if we may not be having the virus around because some people died in the bush. A lot of people escaped quarantine from different locations, and we never accounted for them, to be very honest. Could these people have died in the bush like what happened in Kadalo? Yes, or maybe no. Could these people have crossed to another country and they died there and they were not accounted for? These are all possibilities.

These things happened. From those experiences, we brought in the military guarding the quarantined homes as well. Said, okay, if we quarantine a home, let's have security to guard not only for people not to escape, but also their properties. Because when people are quarantined, a lot of support is given to those quarantined homes which other homes that are not quarantined are not getting. They may tend to come in there to benefit, and during that process, they are contacting the virus and taking it home. That is another thing we learned from the Ebola response, which at the end tail of the Ebola—like, the Ebola ended in Kambia here. [laughs] Ebola ended in Kambia. The strategy we were having at the later part of it was that every community where Ebola is confirmed, we have to do a massive quarantine because nobody will show off nobody now. People were not honest. People were not saying the truth. Because of that, in a smaller community and Ebola cases are confirmed there, we would prefer irrespective of the cost to observe everybody in their respective homes and give them all the necessary support so that the crisscross movement, people moving from other homes to quarantined homes because of the support, may be limited or may be stopped. These ones we are putting—and that helped us a long way.

That brings me to the last case we have in the district, that is Sella Kafta. Sella Kafta, a case was having a link to this same Kadalo community I've just spoken about. It was also a confirmed swab result. From that one case, we also had six other cases coming up. Luckily enough, that was the most successful quarantine we ever had in the district or maybe in the country. Having six confirmed cases with only one dead, all survived. All the five survived. That came about as a result of the community being under quarantine.

Because if somebody is sick, you have nobody to actually find a new way to escape because everybody is restricted in their various homes, and there are security personnel around and all the rest of it. The surveillance activities were so intensified that almost everyone was concentrating, inasmuch that was the last point we had cases. People were there day and night monitoring. In fact, contact tracers were monitoring people four times a day. Four times. Because you may not know if somebody is taking self-medication, but you will not take self-medication four times. If you are getting sick within the day and you are monitored four times, they may notice you within one of these periods, these monitoring periods. That was another very good strategy, that people in quarantined homes should be monitored not within normal—as I said, morning, evening, no. It can be three to four times so that—I mean, it causes you no harm and you may actually get the desired result because people who self-medicate, you cannot stop. But if you really monitor people four times, somebody may not take drug four times. One of those times, you must—especially for fever—you must identify that, and close monitoring, you must come across another manifestation of other symptoms. So that was another thing we put in place which made that quarantine very successful.

From that case, we came back, sat, and discussed so many things that we think can really improve the surveillance and improve the response activities. That is where partners prepared a proposal for Resilient Zero. Resilient Zero means, to my understanding, is to keep the districts of the country under a microscopic eye in terms of continuing especially surveillance activities for early detection and investigation response activities so that cases that may be identified can be contained within that particular area and have better

results. That is where the Resilient Zero initiative came from, and up to now that's what we are having.

We also have this IDSR, integrated disease surveillance response, that has the most strength now to do surveillance activities and taking the surveillance activities to the community level, which is an indicator-based surveillance from health facilities. This also started the end—Kambia District, we had the first training in December 2015, and we started that throughout 2016. With the help of WHO, CDC, GOAL, and other partners' support, we have been able to get at least two health workers as focal persons trained on integrated disease surveillance and response, on early detection and reporting of priority diseases for the country, and also put a system of having district surveillance office—having an alert system, having a district EOC [emergency operations center] that is responsible for coordination of response activities once the surveillance detects anything unusual happening.

