‘Atomic Bombs’ in Monrovia, Liberia
The Identity and Stigmatisation of Ebola Survivors

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ABSTRACT: Survivors of the Ebola virus have been widely profiled as the success stories of the outbreak, yet they still face challenges relating to their identity and reintegration. A survivor’s body takes on new meanings after experiencing Ebola, and the label ‘survivor’ is as problematic as it is celebratory. Using data conducted during fieldwork in Monrovia, Liberia, this article discusses the complex identities of Ebola survivors. In Monrovia, most of the stigma and discrimination relating to survivors was directed towards men, who were considered ‘atomic bombs’ because of concerns that they could transmit Ebola through sexual intercourse. Health promotion messages around sexual transmission were often misunderstood, and communities requested the quarantine of men to reduce what they felt was a threat to the wider community. Understanding the meanings and sources of such stigmatisation is necessary to be able to work with and support survivors through psychosocial care and health promotion activities.

KEYWORDS: Ebola survivors, identity, Liberia, quarantine, stigmatisation

Since the Ebola outbreak began in West Africa in 2014, there are currently estimated to be 15,000 survivors across the region, some of whom continue to suffer with physical and mental health problems after being discharged, including joint pain, tiredness and chronic fatigue, hearing difficulties and problems with their eyesight. The potential for the ongoing sexual transmission of the Ebola virus is also an area of concern clinically and in terms of the ongoing stigmatisation of survivors (Christie et al. 2015; Deen et al. 2015; Mate et al. 2015; Sprecher 2015), especially as recommendations and guidelines around sexual transmission are continuously being updated as new research is conducted (Thorson et al. 2016). In addition to being of benefit to survivors themselves, information about the range of health problems facing them – including viral persistence – is important for health-care workers to have access to so that they can avoid infection themselves (Harries 2016).

The traumatic experience of being inside an Ebola Management Centre (EMC), as well as the potential loss of other friends and relatives in addition to the breakdown of social relationships and ties, and the loss of employment, can also contribute to psychosocial problems. Psychosocial challenges were in fact reported by 35 per cent of survivors in a previous Ebola outbreak in Kikwit, Democratic Republic of Congo (DRC), who reported feeling rejected by their communities as well as their friends and families when returning home (Arwady et al. 2014; De Roo 2002). Survivors are often unable to return to their lives as they were before they became infected and are thus in need of ongoing support, including psychosocial and material support (Lee-Kwan et al. 2014) to assist them with rebuilding their lives after a period of traumatic sickness. Rather than focusing on the clinical and medical aspects of survivors, however, this article looks at the complexities of ‘being a survivor’ and what the identity means to those who lived through a virus that killed so many others. Throughout the article, I consider the meaning and use of the word ‘survivor’ in Monrovia, the experiences – positive and negative – of those who have survived as well as how male survivors in par-
particular were subjected to stigmatisation from those around them.

This article is based on anthropological research conducted in Liberia during October and November 2014. Ethnographic research consisted of participant observation in communities and in the ‘ELWA 3’ Ebola Management Centre (EMC) run by Médecins Sans Frontières (MSF) in Monrovia, as well as in-depth interviews and focus group discussions with survivors, health-care workers, local community members and community leaders across the city.1 The research took place in six different neighbourhoods across the city, which were chosen for their diversity and because they were areas in which MSF had previously worked. Interviews and focus group discussions (FGDs) were mostly conducted in English and covered a range of topics including understandings and local meanings of the Ebola virus and subsequent service provision; perceived needs for survivors and their perspectives on the crisis.

