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An integrated psychosocial approach to Ebola Virus Disease prevention and containment carried out by the Missionary Sisters of the Holy Rosary in Lofa County, Liberia, 2014-2016

November 2017

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Misean Cara acknowledges the contribution to this research made by the Missionary Sisters of the Holy Rosary in Ireland and Liberia. The extensive and essential nature of the Sisters' contribution is described in the following pages, and without their commitment and solidarity, this report would not have been possible.

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List of Acronyms

CDC	Centre for Disease Control
DSAI	Development Studies Association Ireland
ETU	Ebola Treatment Unit
EVD	Ebola Virus Disease
MSF	Medecins Sans Frontieres
MSHR	Missionary Sisters of the Holy Rosary
NGO	Non-Governmental Organisation
PPE	Personal Protective Equipment
SELL	Social Empowerment through Learning Liberia
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund (acronym is from its former name, "United Nations International Children's Emergency Fund", though this is no longer used)
WHO	World Health Organisation

Executive Summary

The scale of the 2014 Ebola Virus Disease (EVD) outbreak in West Africa presented unprecedented challenges for the international humanitarian community, and learning from the successes and failures of the response effort is important for designing future crisis interventions. Lessons learned from the West Africa EVD response include the danger of neglecting psychosocial and cultural considerations, and the importance of non-medical interventions aimed at community mobilisation and behaviour change. As a result there have been calls for further research on EVD response interventions that integrated psychosocial considerations from the outset.

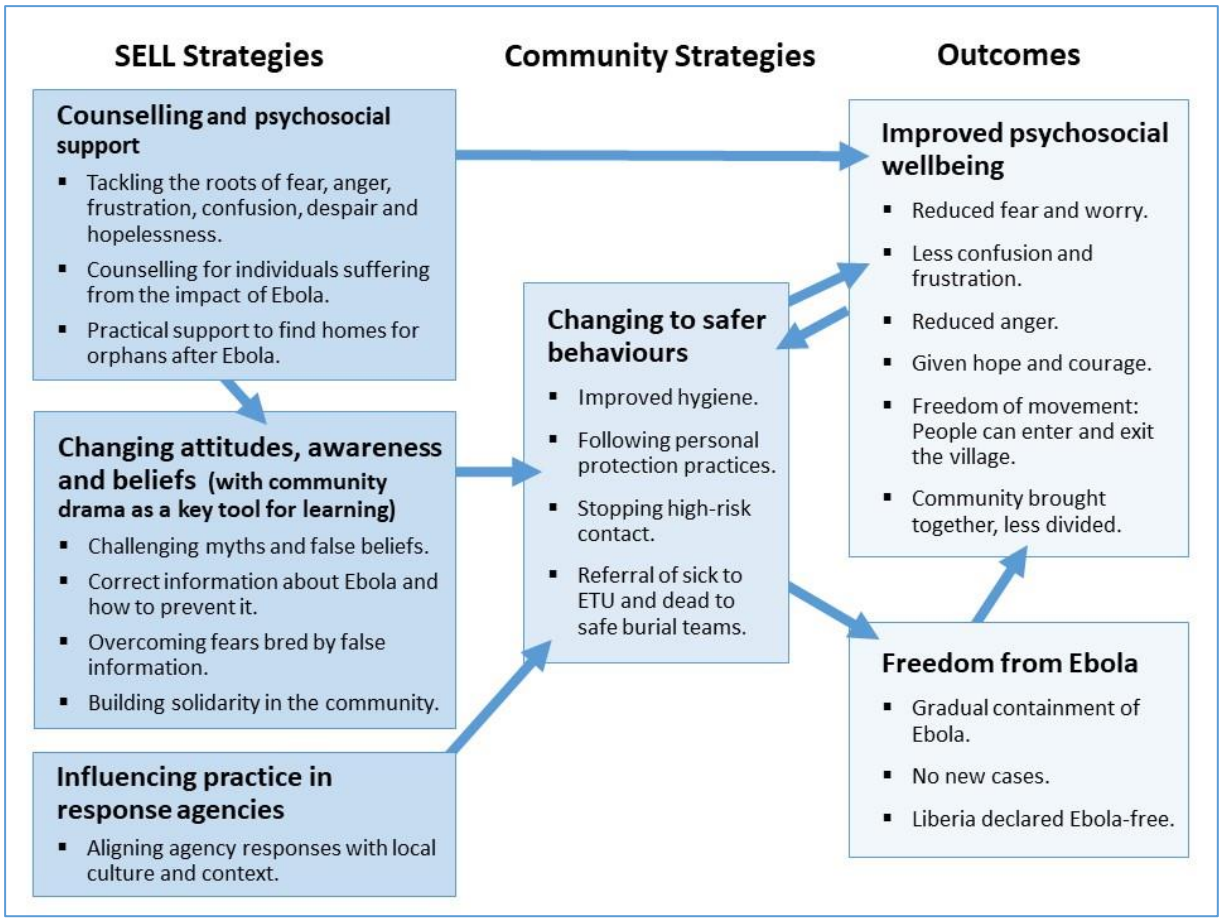
This study explores the mechanisms underlying changes achieved by one such intervention implemented by Social Empowerment through Learning Liberia (SELL), a local NGO based in Lofa County, Liberia, established by the Missionary Sisters of the Holy Rosary (MSHR) in 2007. SELL had been working in villages across Lofa County raising awareness and building solidarity on issues such as land rights, adult literacy and gender-based violence, before changing its focus to the new challenge of responding to Liberia's EVD epidemic in 2014. SELL used community drama and a Critical Pedagogy 'social analysis' approach to teach communities about EVD prevention, and provided trauma counselling to people affected.

This study was based primarily on analysis of qualitative data from a series of extended interviews and focus groups, including discussions and participatory dynamics based on picture drawing, with members of communities affected by the crisis, SELL project coordinators, and SELL facilitators (community education workers).

The findings suggest that SELL was successful in bringing about change. Though SELL uses an integrated and holistic approach where different elements are interconnected and mutually reinforce one another, the SELL strategy as a whole can be seen as contributing to three closely-linked kinds of changes: changing to safer behaviours, improved psychosocial wellbeing and, ultimately, freedom from Ebola.

The main reasons cited for listening to SELL and adapting behaviour were specific elements of SELL's approach, particularly: the community drama approach that encouraged critical thinking and reflection, leading to ownership and implementation of agreed solutions; repeat visits (including monitoring of preventative measures); provision of trauma counselling; talking and listening to people; and support for families taking in orphans.

The diagram below seeks to visualise the relationship between the core elements of the SELL approach, and the resulting changes.



Visual summary of SELL's intervention strategies as mechanisms of change

The SELL approach embodies many of the key characteristic of the Missionary Approach to development as understood by Misean Cara, particularly the long-term commitment of the Missionary Sisters to the communities in which they lived and worked, leading to sensitive and effective interventions; the holistic approach that valued the whole person and their intrinsic human dignity; and the cultivation of spiritual and psychosocial resilience to help people overcome crises in their communities. Although this study considered just one context-specific response to the Ebola crisis, many of the lessons learnt can be effectively put to use in other emergency or humanitarian crisis situations.

1. Introduction

The scale of the 2014-2015 Ebola Virus Disease (EVD) outbreak in West Africa presented unprecedented challenges for the international humanitarian community, and learning from the successes and failures of the response effort is important for designing future crisis interventions.

To support this goal, Misean Cara designed and carried out this research study to explore the mechanisms leading to behaviour changes achieved by an EVD outreach and awareness project run by the Missionary Sisters of the Holy Rosary (MSHR) in Lofa County, Liberia.

In 2007, as the civil conflict which had engulfed Sierra Leone, Guinea and Liberia was coming to an end, the vast number of displaced people from Liberia who had been living in United Nations refugee camps across the border in Guinea began to return home. Having worked for years in the refugee camps, the Missionary Sisters decided to return with them, and so they came to Lofa County in northern Liberia. Here they established a local NGO, Social Empowerment through Learning Liberia (SELL), which worked with the returned refugees to help them rebuild their lives and re-establish their communities.