Going further, also we have this community-based surveillance that is involving community people into surveillance activities that we call active community participation into surveillance activities by detecting cases and reporting to the nearest health facilities, because the health facilities staff are highly technical. The community may not accurately know the difference, or how to screen cases meeting standard case definition, but the health workers can do that. So we gave the community workers, community health workers, basic knowledge. Basic definitions on ten priority disease conditions that they may detect and report to the nearest health facility immediately, and the health facility

staff would take the responsibility to screen the patient as meeting standard case definition from the district. Then we can respond. That is the kind of system we have right now, and that is what we are actually still trying to strengthen in the district. In 2016, the surveillance in Kambia District reporting rate—we have been struggling with reporting, actually. The start of any program may have a lot of hiccups, a lot of challenges. But our reporting, in the beginning, you can see in 2016—

[crosstalk]

Q: We have a graph over here.

Barrie: You can just see a trend here—something like 2016, this is just a trend to week forty—

Q: Percent trend of PHUs reporting, Kambia District.

Barrie: Yes, that is it. It's a percentage. We have sixty-nine in 2016, sixty-nine health facilities which are IDSR-reporting sites, and all these reporting sites are expected every week, every Monday. The epidemiologic week starts on Monday and ends on Sunday, so the next week Monday, that is the time you report for the past week. We expect that every Monday for the previous week, all PHU staff look into their registers, report to us all the cases of priority they have seen in their health facility before twelve o'clock or on twelve o'clock. We get this data collected, and that's where we derive the percentage

from in terms of PHU reporting. We send those aggregated data to the Ministry. But also, within the week, diseases that are immediately reportable. If anyone is being detected by the health worker, they inform us, "We are going there to investigate." We go there to investigate, we go to the community to do some active case searches through the active involvement of community people, engage them so that we can be sure if it is just one suspected case, it's one. If it is more than that, like in the area of measles—you know, in 2016, we had a huge outbreak of measles which was detected by this system because the system was detecting cases. It means that we were getting, collecting samples. We had a massive campaign which actually brought the trend down, down, down to here.

So something like that, these are the systems we are having at the moment, even though it's not one hundred percent yet, but we can say our system at the moment is capable of detecting at the PHU level. At the community level, we have just started, and we are still struggling to strengthen that as well. My belief is if the community-based surveillance works well, we can go to bed and sleep because disease comes from the community and these community people have the responsibility. They actively see this responsibility as something for the benefit of the community. By detecting cases and reporting them early enough, they may help the community, may help their family, and may help the country as a whole. And that may improve our surveillance system in the country. I think so far, that is what I can share. [laughs]

Q: Sure, of course. Would you mind, I have a couple of follow-up questions.

Barrie: No problem.

Q: Okay. One is—sorry, I have a few of them here. Going back to your Ebola times, the international partners you worked with, can you tell me how they were useful and how sometimes they weren't?

Barrie: Thank you very much. To be very honest with you, Sierra Leone, when Ebola struck, we had no expertise. We had very little, or even I could say no knowledge about Ebola. Had there not been the presence of the partners, maybe the level at which we were able to work and contain the disease—I could say if it was not for the involvement of the partners, we would maybe still have Ebola in the country. Maybe some of us would have gone. Ebola may have carried us. Because we never knew even how to investigate the disease, how to control the disease. The message of the disease that brought a lot of conflicting—everybody in the corner may just bring their own information. But when these partners came, they brought out the facts, key facts about Ebola from experience in other endemic countries where Ebola is actually striking every now and then, before we can have the knowledge. In terms of epidemiology, the country was not having—well, I can't remember if Sierra Leone was having any qualified epidemiologists, as a Sierra Leonean. I can't remember. Maybe there was one or two, but I can't remember. But the advent of the partners, they were very useful in terms of capacity building, which made some of us today to say yes, we can investigate, and we can give some quality reports on case investigations or outbreak investigations. They were very useful. They were very useful in terms of supporting the Ministry, the district, and the response activities in terms

of logistics. We had no cars when we started Ebola. The same ambulance we were using to bring, like, pregnant women, [unclear], was the ambulance we were using to bring suspected Ebola cases. There were no ambulances in the district. We had no field support. Without the advent of the intervention of the partners, we were nowhere, to be very honest.

Q: Which partner helped with the ambulances?

Barrie: DfID [United Kingdom Department for International Development] did. DfID brought a lot of ambulances for the country.

Q: What did CDC do? What was their role?