The context in which the research took place – as with most of the articles in this special issue – was complex because the research team were restricted by strict security protocols put in place to minimise the risk of contracting Ebola. I was required to minimise the numbers of people who took part in focus group discussions to avoid creating crowds, and to ensure that the ‘no touch’ policy was respected amongst research participants, as well as ensuring hand-washing protocols were in place. The research team, as was common practice during the Ebola outbreak, did not shake hands with research participants and did not enter their homes, staying instead in outside areas such as on their porches or in their gardens. Focus group discussions were conducted in open-air spaces or community venues identified by local leaders – some discussions were held in empty classrooms, as schools were closed because of the outbreak. These limitations had an obvious impact on the typical relationship between anthropological researcher and participant, reproducing the unnatural boundaries and barriers that Liberians were facing every day through research that should instead be breaking down boundaries. In addition, there was sometimes suspicion about the role of myself as researcher and the other members of the research team, as there were many international organisations working in Liberia at the time of the outbreak, and it was not always clear to community members who was providing which kind of service. It was important not to raise false expectations amongst research participants about what their participation could involve, as many thought we were linked to the provision of goods or services provided by other NGOs working in Liberia at the time.

All data collection was supported by local research assistants, who aided in recruitment of participants, translation and note-taking during interviews and FGDs, and the transcription of audio recordings.

In this context, it was not feasible to interview people with Ebola who had been admitted inside MSF’s EMC in Monrovia: even if access were feasible, writing or recording notes would have been impossible as nothing could be removed from the high-risk area. The only possible experience was as an observer, still wearing personal protective equipment (PPE) but getting a better – albeit brief – understanding of how the inside of the centre worked and trying to understand the EMC from the perspective of a patient, as well as a health-care worker.2 Working a night shift during my time in Liberia offered a limited glimpse into this world and the experiences faced by people – health-care workers and patients – within the ‘high-risk zone’ of the EMC.

The intense period of fieldwork, combining observations in the community with in-depth interviews and focus group discussions, also involved a daily process of data review through discussing the findings and ideas gathered in the field with the MSF teams on the ground, as well as with other anthropologists in the region and through virtual networks.

Understanding Survivor Identity: Who Is a Survivor?

The identity of being a ‘survivor’ is complex: the label can become all-encompassing and the only way people are defined, or choose to define themselves. ‘Survivors’ are caught between being celebrated and at the same time being feared. The identity of a survivor is highly stigmatised because the person is automatically associated with Ebola infection. The fear surrounding Ebola survivors includes concerns about the potential for the transmission of the virus as well as fear relating to the experiences the person had inside the Ebola centre. Rumours and gossip spread, meaning that the EMC was feared and associated with death, as we also see in Manca’s article in this issue. On the other hand, being a survivor can enable people to access additional support structures, such as being a member of a survivor association, receiving monetary or material benefits from organisations supporting survivors and, in some cases, being able to gain employment at the Ebola centres or in other Ebola-related activities such as health promotion.
Interviews and discussions with staff working in the EMC revealed that people who did not have Ebola and who had never tested positive for the virus also considered themselves survivors because they had been admitted to the centre. Indeed, when a person arriving at the EMC in Monrovia was suspected of being infected with Ebola, they were first admitted to the triage area, where the clinical team (dressed in light PPE) would decide – based on a set of clinical criteria and screening questions – whether or not they should be admitted as an Ebola ‘suspect’. If it was decided that they could have Ebola, they would then be admitted to the suspect area and be tested for Ebola. The Ebola suspect area thus contained people with and people without Ebola. Patients discharged with a negative Ebola test often considered themselves exposed, as they often slept one or even two nights in the ‘suspect zone’. They felt that they had experienced the same trauma, stigma and discrimination as those who had been infected, and should have access to the same support and benefits as them. People on the ‘outside’ who had never seen the inside of an EMC also made little distinction between people who had tested positive or negative for Ebola, and considered anyone who had been admitted to an EMC as still being at risk of transmitting Ebola or having an experience that they could not comprehend.

Those who had survived Ebola, however, felt that they were different from those who had not actually been infected with the virus, such as this 67-year-old man from the Chicken Soup Factory neighbourhood of Monrovia:

> There is a difference, there is a difference. The difference is that I went under treatment and those people – I know because I’ve been in the camp [EMC] there – when you are negative, they don’t keep you and they will tell you to go and do this and that; but if you are positive, you will remain there and sustain every treatment until you get out. They are far off from us, they are far off.