For a number of years, SELL worked in villages across Lofa County promoting adult literacy, and through this raising awareness and building solidarity on a range of issues including children's rights, land rights, inheritance rights, micro-finance, business education, skills training, gender-based violence, social services, and liaising with the Lofa County Association for the Disabled (LOCAD). When Liberia's EVD epidemic hit in 2014 they began applying the same education approach to tackle the issues of EVD prevention and containment.

SELL used an integrated psychosocial approach, based on a critical pedagogy 'social analysis' model, utilising community drama and reflective discussion to teach communities about EVD prevention and containment strategies while simultaneously providing trauma counselling and emotional support to people affected. This work is the focus of the research described in this report.

To describe the research project and present its findings, this report is structured in seven sections. After this introduction, Section 2 presents the background to the 2014-2016 Ebola Crisis in West Africa, reviewing key literature on the issue to summarise what is already known about the importance of human behaviour on the spread of infectious diseases like Ebola, and the relevance of psychosocial considerations in its containment and prevention.

Section 3 describes the context for this research in Lofa County, Liberia; then Section 4 explains the MSHR's "Social Empowerment through Learning Liberia" (SELL) approach with its roots in Paolo Freire's Critical Pedagogy. Section 5 sets out the justification for the research, the questions it sought to answer, and the research methodology.

The findings of the research are presented in Section 6, which focuses on three main areas of change: acceptance of EVD as a real disease; increased adoption of preventative and treatment-seeking behaviours; and improved psychosocial wellbeing in the affected communities. It goes on to discuss those mechanisms seen as contributing to change in all three areas. Finally Section 7 offers a summary of the conclusions, and recommendations for future action. A full reference list is provided, with links to key resources on-line.

2. Background: Understanding the challenge

2.1 The Ebola epidemic in West Africa 2014-2016

Ebola, more correctly known as Ebola Virus Disease (EVD), is a severe, often fatal, infectious disease, caused by the Ebola virus, that typically results in the death of about 50% of those affected. It is spread from person to person, mainly through contact with bodily fluids. It was first reported in 1976, and one of the earliest recorded outbreaks was near the Ebola River in the Democratic Republic of Congo, from which the disease takes its name (WHO, 2017).

In the 2014-2016 Ebola epidemic in West Africa, the earliest cases were identified in January 2014, and the subsequent International Public Health Emergency status was finally lifted in March 2016. During the intervening period, the epidemic comprised 28,616 reported cases leading to 11,310 deaths, which represents a case-fatality rate of 40% (WHO 2016). It was the largest EVD epidemic to date by a significant margin.[1] Such was its severity that Margaret Chan, Director-General of the World Health Organisation (WHO), described it as "the most severe acute public health emergency in modern times" (Cumming-Bruce, 2014).

Map of West Africa EVD epidemic (WHO, March 2016)

[1] The largest previous outbreak was in Uganda in 2000-2001, with 425 cases and 224 deaths (Hewlett and Amola, 2003).

The rapid spread of EVD in Liberia, Guinea and Sierra Leone was due to a number of factors, some of which were identified by the WHO (2015a) as unique to the West African context. Most significant of these was that EVD was not previously known to either local health professionals or the general population in the region, and initially exhibited symptoms nearly identical to other prevalent diseases.[2] Transmission within communities (rather than amplification in healthcare facilities) played a far more significant role and, for the first time, urban centres became epicentres of intense virus transmission. Very high population mobility across porous borders presented significant challenges for contact tracing and containment. Unsafe burial has been connected with Ebola spread in previous outbreaks but the West African culture particularly stresses compassion for the sick and ceremonial treatment for the bodies of the dead, including washing before burial. Because of recent lengthy civil wars, health systems and national infrastructure were particularly lacking in all three countries, and distrust of the state and state institutions was particularly high (Wilkinson and Leach, 2014). These factors converged to make EVD in West Africa "an old disease in a new context that favoured rapid and initially invisible spread" (WHO, 2015a).

2.2 Influence of human behaviour on EVD spread

During the 2014 West African EVD epidemic researchers and responders placed great emphasis on technical interventions, such as increasing capacity of Ebola Treatment Units (ETUs), case isolation and contact tracing with quarantine (Meltzer et al, 2014; Lewnard et al, 2014; Rivers et al, 2014; Pandey et al, 2014). The majority of resources committed to the response were targeted at these areas, particularly towards increasing ETU capacity (Kirch et al, 2016). In West Africa, however, the key impediments to successful containment were behavioural. This was due to traditional beliefs and practices (Kirch et al, 2016; Fast et al, 2015; WHO, 2015a), fear and denial among a local population who had never before experienced an Ebola outbreak (MSF, 2014), and rumours (fuelled by pre-existing mistrust of government) that healthcare workers, NGOs and the state were conspiring to kill people (WHO 2015a, Wilkinson and Leach, 2014). As late as July 2014 a survey of Monrovia residents showed that a large majority (84%) did not believe EVD even existed (Samaritan's Purse, 2014). These combined factors caused communities to forgo preventative measures and, in some cases, resulted in active resistance to response efforts (WHO, 2015a).

It has been shown that human behaviour can have a dramatic influence on the spread of infectious disease (CDC, 2013; Crabtree, 2011). Kirch and colleagues (2016) constructed a detailed timeline of interventions and resources targeted at ending the EVD epidemic in Liberia and compared these data to the epidemic curve to establish a relationship between intervention type and national EVD decline. Fast et al. (2015) investigated the relative effect of social mobilisation, behaviour change and increased ETU capacity on the decline of EVD in Lofa County. Both studies found that the vast majority of additional ETU treatment beds only became available after the epidemic curve had already started to decline and that the turning point is better explained by changes in beliefs and practices, social mobilisation and the

[2] Early EVD symptoms such as diarrhoea and vomiting are similar to malaria, a disease prevalent in places with previous EVD outbreaks, but in West Africa Lassa Fever is also prevalent and, like later stage EVD, causes haemorrhagic bleeding.

emergence of community leadership in control efforts. These findings led Kirch et al. (2016) to conclude that "behaviour changes were the core driver of the epidemic's decline" in Liberia (p8), and Fast et al. (2015) to conclude that "behavioural change in the population of Lofa County was instrumental in bringing the outbreak under control" (p17). Both studies note that technical aspects of an intervention are complemented and made more effective by education, awareness and social mobilisation. This may have been particularly so during the West African outbreak, where in-community transmission and denial were particularly high, and awareness of the virus and its means of transmission particularly low.

2.3 Integrating psychosocial considerations

In Liberia, failure to account for psychosocial considerations resulted in increased risk-taking behaviour and community resistance to response efforts. One example is the mandated cremation of dead bodies from August to December 2014. Cremation is an efficient control method but the practice was alien to Liberian culture. The mass burning of bodies resulted in significant trauma to families who had lost loved ones and caused people to hide dead bodies (Williams and Mark, 2015; Harmon, 2014). Another issue was overly pessimistic health messaging. Despite the fact that feelings of hopelessness are known to increase risk-taking behaviour (Carr-Gregg et al, 2003; Sanci, 2001), the majority of health messages issued to the public emphasised that EVD is deadly and has no vaccine, treatment or cure, which encouraged rational individuals to risk caring for sick loved ones at home rather than sending them to an overcrowded ETU to die alone (WHO, 2015a). In Lofa County public radio disseminated such messages, sometimes to communities that had no other source of information. Boscarino and Adams (2015) suggest that more effective communication can reduce fear, promote self-protecting behaviours, and prevent misinformation. MSF's evaluation of the EVD response (MSF, 2015) noted the critical importance of raising awareness, as behaviours such as not touching the sick and seeking care early can significantly limit the spread of the disease. It further noted, however, that fear and misinformation remained significant challenges throughout the first year of the response.