Barrie: CDC, WHO were very instrumental, one, in capacity building; two, actively involved in case investigations, the containment—all the response activities, they were actively involved in that. They were providing some logistical support as well. Most of the trainings we were having, CDC was conducting those trainings. WHO was also conducting those trainings, different trainings. They were providing tools. Like the CIFs we were using, the case investigation forms, were provided by CDC for VHF, viral hemorrhagic fevers. CDC provided the VHF database[1] that we were using here. They were very useful. WHO was also providing field support, vehicles, and those supports

[1] This was the CDC database Epi Info, which had a viral hemorrhagic fever module developed by CDC's Viral Special Pathogens Branch.

were given to the DHMT by them. Till DfID later on procured these ambulances for the district.

So they were very useful. From them, we learned a lot. Even now, we are still learning. I never knew anything about computers. I was in my village there. I don't even have a phone that is having internet. But with the interaction of these partners, CDC and WHO, now I can say, well, I can do basic analysis, I can manage my data, I can read my data and it make sense to people. Those things. These are things we are actually very proud of, that is a legacy now. Luckily enough for us, an epidemiological training has also started in the country which is also another very, very important capacity-building aspect for the Ministry of Health and the country as a whole. The country was not having epidemiologists, and now CDC is helping the country to have epidemiologists in the country, which is a plus, plus, plus to the country, which is a very good thing.

Q: This is the Field Epidemiology Training Program?

Barrie: Yes. The Field Epidemiology Training Program.

Q: Which you yourself have gone through.

Barrie: I have gone through—I was part of the first cohort. We were the first batch that went through the FETP, which sounds very interesting to me, which actually I am—

[interruption]

Barrie: —I am inspired to do further epidemiologist courses, if I have the support. Really, I'm really impressed to have these public health studies.

Q: Why did you decide to do the program?

Barrie: Why I decided to do the FETP program? Because I looked at the FETP program to be an eye-opener for me to go into epidemiology proper. As far as surveillance is concerned now, it's not only going to the field, how many cases [unclear], and stop there. No. You should have the skill, the knowledge, to analyze your data, interpret your data, make sense out of it, communicate your findings. Then, you can plan to actually know how to prevent the people in the community from [getting sick]. So that kind of stuff, you can only achieve that if you are actually trained in the epidemiology course.

Q: Has that training impacted your work yet after you graduated? The training you got there?

Barrie: Very positively. That has also inspired my colleagues. As I graduated, another colleague has already graduated, and we are also trying to send other colleagues to start the program. Because we are always seated together, they are seeing the wonders we are doing with this [Microsoft] Excel, making powerful presentations, very nice. Everybody's

inspired, wants to be part of it, wants to do it. Every surveillance officer wants to be an epidemiologist. That is very, very important.

You asked me about what are some of the things that the partners did that was—

[interruption]

Q: I had also asked something about the international partners.

Barrie: Yeah, some of the things that never went well. There were a few things. What we actually learned from the response as far as the partners' support that was coming. Here, we are so pleased. But again, too many partners. We had too many partners. At the end of the day, they were duplicating efforts, which actually in resource management was not well done. A lot of resources were used extravagantly. Somebody may be bringing this thing and the other person is duplicating the same thing, the same thing over again.

Q: Can you give an example?

Barrie: Yeah. For example, we were having a lot of community engagement officers from different partners. This partner may say, "I have five hundred community engagement officers," this partner will say, "I have one thousand community engagement officers," which most of these people were playing dual roles. It may be the same person with this partner, the same person with this other partner. The same people, just to have money

from this partner and have money from this partner. In short, the coordination with partners was not very, very strong in the beginning, so everybody was doing their own thing, which actually, from experience, I think a better coordination in partners' effort in the future would be the best thing for every outbreak response. The support is needed, it's fine, but the coordination so that one cannot duplicate the effort, so the resource management can also be effective.