Whilst it may seem clinically clear who is or is not a survivor, people’s individual experiences differ and the label ‘survivor’ is heavily loaded. For some, the experience of the EMC makes them a ‘survivor’, whereas for most people, they take on the identity if they have been infected with the virus and survive.

**Proving Identities**

The term ‘survivor’ was used by humanitarian agencies, EMC and outreach staff, the local and international media and survivors themselves, but what makes someone a survivor and what does this name really mean? Medically speaking, the term ‘cured’ does not apply in the case of Ebola, because there is – as yet – no cure for those who are infected. Instead, we talk about those who survived, through their own immune response rather than because they were treated with a specific medication or therapy. Any treatment given is symptomatic and supportive (such as oral rehydration and the provision of IV fluids and nutritional support) and, outside of clinical trials, not against the virus. In addition, systematic treatment for potential co-morbidities (such as antimalarial treatment and antibiotics) was given.

Survivors of Ebola – those who were admitted to an EMC and recovered – were given a certificate by EMC staff declaring that they were ‘Ebola free’. Certificates became a form of public currency: rather than being a confidential medical record, they were viewed as documents that proved someone was Ebola negative, and something that others felt entitled to have access to as a means of protecting themselves from what they perceived to be the risk of becoming infected. It was not uncommon during FGDs to hear people saying that ‘they [survivors] must show their certificate’ or ‘I would need to see their certificate’ when talking about how they would feel if survivors came back to their communities.

Survivor certificates became a source of pride and emotion as they were a reminder about how close someone had come to death, but they also became a passport to ease access to material resources, benefits and support structures. For others, certificates were the proof that the survivor was no longer infectious and for the individual person, the certificate was an (un)welcome reminder of their experience. The certificate was also a source of stigmatisation: despite stating in writing that the individual was Ebola negative, it was proof that they had experienced the inside of an EMC and were thus associated with the fear of death and disease.

**Celebrating Ebola Survivors**

Survivors were also celebrated upon departure from the EMC, which included being given a certificate, new clothing and basic food supplies; singing, dancing and even interviews with local and international media organisations. Despite this, it was difficult to ask survivors to reflect critically on the label ‘survivor’ that had been given to them because – despite the challenges of reintegrating into their lives after
the EMC – they were all obviously happy and relieved to be alive after their near-death experiences, and considered surviving as a positive, celebratory state. They compared themselves to those who had not survived, and talked about how they had been ‘saved’ when others had not:

Yes, yes if you call me survivor it’s no problem with me. People go there and never came back and I went there and came back, so you called me survivor. It can’t make me vexed [upset]. (Male survivor, Liberia, age unknown)

A young woman talked to me about how she liked the term ‘survivor’ because it was a reminder to her that she was alive when she could have died, as many others did:

I like the survivor name. When we were coming home from the hospital, they were calling us the Ebola Survivor name. Some people go there and they did not survive, and me I survived from it: that is why I like the name. (Female survivor, 24 years old, Chicken Soup Factory)

The celebrations surrounding individual survivors were extremely welcome, and rather than suggesting that such public and private displays of joy should not take place, I am instead offering a more complex reflection of the situation in which such survivors found themselves after being discharged from an EMC.

**Challenges and Negative Experiences of Being an Ebola Survivor**

Although, upon leaving the EMC, survivors were publicly celebrated, outside the protective confines of such an environment, their Ebola status was not necessarily known to others and was not always something they wanted to share. Some people wanted a public ceremony to welcome them home, whereas others preferred to take unmarked transport home (without an MSF logo or a staff member wearing identifiable clothing) and slip back into their previous life unannounced. The experiences of survivors when returning home varied, but many were exposed to stigma and discrimination and faced difficulties in reintegrating into their home life. During interviews, survivors spoke about their experiences, and the reactions that people had towards them, such as this man describing his story:

[S]ome of them used to pass by to speak to us, talk to us but the manner of contributing something to-wards us was not there … Here, nobody used to pass here, they were on that side, just like that [indicating across the road]. I was feeling bad because at least if something like that happens you can come around and say ‘oh my brother, hello’, but nothing … Since we brought these documents [survivor certificate] and all these kind of things, some of them started coming around and this and that and so and so. […] Through these papers and those kind of things they started getting brave to come closer to us but before that it was … Until now even some of … even my children or my very close friends say they are still in doubt of this thing. (Male survivor, Chicken Soup Factory, 67 years old)

The female survivor cited below talked about how people in her community were scared of her and enforced their own 21-day period of quarantine to protect themselves against the threat they perceived she still held:

I feel bad because people ran away from us. They never used to come here; before they put us for 21 days and they never brought food, nothing. When it became safe for people to come around me, they were scared. People ran away from us; they put us on 21 days: no going in the market, no going anywhere. My pastor used to bring things and put them on the road for the children to take. Not a small thing we go through. Now people are coming around me because I [have] no sickness, nobody is dying in the house so people can come now. (Female survivor, 24 years old, Chicken Soup Factory)

Both of these experiences show how their communities reacted to their return home, as well as how an additional 21 days of quarantine (the incubation period for the virus) was enforced by the community to minimise what people still considered the risk of transmission (see also Pellecchia 2017, this issue).

As the other articles in this special issue also discuss, the history and context of a country cannot be ignored – Liberia’s history of civil war cannot be forgotten when analysing the epidemic, and for many people, Ebola felt like a new battle that they were fighting within their society. The language of war was adopted readily and regularly – people described themselves as fighting against Ebola, but they also began to battle against the perceived threat of male survivors who were viewed as outsiders.

In the FGDs, conversations centred around the idea that survivors should be welcomed back into their own communities. Thus participants made a distinction between survivors from their own neighbourhoods and those from ‘other’ outside areas, who were considered a threat. Survivors from their own
community were welcomed home and they suggested that survivors should be given work as health promoters or in community outreach teams, but said that they would not trust or accept survivors coming from other communities, particularly if they were going to be engaged in paid employment. These sentiments were based on the fear of being infected by someone from the ‘outside’ but also alluded to the need to protect themselves through engaging in activities of economic benefit. There was a sense of fear that an ‘outsider’ from another community could take a job that they wanted or needed themselves.

Whilst much of this discussion focuses on the stigmatisation and discrimination experienced by survivors, not everyone had the same kind of experience and many survivors were welcomed home by their communities, friends and families and reported being given gifts of food and clothing upon their return.

### Are There Any Benefits to Being a Survivor?

Apart from the obvious celebratory fact of being alive and having survived a terrible disease, there are several ways in which the identity of being a survivor was also observed to have been a means to access essential goods and resources. On arriving in a neighbourhood near the ELWA 3 EMC in Monrovia one morning, I was stopped and called over by a woman – a survivor – who I had interviewed a few days earlier. She waved her phone at me excitedly, saying that she had ‘registered’ and wanted to know when we would be giving her the money. I was unsure of what she meant and what she had registered for until I remembered a meeting I had attended the previous day in which survivors were going to be given cash instalments by another NGO to help them buy essential goods after they had been discharged from various EMCs around the city. These cash instalments were to be paid via a form of ‘mobile money’, which required the recipient to register a mobile phone in order to receive the payment. She assumed that I was part of this service.

Another time I was walking along the road to the office – the MSF offices were well known to people in the community and there were often queues of people waiting outside in the hope of picking up daily work – when I was stopped by a man. His only words to me were ‘I’m a survivor. Do you have a job for me?’ He was desperate to find work, as he no longer had a job as a result of stigmatisation after being infected and spending time inside the EMC and had also realised that there were organisations offering assistance and employment to survivors such as himself.