Psychosocial interventions, in their design and implementation, assess and account for cultural, social and psychological factors, such as those at play in the above examples. The importance (and neglect) of psychosocial considerations in the response to West Africa's EVD epidemic has been highlighted by researchers and practitioners alike (see: MSF, 2014; DSAI, 2015; Shanahan and Peddle, 2015; Van Bortel et al, 2016). Both the WHO (2015b) and MSF (2014) credit Lofa County's impressive EVD decline to a comprehensive intervention that included community outreach and psychosocial support. This integrated approach caused MSF to label the intervention in Lofa *"a model example of an effective response".* In a context like Liberia, where people did not believe EVD existed but rather believed those providing treatment and awareness were causing the crisis, psychosocial considerations must be integrated into interventions if they are to inspire the types of behaviour changes and social mobilisation credited with the epidemic's decline. Such an approach requires talking and listening to local communities (Kirch et al, 2016; Kutalek et al, 2015; Abramowitz et al, 2015; WHO 2014), so that their fears, perceptions, cultural practices and social rules can be accounted for, and culturally relevant, acceptable and appropriate solutions generated (Van Bortel et al, 2016; WHO, 2014; Wilkinson and Leach, 2014).

3. The context

The specific context of this study is Lofa County, situated in northern Liberia. According to the 2008 National Census, it has a population of 276,863 (133,611 male and 143,252 female) and contains six tribal groups: Lorma, Kissi, Gbandi, Kpelle, Mande and Mandingo. Lofa was at the epicentre of Liberia's EVD outbreak in March 2014, but was also the first county to achieve a confirmed decline in the epidemic curve (December 2014); a particularly impressive feat given its border with Guinea where intense virus transmission was ongoing (WHO, 2015b).

Before the Epidemic, Liberia was ranked 175th out of 187 countries on the UN's Human Development Index (UNDP, 2014), marginally ahead of Guinea (179th) and Sierra Leone (183rd), indicating that these were some of the poorest and least developed countries in the world. Before the crisis, Liberia counted only 0.014 physicians per 1000 population, the lowest physician-to-population ratio in the WHO database (Guinea counted 0.1 and Sierra Leone 0.022) (WHO, 2015c). Liberia suffered the greatest systemic health system loss during the crisis: by May 2015 over 8% of healthcare workers had been killed by EVD, compared to 1.45% in Guinea and 6.85% in Sierra Leone (Evans, Goldstein and Popova, 2015).

All the distinctive features of the 2014 EVD outbreak mentioned in the previous section were evident in Lofa County, with some particularly pronounced. For example, Lofa shares a porous and relatively unregulated border with Sierra Leone to the west and Guinea to the north, and cross-border mobility is particularly high. Lofa is a ten-hour drive from the capital city, Monrovia, mostly on unpaved road that can be impassable in the rainy season. Local informants described the area as consisting mainly of farming villages, linked by rough bush tracks, many of which are inaccessible by car. It was also a key conflict zone during Liberia's civil war and general suspicion and distrust of government was high. Lofa's combination of geography and history had resulted in particularly weak infrastructure and services. Health services were scant and people placed little confidence in them. Local informants stated that as a result people tended to rely on family care at home, self-medication, pharmacists and traditional healers.

4. Social Empowerment through Learning Liberia (SELL)

4.1 The origins of SELL

This report focuses on a particular EVD awareness intervention implemented by Social Empowerment through Learning Liberia (SELL), a local Liberian NGO established in Lofa County in 2007 by the Missionary Sisters of the Holy Rosary (MSHR). The MSHR is a women's missionary religious order founded in Ireland in 1924, which began its African missionary work in Nigeria in 1928. The Sisters are now active in nine African countries as well as Brazil, Mexico, USA, UK and Ireland.

The Missionary Sisters had worked with Liberian and Sierra Leonean refugees in UN refugee camps in neighbouring Guinea from 1995-2006 during the civil wars in both countries. MSHR decided to accompany the Liberian refugees when they returned to their homes in Lofa County after the conflict. Thus they came to Liberia and established their organisation, SELL, in Lofa County, where they continue to manage and coordinate it today.

SELL's model is based on Catholic values, but it is not an overtly religious organisation, does not engage in evangelising, and works with people from different religious traditions without discrimination.

4.2 The SELL approach

SELL's approach is based on Paolo Freire's Critical Pedagogy (Freire, 2007) and also draws on Hope and Timmel's "Training for Transformation" approach (Hope and Timmel, 1984), using community drama as a key teaching/learning methodology. This approach encourages behaviour change by presenting a problem through short animated dramas, facilitating discussion on the content of the drama, encouraging critical reflection on the issue raised, and inspiring suggestions for solutions and/or alternatives. The aim is that community members gain awareness through interaction and participation, they come to their own understanding of the problem through discussion and reflection, their fears are confronted, their needs clarified, the barriers to positive behaviour change identified, and their own solutions proposed. Through this process learning is internalised, and proposed solutions are culturally appropriate and locally owned.

Since its founding SELL has worked in villages across Lofa County promoting adult literacy, and through this raising awareness and building solidarity on a range of issues including children's rights, land rights, inheritance rights, adult literacy, micro-finance, business education, skills training, gender-based violence, social services, and liaising with Lofa County Association for the Disabled (LOCAD). As a result SELL teams were known and accepted in local communities. Thus in 2014, SELL was able to reorientate its established approach to the new priority of raising awareness and encouraging behaviour change in response to Liberia's EVD epidemic. This was an integrated psychosocial intervention that included counselling for affected people and open discussion, reflection and analysis of fears, myths, cultural practices and beliefs with consequences for the spread of EVD.

Key activities:

- EVD awareness-raising using the Critical Pedagogy approach (see 'Issues Covered' below).
- Provision of items needed to prevent the spread of EVD (e.g. buckets, chlorine).
- Repeat home visits to monitor uptake and continuation of preventative behaviours.
- Psychosocial support and trauma counselling for affected groups and individuals.
- Financial and psychosocial support to trace extended families and find new homes for children orphaned by EVD.
- Sharing of local knowledge with international NGOs in strategic planning and coordination meetings.

- Sharing information with the health teams in the four districts.

The issues covered:

- Exploring and questioning myths and conspiracy theories about EVD.
- Provision of accurate information on EVD, including:
  - signs and symptoms of EVD and how the virus spreads;
  - prevention and containment measures (e.g. 21-day observation, hand washing and avoiding physical contact);
  - how to contact health and burial services.
- Analysis and management of fears of EVD, which led to behaviours that hindered control of the virus (e.g. confronting people's fear of health workers).
- Exploring traditional practices and beliefs that hindered control of EVD, and reflection/ sharing of those that could help control the virus.
- Encouraging input from community members on their psychosocial needs: e.g. trauma counselling, and support to, or information about, family members quarantined in treatment centres.
- Offering psychosocial support, and sometimes financial assistance, to communities quarantined in their villages.

4.3 Scope and reach of SELL

The intervention was implemented by 35 facilitators, all of whom were local to the area they covered, came from the same tribe and religion as the communities where they worked, and spoke the native language. All were trained by MSHR in facilitation of Critical Pedagogy and in trauma counselling. Eleven facilitators received additional, more intensive training in trauma counselling and were assigned to post-quarantine villages. The awareness intervention covered a total of 300 villages with a combined population of approximately 40,000 people across four districts of Lofa County: Voinjama, Quardo Gboni, Kolahun and Foya. At any one time SELL employs 35 facilitators in 35 villages, and after about two years these facilitators move to 35 new villages. However, when the outbreak occurred, SELL needed to expand considerably from 35 to 300 villages. This was accomplished through visiting the villages neighbouring the centres, with facilitators walking to reach the remote villages.

5. Research focus and methodology

5.1 The scope and focus of the research

Most of the research so far conducted on the Ebola crisis has focused on Sierra Leone. Liberia was selected for this study because of the lack of previous research on the Liberian experience, and particularly on experiences in rural communities.