One thing I didn't mention in the response was the intervention of the CCCs. I didn't mention CCCs, community care centers, Ebola community care centers. How did this come about? In the response, we were taking people from the community, transporting them to Freetown, transporting them to the district here just to isolate them, take samples to know whether it's confirmed or not. And the community people were having a lot of resistance because they want to have their people isolated in their chiefdom, in their locality, and be tested before evacuation. They were making it very clear to us that if we want to take somebody out from their community, that person's result needs to be known first, and they will only allow us to take people out of the community, even when they are sick, when the results of that relative is confirmed to be Ebola. Then, after a group discussion, UNICEF said, okay, I will give the support. In every chiefdom, we are having isolation facilities built in those chiefdoms, not as taking sick people now from Briama Chiefdom to the district quarantine here. And also to limit the transmission of the disease in the district health quarantine because we were having infection either on the way or on arrival or in the ETC [Ebola treatment center] or in the isolation [facilities]. So, we started isolating people now at the community level, taking their samples right there,

sending the sample to the laboratory, and the result determined whether the person [had] Ebola or not. Their status.

Also, another thing I forgot to mention, which is another very good strategy for communities that are having limited knowledge on diseases like Ebola. It will be better for people to be isolated in their locality, followed up until their result is actually confirmed to be Ebola, or the disease you are isolating for, before taking the person out of that community. So that one, you build the confidence of the people; two, the people will have access—not actually getting in contact with the person, but may have access to hear information about their relative and maybe see their relative from a distance and all those things. Confidence building, that's very key, that I didn't mention.

Q: Thank you for that. I had one question also. Did you ever have the opportunity to ask people who had escaped quarantine what motivated them to escape?

Barrie: I think yes, that was actually investigated, because many people would stay in quarantine throughout the period, and many people were running away, they were escaping quarantine. The reasons behind that were misleading information from other people, like in the country. As I said, we had limited knowledge of Ebola, and people were having misleading information. People may call from Freetown, they call their relative in quarantine [and tell them], "Leave the quarantine! The government wants to make money out of you, they will be collecting your blood to go and make business!" And all those kind of things. People were scared and they were escaping quarantine. That

was happening in the initial—and even in the meat of the response period, these things were happening. A lot of people were [escaping quarantine] because of fear. They were just afraid. We have this infrared thermometer. They were calling it a pistol. Infrared thermometer, which it looks like a pistol. They say when they point that thing on you, they are—you know, so a lot of things. People were having misleading information on the use of that thing, so they were afraid, so most of them were escaping quarantine.

Q: I—sorry, I see you checking your phone.

Barrie: Somebody was calling.

Q: Do you need to end the interview pretty soon?

Barrie: Yes.

Q: Okay. Let me just ask you then, Mr. Osman Barrie—first, thank you again for giving us your time. Is there anything else that we have not described—I know you just talked about the CCCs, but any reflections or any memories about your Ebola experiences which you would like to share before we end the interview?

Barrie: Yeah. I think a couple of them have already been mentioned. [laughs] I think the Ebola that came to Kambia District specifically made us actually have a lot of experience in terms of outbreak response. First of all, planning for an outbreak. Because from the

experience we have—the country had never planned for an outbreak, not to talk about the districts. They had no plan. There was no plan. So that is one thing actually—even now, the Ministry, we are always talking about district plans, emergency preparedness plans. Always be planning not only for Ebola, but for other diseases that have the potential to cause an epidemic, like cholera. Of course, we are in a cholera-prone district. Sometimes we have cholera in the district. That is one thing. It taught us how to have an emergency preparedness plan, and also to be triggering ourselves as to whether we are actually up to task. Having simulations. That is another thing that Ebola [educated] us, and having the coordination unit. When Ebola came, everybody was doing their thing. It was not well coordinated. But now, having the coordination structure at the district level, it is something very remarkable that every district is having a district emergency operating center. When something happens, you can immediately call all your partners, your stakeholders, and discuss and plan how to respond to it. That's another thing that's very key I think, that is very remarkable. We can continue it.

Q: I just want to thank you for your time, for your reflections, for everything. Thank you so much.

Barrie: Thank you very much. I am also pleased to have you with me.

Q: Thank you.

END