During the time of this fieldwork, MSF began to employ survivors to work in the high-risk zones of the EMC and in outreach and health-promotion activities in Monrovia, as they understood the situation that EMC patients were in and were able to offer other patients support. Within the EMC, they were able to comfort children and babies who may have been lost or separated from their parents, and they could stay inside much longer because they did not have to wear full PPE, wearing instead a lighter version which kept their faces visible and did not restrict their movement in the same way as the ubiquitous, anonymising yellow suits. Although many survivors appreciated their status and wanted to be able to ‘give something back’ to others after their own EMC experiences, there was some concern amongst Liberian staff about their presence as they believed they were being put at risk because the survivors were not following the restrictive and stringent safety regulations that they had been trained to abide by on a daily basis. In addition, survivors needed support from the mental health team before coming back to work in the EMC because of the trauma they had experienced as patients.

Although providing survivors with essential material and psychosocial support and opportunities after they have been infected with Ebola is justified and necessary, the identity of who is and who is not a survivor becomes even more poignant when there are resources involved. The individual survivor must accept being publicly known as a ‘survivor’ to access essential support – whether material or social networks such as survivor groups or associations – as without this label they would not be able to benefit from such resources.

We must also consider the degree and kind of support given to survivors, especially when thinking about material or financial assistance as well as psychosocial or clinical follow-up. Providing economic or material support – whilst giving survivors essential equipment or the financial means to begin to rebuild their lives and replace items that may have been lost when their homes were damaged by the spraying of chlorine during disinfection – can be ethically complex and raise issues of dependency. Access to such support is also closely linked to survivor identity and may be restricted to those who have been defined as Ebola survivors or who were treated at specific health-care facilities, thus may not be inclusive to everyone who defines themselves as a survivor, as discussed in more detail above. Chal-
Challenges with data collection and storage may also mean that some people are not listed as survivors, or their details may be lost, thus preventing them from accessing support available to others.

**Stigmatisation of Male Survivors: Understanding the Threat of 'Atomic Bombs'**

Whilst the previous discussion highlights the issue of stigma, at the time this data was collected, the main discrimination encountered by survivors seemed to be aimed towards men because of the perceived risks around sexual transmission of EVD. Interestingly, although there was also a potential risk of transmitting Ebola through breast milk, these messages were not picked up on in Monrovia, and instead the focus and indeed blame for transmission became linked to men. In one particularly heated FGD, a local religious leader talked of male survivors as being ‘atomic bombs’ which were threatening the entire nation.

In 2015, the WHO’s official guidelines on the risk of sexual transmission of Ebola were as follows:

No formal evidence exists of sexual transmission, but sexual transmission from convalescent patients cannot be ruled out. There is evidence that live Ebola virus can be isolated in seminal fluids of convalescent men for 82 days after onset of symptoms. Evidence is not available yet beyond 82 days. There is no evidence of live Ebola virus in vaginal secretions. (WHO 2015)

These guidelines also added that ‘all survivors, their partners and families should be shown respect, dignity and compassion’ (WHO 2015). The most recent, updated guidelines (published as this article was being written) provide more information and research into the sexual transmission of the virus:

Recent data suggest that Ebola virus can persist in the semen of males for a year or more after acute infection, although it is not clear for how long the virus is still infectious. Although thought to be rare, sexual transmission of Ebola virus has been reported. Consequently, all EVD survivors and their sexual partners should receive counselling to ensure safe sex practices until their semen has been determined to be free of Ebola virus. (WHO 2016: 22)

These official guidelines, however, became distorted, misconstrued and adapted by individuals who were understandably terrified of becoming infected and wanted to minimise their risk of contracting Ebola as much as they could. Locally produced variations on the initial ‘82 days’ mentioned above include what became known locally as the ‘90-day rule’, men abstaining for an additional six months and Liberians requesting that men be quarantined in camps. The often confusing and contradictory information depended on the organisation that provided it, as well as the access people had to information circulating in the local and global media.