The Missionary Sisters of the Holy Rosary had received €30,000 from Misean Cara in 2014-15 for an emergency response project aimed at reducing the spread of Ebola through community level activities in Lofa County, the initial epicentre of Ebola transmission in Liberia. The Sisters were working in particularly underserved and remote villages where they had built up a relationship with the local community. Before the Ebola crisis they had been working on a community approach to women's empowerment through literacy initiatives, and they were able to adapt this earlier intervention to address the Ebola crisis, thus building on pre-existing strengths and relationships. Also, their sensitisation campaign was executed by a team of local facilitators with real knowledge of the culture and traditions of their target group. The Sisters emphasised psychosocial support, particularly for widows and orphans; and integrating this with pragmatic prevention and containment advice was central to their intervention from the beginning.

The Sisters of the Holy Rosary's intervention strategy therefore reflected a model that others were increasingly keen to follow (see 2.3 above); which suggested that further research into this type of intervention would be valuable to a range of humanitarian and other development actors, and could help to inform future crisis response efforts.

5.2 Research questions

The research was designed to gather and analyse evidence from a variety of sources that would help find answers to the following key questions:

1. On the key issues and evidence of change:
   - What were the key issues to address through awareness-raising in the communities?
   - What was SELL's approach to awareness-raising?
   - What evidence is there that community members changed their beliefs and/or behaviour in relation to each of these issues?
2. On the mechanisms leading to change:
   - By what mechanisms did change occur; i.e. why did the communities listen to the awareness information provided by SELL, and change their behaviour as a result?
3. On the challenges still to be met:
   - Where the hoped-for changes did not occur, why was this the case, and what more might be done to address these issues?

5.3 Research methodology

The research process embraced three main participant groups:

- The SELL Coordination team (13 participants, 9 Men and 4 Women, including the MSHR Project Coordinator);
- SELL facilitators: local community education and support workers involved in implementing the awareness intervention during the EVD crisis (26 in total);
- Community members who received the SELL awareness intervention during the EVD crisis (59 in total in three locations).

Data was gathered using the following qualitative methods:

- Two key informant interviews with the MSHR Project Coordinator.
- One half-day focus group, including a participatory ranking exercise, with the SELL Coordination Team.
- Three separate half-day focus groups, including participatory ranking exercises and demonstration of specific community dramas, with SELL facilitators who were involved in implementing the awareness intervention during the EVD crisis in:
  - Kolahun: 12 facilitators (11 men and 1 woman);
  - Voinjama and Quardo Gboni: 10 facilitators (10 men);
  - Foya: 4 facilitators (2 men and 2 women).
- Three separate half-day focus groups, including participatory 'before and after' drawing exercises and group interviews, with community members who received the SELL awareness intervention during the EVD crisis in:
  - Kolahun: 23 participants (11 men and 12 women);
  - Voinjama and Quardo Gboni: 21 participants (6 men and 15 women);
  - Foya: 15 participants (6 men and 9 women).
- Observation of the Critical Pedagogy approach implemented in an adult literacy group in Kolahun to raise awareness of women's right to land inheritance (1 facilitator and 20 participants, all women).

SELL facilitators were asked to list the key issues they had to tackle through the awareness project in their respective communities of work. They then voted to rank the importance of these, based on both the implications each issue had for EVD spread and the level of difficulty they faced in tackling the issue at community level. The votes were weighted to ensure equal representation from each of the three districts. In focus groups with community members, participants were divided into small groups of 3-6 people for the participatory exercise. There were separate groups for men and women, for affected and unaffected communities, and for different tribal groups (see Table 5.1 below). Each group was asked to collaboratively draw the change they had seen in their communities as a result of the SELL EVD awareness project, and then individually asked to explain what they had drawn and, where change was noted, asked why that change occurred. The number of groups that noted a specific change or specific reason for change was counted and results were weighted to represent the number of people in each group.

Table 5.1 Demographics of Community Focus Groups

Tribe	Affected communities		Unaffected communities		Total
	Women	Men	Women	Men	
Gbandi	0	5	8	0	**13**
Kissi	6	6	3	0	**15**
Lorma	5	0	5	0	**10**
Mandingo	5	6	4	6	**21**
Total	**16**	**17**	**20**	**6**	**59**

6. Findings: Key issues and evidence of change

6.1 The issues

6.1.1 Overview

Facilitators identified and ranked the importance of the key issues they had to tackle through the SELL awareness project in their respective communities. Their answers, which were largely consistent across the three districts, identified issues across three broad categories:

- Denial that EVD was a real medical condition, or belief that it was a government conspiracy or curse from God (361 votes, 25% of total);
- Rejection or low uptake of preventative or treatment-seeking behaviours (1026 votes, 72% of total);
- Social issues and psychosocial well-being (34 votes, 2% of total).

These are discussed in turn in the following sections.

6.1.2 Denial of EVD as a real medical condition

> *"We believed the pump was poisoned; we closed it - nobody could drink. SELL showed us it was okay – the facilitator drank water to show us so we started drinking again. We didn't believe in Ebola. SELL gave us education, showed us Ebola was real."*
>
> Female community member, Kolahun

Facilitators noted that EVD denial (community members not believing EVD was a real medical condition) and belief in myths and conspiracy theories were the first issues they had to tackle when they first entered communities. EVD denial was identified as one of the main reasons why people did not adopt preventative and treatment-seeking behaviours. Similarly, belief in conspiracy theories fuelled fear of health workers, ambulances, the ETU and even NGO workers spreading awareness messages.

Among the myths and false beliefs most frequently mentioned by facilitators and community members were:

- Belief that Ebola was being spread from the hospital or ETU. This caused people to fear going to the hospital or health centre, and to flee from ambulances that came to take sick people to hospital. Because of this fear, it was said that it was common for sick people to run away to the bush in order to avoid being found by health-workers and taken to hospital.
- Belief that Ebola was being spread by health workers. There were many accounts of NGO workers being met with hostility and even chased away from villages, never to return (by contrast, people spoke about how SELL "kept coming back" – see section 6.3.4 below).
- There was a related belief that chlorine and the chemicals used in preventative measures to spray houses and ambulances were themselves poisoned and their use would cause Ebola.
- Belief that wells and water pumps had been poisoned with Ebola. This led people in some villages to seal off the village's principal clean water supply so it could not be used, with the result that people used water from streams and water-holes which was more likely to be contaminated.

Another set of false beliefs that stopped people adopting preventative and treatment-seeking behaviours were those that attributed a supernatural cause to Ebola, particularly the belief that is was a curse sent from God. The promotion of these beliefs in certain religious communities led to the spread of infection through large public gatherings in places of worship. In some Evangelical churches there was a particularly risky tradition of taking sick people to the church where the whole congregation would pray for their recovery, usually involving touching the sick person.

Also, linked to the fear of hospitals and health workers mentioned above, it was said that many people preferred to take the sick to traditional healers or witch doctors, leading to increased risk of further infection.

6.1.3 Rejection or low uptake of preventative and treatment-seeking behaviours

> *"When the ambulance came before and took people away, they were never heard from again. So when the ambulance came back, everyone who had contact with the people who were taken the first time, particularly family members, ran away for fear they would be taken too."*
>
> Male community member, Voinjama

The issues identified as most problematic by facilitators belonged to the category of rejection or low uptake of preventative and treatment-seeking behaviours. One reason for this was local people's persistent refusal to accept that Ebola was a real medical condition, as discussed above. However, even after the myths and false rumours had been shown up as such, the harsh reality of the situation still gave rise to more logical and justified fears of what might happen to family members once the authorities were contacted and the "correct" measures were put in train. These genuine fears included being taken a long way from home, isolated

and losing contact with family, and risk of cross-infection in overcrowded and under-resourced treatment centres (given that people were taken away when they showed symptoms, even if it hadn't been confirmed that they had Ebola).

According to the SELL facilitators, this "fear factor" was linked to, and reinforced by, two additional factors:

1. *Lack of information*

   Many of the communities where SELL worked lacked information on how EVD can be prevented, and some were unaware that EVD could be prevented at all. Many of these communities are remote and inaccessible with no access roads. In many cases the only information available was via public radio, which repeatedly informed listeners that EVD was deadly and that there was no treatment or cure. Community members, particularly in Foya, reported that other NGOs doing awareness-raising and outreach only provided information on signs and symptoms of EVD and a phone number for the hotline, usually by hanging a poster on the wall and leaving without further explanation. In other cases, basic materials for prevention such as buckets and chlorine were being distributed, but people received no guidance on how to use them correctly (and in many areas, even this basic equipment was unavailable – see below).

   The lack of correct information fostered adherence to alternative local customs. Many people neglected real preventative measures because they believed they would be safe if they implemented certain 'local laws'. These included non-medical cures like bathing in salt water or consuming alcohol, or barricading the town to outsiders – assuming anyone remaining within was safe. According to facilitators, this only escalated the crisis, as people infected with the virus ended up wandering from village to village. Facilitators encouraged communities to stop turning away outsiders but to take them in, put them under observation, bring them food and water without physical contact, and call the hotline if they begin to show symptoms.

2. *Lack of resources or supplies*

   Many communities did not have latrines. In those that did, they were generally few in number and shared between large numbers of people, which encouraged the spread of EVD. Many communities did not have pumps for potable water, or had blocked access to them because they believed the water was poisoned (see 6.1.2 above). Households did not have sinks or buckets to wash their hands. Personal Protective Equipment (PPE), priced at around $40 per one-use outfit, was unaffordable. At the height of the crisis even basic protection materials – plastic bags, chlorine and soap – were reportedly in scarce supply.

Table 6.1 lists the problem issues identified by facilitators, broken down into sub-categories, and shows how they were ranked, based on both implications for Ebola spread, and the difficulty of tackling them.

Table 6.1: Facilitators' perception of importance of problem issues

Problem issues	No. of votes	% of total
High Risk Physical Contact (i.e. contact with infected people)		
Traditional burial practices	277	19%
Caring for sick people at home	146	10%
Bringing sick people to church for prayer	75	5%
People visiting when someone is sick	46	3%
Other (includes people gathering in the Church or Mosque, sexual transmission from EVD survivors, people going to traditional healers/witch doctors instead of the ETU when sick, and people accompanying those with symptoms to the ETU)	49	3%
Sub-total	*592*	*42%*
Physical Contact (with people in general, not showing symptoms)		
Shaking hands / social physical contact	210	15%
Injections in the pharmacy	50	4%
Sharing transport	36	3%
Going to market	8	1%
Sub-total	*305*	*21%*
Bad Hygiene/ Sanitation		
Lack of hand-washing / not using latrines	98	7%
Lack of Containment Measures		
Running to the bush when Sick	54	4%
Hosting visitors (without observation)	36	3%
Running to bush / migrating to safe villages to avoid EVD	10	1%
Sub-total	*100*	*7%*
Other risky behaviour		
Eating bush meat	*65*	*6%*
False sense of security from non-medical 'cures' (e.g. drinking alcohol, bathing in salt water)	*25*	*2%*
Sub-total	*90*	*8%*
Total votes for lack of preventative or treatment-seeking behaviour	**1184**	**83%**
Out of overall total votes cast in exercise	1421	100%

6.1.4 Social and psychological impact of Ebola on individuals, families and communities

> *"It was like a war, but we didn't know where to hide. In a war you can see the gun but we couldn't see the sickness."*
>
> Female community member, Voinjama

Though the facilitators tended to focus more on the importance of prevention and containment measures in the early stages of the crisis, psychological support to individuals and families who had come through the Ebola crisis was also an important part of the SELL

approach, and facilitators drew attention to a number of social issues causing stress and trauma in communities. The first and most significant of these was the fear that spread through whole communities as Ebola threatened them. People began to treat one another, even their neighbours, with fear and hostility, and formerly reliable networks of social support and solidarity began to collapse. Indeed from 2015 MSHR/SELL implemented a post-Ebola psychosocial project, funded by Misean Cara and other donors, that focussed primarily on acutely traumatised villages in all four districts, addressing communities' psychosocial needs through business and farming groups, school children and staff needs through the school systems, and the needs of widows and orphans.

Community members, in speaking of the changes in their wellbeing brought about as a result of SELL's psychosocial support and counselling, alluded to the fear, worry, anger, frustration, confusion, despair and hopelessness that they and their families experienced as the crisis invaded their communities, and spoke about how the SELL approach had helped them overcome this fear and confusion and generally improved their psychological wellbeing.

A second, related issue identified by the facilitators was the closing of towns and villages to outsiders, isolating those within, preventing social interaction and weakening the social fabric.

6.2 Evidence of change

6.2.1 Acceptance of EVD as a real medical condition

> *"They did the drama in the community, then we learned that Ebola was real, then we started prevention."*
>
> Male community member, Kolahun

Despite significant challenges (particularly in communities that had not previously suffered an outbreak or where they did not have a pre-existing relationship with SELL), facilitators claimed that EVD had eventually been accepted as a real medical condition in all of the communities where they worked.

Meanwhile, over half of the 59 community members consulted (54%) stated outright that they had come to believe EVD was real because of SELL's awareness intervention. In addition, all 59 (100%) cited having adopted at least one preventative behaviour. The following section (section 6.2.2) describes the full range of behaviour changes that were mentioned. This evidence of such practical behaviour change suggests that people had indeed accepted EVD as a real medical condition, and so believed that the behaviour changes being advocated by SELL and others were likely to be worth pursuing.

6.2.2 Adoption of preventative and treatment-seeking behaviours

> *"Before SELL we heard Ebola was killing people on the radio but nobody explained it to us. SELL was the first to explain ... SELL counselled us, talked with us about sanitation, told us about prevention. Some others told us about prevention but stayed very far from us. Ebola never entered our village. SELL is doing well for us, they helped us.*
>
> Female community member, Voinjama

Table 6.2 shows the changes in preventative and treatment-seeking behaviours reported by community members as a result of SELL's interventions. All community members (100%) reported the adoption of at least one preventative and/or treatment-seeking behaviour within their community. Some categories and sub-categories, however, were more prevalent than others.

Table 6.2: Changes reported by community members

	Affected communities		Unaffected communities		All communities	
	No.	**% of Total**	**No.**	**% of Total**	**No.**	**% of Total**
Noted adoption of at least one preventative/ treatment-seeking behaviour	33	100%	26	100%	59	100%
Improved hygiene/sanitation	33	100%	26	100%	59	100%
Hygiene	33	100%	26	100%	59	100%
Sanitation	30	91%	22	85%	52	88%
Reduced high risk physical contact and increased referral	25	75%	14	54%	39	66%
Began referral to hospital/ETU/clinic	17	52%	10	38%	27	46%
Ceased contact with sick people	11	33%	10	38%	21	36%
Ceased contact with dead bodies	16	48%	0	0%	16	27%
Began referral to burial team	8	24%	0	0%	8	14%
Reduced Physical Contact (Shaking hands/ hugging/social contact)	17	52%	13	50%	30	51%
Stopped eating bush meat	11	33%	0	0%	11	19%

The evidence of these behaviour changes noted by the facilitators in respect of each sub-category is discussed below.

Improving hygiene and sanitation

Improved hygiene and sanitation were the most widely reported changes. Every community member (100%) reported that they had begun washing their hands (8% also noted that they began to wash vegetables and fruit before eating). All mentioned using the buckets SELL had

provided for hand washing, 17% specified using soap or chlorine to wash their hands and 32% specified an appropriate hand washing time (e.g. after the toilet, before eating). Improved sanitation was reported by 88% of community members (91% among participants from affected communities and 85% among those from unaffected communities). This included the use of pit latrines instead of open defecation in the village, creek or bush (88%), keeping their community clean (14%), and no longer walking barefoot (8%). Facilitators confirmed that hand washing, despite no previous culture of it, was widely adopted in every community they worked in.

Reduction of high-risk physical contact (contact with symptomatic individuals or dead bodies)

High-risk physical contact was the problem category considered most important by facilitators (83% of votes), with adherence to traditional burial practices seen as the issue of greatest concern. 39 community members (66%) reported reduced high-risk physical contact and/or increased referral to health or burial teams (which reduces high-risk contacts) as a change they had observed in their communities. This included referral of sick people to the hospital, ETU or clinic (46%); ceasing physical contact with symptomatic individuals (36%); ceasing contact with dead bodies (27%); and contacting the burial team in the case of a death (14%). In every sub-category, change was noted more frequently by people from affected communities, which is to be expected given their greater exposure to these circumstances, and conversely suggests the greater challenge to be met in encouraging behaviour change where the impact of Ebola is not yet felt.