During my fieldwork in Monrovia, I would repeatedly hear anger and fear directed towards male survivors as community members picked up on and interpreted the WHO warning about the potential sexual transmission of the Ebola virus through semen in ways that were meaningful to them, and that became stigmatising to others. Much of this fear was paralleled with a desire to protect themselves and those around them – especially women in their communities – from the unknown and invisible threat survivors were believed to bring. Whilst no interviewee or focus group participant directly used the term ‘rape’ or ‘sexual violence’, the discussions that took place during focus groups hinted at this threat and referred to the ‘lack of control’ they felt men would have when being discharged from an EMC, and would thus transmit the virus sexually to others.

Focus group participants across Monrovia would often request separate ‘camps’ for men, saying that they wanted them to be put in quarantine for an additional three or six months as a way of controlling and containing the virus. They imagined that creating such a camp would be for the ‘good of the nation’, with people wanting to prioritise the collective rights of the country over the individual rights of Ebola survivors.

At times the ‘blame’ for sexual transmission seemed to shift towards women, who were told during public campaigns that they should not encourage or entice their boyfriends or husbands into having sex with them as they would then be responsible if they became infected with Ebola. One memorable radio show gave women the advice that they should not wear clothing that could be considered ‘sexy’ in case this encouraged men to want to have sex with them. Even though publicly men were feared because they were seen as the ones who could transmit the virus, this example shows how the blame was also shifted towards women.

**Supporting Survivors**

Whilst health promotion messaging from different NGOs and institutions across the region originally
focussed on modes of transmission and the prevention of Ebola, it became clear that messages needed to be changed and updated constantly. It was necessary first to update and give out accurate health promotion messages about EVD in general but then to include messages that went beyond classic prevention to include messages about avoiding stigma and welcoming survivors home when the epidemic shifted.

One of the main challenges in trying to combat the stigmatisation experienced by survivors was ensuring that people had access to accurate, timely information through health promotion activities that went beyond early messages about preventing the transmission of the virus (such as hand-washing and avoiding touch) to include information about the potential risk of sexual transmission. While conducting fieldwork, the editors of this special issue both noticed how ‘connected’ Liberians living in Monrovia were to media news and sources of information, and were often asked to defend or clarify stories that had been reported in the local or international media, including updated information about the sexual transmission of the virus. This meant it was paramount to stay ‘one step ahead’ and give accurate and up-to-date information before it became distorted and diluted or became damaging rumours.

There are many different ways that survivors need continuing support, and these will continue to develop and change as more is learned about the physiological and psychosocial effects of Ebola upon the virus’ survivors, not just in Liberia but across the West African region. One of the main ways of offering people support is through survivor groups or associations – groups of survivors who meet regularly to discuss their challenges and look for ways to help each other (Gortor 2015). These networks serve as a way of replacing social networks and ties that may have broken down as a result of Ebola, and such groups have been set up in the three most affected West African countries. As many people find themselves excluded from their communities, they need to find new ways of receiving support and new groups of people to interact with, hence the need for such associations.

The potential for sexual transmission is also an opportunity for providing counselling around HIV and STIs to survivors, their partners and their wider communities. Parallels between HIV and Ebola have been discussed elsewhere, and much of the stigma surrounding Ebola is similar to that experienced by people living with HIV (Calmy et al. 2015; Paul 2015). When considering the potential of sexual transmission, it is essential to involve not just the individual survivor themselves but also those that they are in a sexual relationship with.

**Conclusion**

The nature and identity of Ebola survivors – and the kind of care and support they require – continues to change as we learn more about what it means physiologically and psychosocially to be a survivor. Health promotion messages and information given out across the region need to be consistent – something which is challenging when scientific research into survivors, their health needs and the potential transmission risks are ever-evolving. Survivors, particularly men, were stigmatised and misunderstood due to a lack of accurate and consistent information given out to local communities about the sexual transmission of the virus. Survivors are in need of ongoing support, but they also need assistance in setting up their own networks and associations which can directly meet their daily needs.

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**Notes**

1. ELWA 3 was the local name given to the EMC due to its proximity to the ELWA hospital.
2. PPE was commonly seen in media images of the Ebola outbreak, and refers to the personal protective equipment worn by healthcare workers coming into contact with an infected person or their bodily fluids to prevent them from becoming infected.

**References**