The issue facilitators deemed most significant, traditional burial practices, was the least reported change by community members. This was particularly so in unaffected communities, where ceasing contact with dead bodies or referral to burial teams were not reported by any participant. In the validation meeting facilitators clarified that they had voted this into first place because it remained one of the most significant challenges throughout the crisis, until MSF and other actors began to adopt dignified safe burial practices. They found that, until the external context changed, even people who had accepted EVD as real would not call the burial team because of the undignified way burials were being conducted. In Foya, where SELL coordinators were engaged with the MSF strategy team and pushed for the introduction of dignified safe burials, this practice became the norm towards the end of the crisis, which reportedly increased referral. This was apparently not the case in Voinjama and Kolahun where facilitators admitted facing this challenge right to the end. Although not fully represented in the data from community members, facilitators also noted the challenge of getting people to refer their sick for testing and treatment. This was due to fear of conditions in the ETU: that family members would not be treated well, that they would never hear from them again, or that they would go to get tested and then catch EVD from an infected person in the ETU. These were all rational concerns, particularly for people from Voinjama, located a number of hours' drive from the only ETU in Lofa County (in Foya), who could not visit their loved one or bring them food and water.

SELL Facilitators responded to this by accompanying symptomatic individuals to the ETU and bringing back information to their families. As before, however, facilitators noted that the external context had to change before behaviour change followed, and that significant factors in this regard included allowing family members to visit in the ETU, sending back information about family members, and the reopening of local clinics and health facilities, particularly in places located at a distance from the ETU. In both of the above cases facilitators were open

about the challenges faced, but noted that the practices of caring for the sick at home and burying dead bodies without assistance, although not safe, became less risky once people had reliable information about EVD transmission routes and prevention methods.

Reduction in general physical contact

General physical contact, i.e. contact with non-symptomatic people, was the second most important sub-category identified by facilitators. This included shaking hands and general social contact, receiving injections in the pharmacy, sharing transport (particularly moto-taxis), and public gathering in the market place. Over half of the community members (51%) reported reduced physical contact, stating that they had stopped shaking hands (42%), stopped hugging (6%), or stopped touching generally (22%). Facilitators noted that this was an issue due to the importance of hand-shaking in Liberian culture. Some community members noted that hand-shaking was a way of showing love, or that they felt bad refusing someone's handshake. However, facilitators did feel that, once community members accepted EVD as a real medical condition and became aware of its transmission routes and preventative measures, unnecessary physical contact was practically eliminated.

Reduced consumption of bush meat

Facilitators noted the near impossible challenge of stopping the consumption of bush meat, saying this was due to the far more glaring and devastating effects of high risk physical contact (e.g. everybody who attended a funeral or visited the bedside of a sick relative becoming infected). Although many people stopped eating the animals known to host the virus (baboon, chimpanzee and bat), it was suggested that the virus could be contracted from other animals. The ban on bush meat was most flagrantly ignored in Foya where, according to facilitators, even the people employed to confiscate bush meat were eating what they had confiscated. They also noted the difficulty in monitoring this behaviour, and the lack of other protein sources in poor villages.

6.2.3 Improvement in psychosocial well-being

> *Other NGO partners would stay very far away; SELL would sit with us, ask about our family, ask if anyone was sick, would go and talk to children, play with the children, give support for the school, gave us hope.*
>
> Female community member, Foya

An improvement in psychosocial wellbeing was reported by 80% of the 59 participants (67% of women and 100% of men). A breakdown of the different kinds of improvements mentioned, in both post-quarantine and unaffected communities, is shown in Table 6.3 below.

Table 6.3: Reported improvements in psychosocial wellbeing following SELL's interventions

	Post-quarantine Community		Unaffected Community		*Total*	
Number of community members who reported at least one improvement in psychosocial wellbeing (of total 59 participants)	**28**	**85%**	**19**	**73%**	**47**	**80%**

	Post-quarantine Community		Unaffected Community		*Total*	
Psychological wellbeing						
Less fear/worry	20	61%	13	50%	23	39%
Less confused/frustrated/angry	11	33%	7	27%	18	31%
Given hope/courage	17	52%	0	0%	17	29%
Social wellbeing						
People can enter/exit the village	10	30%	18	69%	28	47%
Community brought together/less divided	8	24%	5	19%	13	22%
Total	33	100%	26	100%	59	100%

The fact that SELL's interventions helped overcome fear, worry, confusion etc. was fundamental to the programme's success with containment and prevention of Ebola. As discussed above, denial of the *reality* of Ebola was an important factor in people's failure to seek medical treatment, and thus contributed to the spread of EVD and continuing fatalities. When people learned about and eventually accepted the reality of Ebola, they were more likely to adopt preventative measures (hand-washing, avoiding unnecessary contact etc.). However, even knowing the reality, the fear persisted, based not on myths, but often on hard facts, such as family members taken away in ambulances and never heard from again, children left unaccompanied in distant treatment centres, and those who died subjected to unacceptable and undignified cremation. As SELL's psychosocial approach recognised and responded to these fears, more people were able to overcome their fear and worry sufficiently to make the necessary referrals to hospitals, treatment centres or burial teams. Psychosocial support and counselling therefore played a vital part in the early stages, underpinning the containment of Ebola, as well as helping families and communities rebuild their lives in the aftermath of the crisis.

Psychosocial support was specifically targeted at post-quarantine families and communities, and a larger proportion of participants from such affected communities (85%) reported change in this area, compared with unaffected communities (73%). While people in both types of community spoke of how SELL had helped them overcome negative feelings of fear, worry, anger, confusion and frustration, a notable difference was that it was only in the post-quarantine communities that they spoke of how these had been replaced with positive feelings of hope and courage.

6.3 SELL's intervention strategies as mechanisms of change

6.3.1 Overview

SELL's intervention strategies in response to the Ebola epidemic were outlined in Section 4.2 above, and the evidence for changes that came about as a result of these strategies was

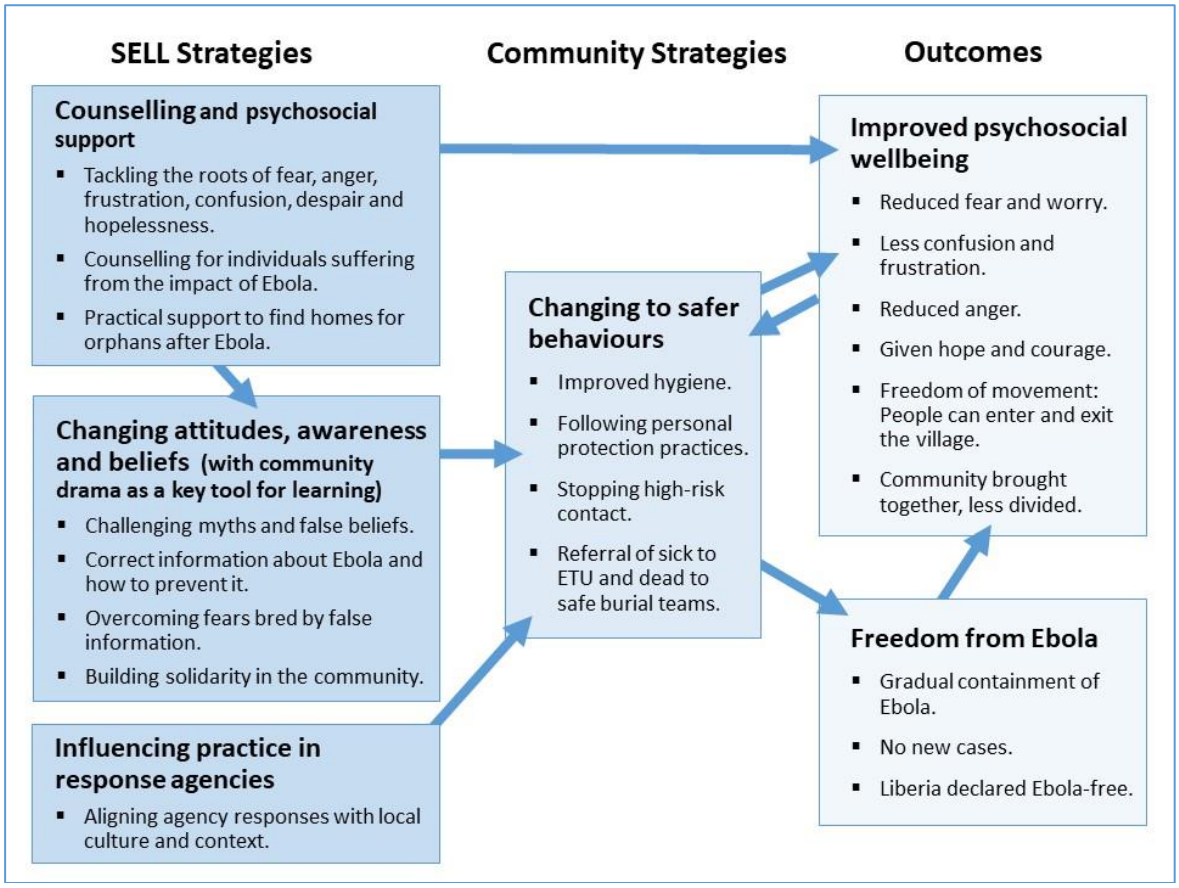
presented in the previous section (6.2). Community members who had identified changes in their beliefs, behaviours and wellbeing were asked to reflect on the different elements that made up the SELL programme, and identify those aspects of the SELL approach that they believed had contributed to the changes that had occurred. Their responses are shown in Table 6.4 below.

Table 6.4: Perception of community members regarding which aspects of SELL's strategy led them to change their beliefs and practices

Aspects of SELL approach contributing to change	In communities that knew SELL		In communities that did not Know SELL		All communities	
	Mentioned by	*%*	*Mentioned by*	*%*	*Mentioned by*	*%*
SELL's Awareness/ Education/ Training	28	100%	31	100%	59	100%
Use of drama as a Teaching Tool	4	14%	15	48%	19	32%
Materials/equipment provided by SELL	28	100%	31	100%	59	100%
Repeated home visits	11	39%	19	61%	30	51%
Psychosocial Approach	19	46%	22	71%	41	69%
SELL talked to us	16	57%	13	42%	29	49%
SELL listened to Us	6	21%	0	0%	6	10%
Counselling	16	57%	6	19%	5	8%
Accompanied to ETU/brought info. back from ETU	3	11%	3	10%	6	10%
SELL got close to the people	5	18%	6	19%	11	19%
SELL brought it down to a level people could relate to	0	0%	6	19%	6	10%
Knew/trusted SELL from previous literacy project	28	100%	0	0%	28	47%
Financial support for families	9	32%	11	35%	20	34%

Though SELL uses an integrated and holistic approach where different elements are interconnected and mutually reinforce one another, it is useful to think of the SELL strategy as a whole contributing to three closely-linked kinds of changes: changing to safer behaviours, improved psychosocial wellbeing and, ultimately, freedom from Ebola. The diagram below seeks to visualise the relationship between the core elements of the SELL approach, and the resulting changes.

Visual summary of SELL's intervention strategies as mechanisms of change



6.3.2 Counselling and psychosocial support

The psychosocial component of SELL's work, as described by facilitators and community members, involved an effective mixture of specific targeted interventions, and a less specific, but equally valuable, way of being with the people and accompanying them as they confronted the crisis in their communities.

Community members were asked to describe those aspects of the SELL approach that they believed had contributed to change in the community. In the area of psychosocial well-being, the specific interventions included:

- Repeated home visits (mentioned by 30 participants, 51%);
- Trauma counselling;
- Accompanying people to the ETU, or bringing information on family members back from the ETU;
- Helping to find alternative homes for children orphaned as a result of Ebola, usually by tracing members of their extended family who would be able to look after them;
- Financial support for families in specific cases of need, and particularly for those offering new homes to orphans.

In addition to these specific actions taken by SELL facilitators and their teams, community members also mentioned aspects of the general approach taken by SELL and its workers; particularly how they made contact with, related to and dealt with people and communities.

For example they spoke of SELL workers getting close to the people, listening to the people, and talking with people at a level they could relate to. Above all, they stressed the importance of SELL workers not abandoning them, but always returning.

Some community members also mentioned that they felt supported because they already knew and trusted SELL through their involvement in SELL's previous literacy and rights projects; though this only held true in those villages where SELL had had a presence before its scope was expanded during the Ebola response.

6.3.3 Changing beliefs and attitudes

SELL used community dramas that demonstrated the facts of EVD and how it is transmitted, followed by a facilitated discussion. In affected communities facilitators would point to evidence, such as every person present at a funeral contracting EVD after touching the body. In discussion facilitators would ask people to remember the myths and conspiracy theories that had emerged during the civil war and which were later found to be untrue.

These dramas were also used to teach practical information about prevention, highlighting issues such as:

- Disease spread through physical contact, particularly high risk physical contact when caring for sick people and preparing dead bodies for burial;
- How to protect oneself using plastic if contact with a symptomatic individual was unavoidable;
- Disease spread through open defecation, and how this can be prevented by the digging of pit latrines (SELL also provided materials such as cement and steel reinforcing rods to facilitate this practice);
- The importance of keeping the community clean;
- The importance of regular and thorough hand washing (which was not previously part of the local culture): Buckets and chlorine were distributed to facilitate this, and the dramas included demonstrations of their correct use, as some people were burning their skin by washing with undiluted chlorine;
- The importance of prompt referral to health and burial teams via the hotline (with the relevant contact information also provided).

The use of this drama-based approach to raising awareness around Ebola was distinctive in that it offered people a shared, inclusive, and less-controlling way of coming to terms with the serious problems affecting their families and communities. It thus gave them a greater sense of ownership of the solutions they eventually agreed on, and a sense of empowerment which helped to counter widespread feelings of hopelessness, so that agreed solutions were put into practice.

Regular monitoring and follow-up visits were then made to the communities to ensure people were maintaining the preventative behaviours they had discussed and agreed on.

Besides drama and discussion, there were concerted efforts find alternatives to dangerous practices, such as public gatherings for religious purposes. For example, in one community, after discussing the issue with the SELL team, the Imam of the local mosque informed the Muslim community on scriptural authority that Islam allowed them to pray from home rather than coming to the mosque for prayer.

Discouraging the dangerous Evangelical practice of bringing sick people to the church for prayer was a challenge. In Foya, following an outbreak where an entire congregation contracted EVD after praying over an infected individual in a church, the SELL Coordinator for the district met with the church's head prophet and convinced him to write a letter to each pastor asking them to end the practice. Within communities SELL facilitators would go door to door to sit and talk with families that remained in denial.

6.3.4 Influencing practice in response agencies

Besides working directly with local communities, SELL was actively involved in weekly NGO coordination meetings, which were organised by the WHO in Foya and Kolahun and by UNICEF in Voinjama. In Foya SELL Coordinators were also involved in a district strategy team coordinated by MSF. Within these spaces SELL facilitators and coordinators shared their local knowledge and pressed for more socially and culturally sensitive response efforts such as dignified safe burials and communication of information about family members taken to the ETU (SELL's own practice of accompanying people to the ETU for testing and bringing back information about family members who had been taken there served as a positive example).

7. Conclusions and recommendations

7.1 Conclusions

Studies of the international community's response to the West Africa EVD crisis have suggested that interventions could have been more effective if psychosocial considerations had been taken more fully into account, and a greater emphasis placed on non-medical interventions aimed at community mobilisation and behaviour change.

This study, therefore, was undertaken to explore the mechanisms underlying changes achieved by one such intervention, implemented by the Missionary Sisters of the Holy Rosary through their Liberian community education organisation Social Empowerment through Learning Liberia (SELL).

The findings of the study are based on the analysis of extensive qualitative data from different stakeholders, including members of the affected communities. In summary, it can be concluded that:

- SELL was successful in convincing community members to accept Ebola Virus Disease as a real medical condition, and countering commonly held false beliefs and myths.
- As a result people were more willing to change their behaviour, adopt preventative practices and healthcare-seeking behaviour.
- Engagement with the programme led to improvement in the psychosocial wellbeing of those affected directly or indirectly by EVD which further bolstered their efforts to adopt preventative and treatment-seeking behaviours.
- Besides working directly with local communities, SELL workers collaborated strategically with other response agencies (UN agencies and NGOs) sharing local knowledge and pressing for more socially and culturally sensitive response efforts.

The reasons given by participants for changing their attitudes and adapting their behaviour, with positive benefits both in terms of disease containment and prevention, and of psychosocial wellbeing in affected communities, were directly related to specific aspects of the SELL approach, including:

- SELL's work on awareness-raising, education and training;
- The use of community drama as an awareness-raising and collective learning tool, particularly in (a) enabling people themselves to expose false beliefs and scare stories for what they were; and (b) giving people a greater sense of belief in and ownership of the solutions agreed on, which in turn increased the chances of sustained behaviour change;
- Materials and equipment provided by SELL for containment and prevention (buckets, equipment for latrines etc.);
- Repeated home visits in affected communities, which was seen by local people as a sharp contrast with the practice of UN agencies and some other NGOs who were said to have visited once, and when met with a hostile reaction, never returned;
- The application of a culturally sensitive psychosocial approach; working at a level that local people could understand and relate to;
- Listening to people's concerns; offering counselling and accompaniment;
- The fact that many people had already come across SELL and had learnt to trust them based on experience with earlier projects;
- Financial support for families who had offered homes to children orphaned by EVD.

These findings provide compelling evidence of "what works", and in so doing further highlight the importance of context-appropriate community engagement through integrated psycho-social approaches in humanitarian crisis responses. For example, communicating risk in a way that was sensitive to people's fears and attempted to quell them, was a more effective way of promoting risk-reducing behaviours than other approaches common at the time which were based on heightening fear in an effort to force people to change.

The way the Missionary Sisters of the Holy Rosary accompanied local communities as they confronted the Ebola crisis in many ways epitomises the Missionary Approach to development as understood by Misean Cara (Misean Cara, 2017).

One of the foremost characteristics of this approach is its embodiment of **long-term commitment**. Because missionaries make such a commitment and are rooted in the communities they serve, they not only earn the trust and confidence of local people, but also have an understanding of local context and culture that leads to more sensitive and effective interventions, as this study has demonstrated.

Another key characteristic is the **holistic approach** of missionary work. Whatever the immediate concern of a missionary project (in this case the urgency of responding to the Ebola crisis), missionaries look beyond specific health or education needs to consider the needs of the whole person, in line with their commitment to human dignity. From this comes the missionary commitment to "accompaniment" or walking alongside individuals or families in times of need, which is exemplified in the SELL approach described above.

7.2 Recommendations

Although this study considered just one context-specific response to the Ebola crisis, many of the lessons learnt can be effectively put to use in other emergency or humanitarian crisis situations. In that regard the following recommendations are noted for consideration:

1. **Recognise the principle of human dignity:** Human dignity is a core value in every culture, not just in Liberia. Respect for human dignity is particularly important when people are ill, and continues to be important after they die. Emergency measures taken to control epidemics are unlikely to be effective if they fail to recognise this fundamental principle.
2. **Draw upon the resources of those who know local communities:** Workers such as missionaries, who really know communities, can be a valuable resource to NGOs and international agencies newly arrived in an area facing a humanitarian crisis. Engaging with missionaries and relying on their knowledge and understanding of local people and their needs can help to avoid costly mistakes.
3. **Draw upon the knowledge and skills of local people:** There is great value in training local people as front-line workers in an emergency response context. They understand the context and culture, know the language, are fully engaged in the situation, and are likely to be accepted and trusted by local people like themselves.
4. **Encourage and facilitate critical reflection:** Community drama can be seen as a particularly useful approach in supporting humanitarian interventions, as it pushes people to explore for themselves the myths that are circulating in their communities. Rather than being "told what to think" by outsiders, people are able to discover for themselves why these myths cannot be true, and come to a valid understanding of their situation through critical reflection and analysis. This process also gives them a greater sense of ownership of solutions agreed on, and thus greater motivation to make and sustain behaviour changes.
5. **Take time to build trust:** In order to build and consolidate trust, repeat visits to families and communities, and particularly persistence in the face of initial rejection, are very valuable.
6. **Motivate with trustworthy information:** Promoting fear is not a reliable way to motivate people to positive action. Such action is more likely to be triggered by hope and trustworthy correct information. Therefore the giving of trustworthy information should be an essential part of crisis intervention strategies.
7. **Recognise that listening is as important as information-giving:** In times of crisis, listening to people, showing empathy and trying to understand their concerns may be just as important as information-giving.
8. **Share learning:** The findings of this study, and other similar studies of experiences during crisis, should be disseminated through appropriate media to help advance public and wider sectoral understanding of what works well in crisis situations.

References

Abramowitz, S., K. McLean, S. McKune, K. Bardosh, M. Fallah, J. Monger, K. Tehoungue and P.A. Omidian (2015). 'Community-centred Responses to Ebola in Urban Liberia: The View from Below'. *PLoS Neglected Tropical Diseases*. 9(4): e0003706. http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0003706

Boscarino, J.A. and Richard E. Adams (2015). 'Assessing Community Reactions to Ebola Virus Disease and Other Disasters: Using Social Psychological Research to Enhance Public Health and Disaster Communications'. *International Journal of Emergency Mental Health*, 2015: 17(1): 234-238. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4382086/

Carr-Gregg, M.R.C., K.C. Enderby and R. Grover (2003). 'Risk-taking behaviour of young women in Australia: screening for health-risk behaviours'. *The Medical Journal of Australia*, 178(12): 601-604. https://www.mja.com.au/system/files/issues/178_12_160603/car10800_fm.pdf

CDC [Centre for Disease Control and Prevention] (2015). 'Show me the science: Why wash your hands?' Centre for Disease Control and Prevention, page last updated 18/11/2015. https://www.cdc.gov/handwashing/why-handwashing.html

Crabtree, A. and B. Henry (2011). 'Non-pharmaceutical measures to prevent influenza transmission: The evidence for individual protective measures.' *National Collaborating Centre for Infectious Disease*, no. 88, September 2011. http://nccid.ca/publications/non-pharmaceutical-measures-to-prevent-influenza-transmission/

Cumming-Bruce, N. (2014). 'WHO chief calls Ebola outbreak a "crisis for international peace"'. *New York Times,* 13 October 2014. https://www.nytimes.com/2014/10/14/world/africa/ebola-virus-outbreak.html

DSAI [Development Studies Association of Ireland] (2015). 'Psychosocial Considerations in the Ebola response and promoting resilience in post-Ebola programming'. *Development Studies Association of Ireland*, Roundtable Report, 1/10/2015. http://www.dsaireland.org/download/pdf/20160107115818.pdf

Evans, D.K., M Goldstein and A. Popova (2015). 'Healthcare worker mortality and the legacy of the Ebola epidemic'. *The Lancet (Global Health),* Vol 3(8): 439-440. https://reliefweb.int/report/sierra-leone/healthcare-worker-mortality-and-legacy-ebola-epidemic

Fast, S.M., S. Mekaru, J.S. Brownstein, T.A. Postlethwaite and N. Markuzon (2015). 'The Role of Social Mobilization in Controlling Ebola Virus in Lofa County, Liberia'. *PLOS Currents Outbreaks*, published online 15/05/2015. Edition 1. http://currents.plos.org/outbreaks/article/the-role-of-social-mobilization-in-controlling-ebola-virus-in-lofa-county-liberia/

Freire, P. (2007). *Pedagogy of the Oppressed.* New York: Continuum. http://www.msu.ac.zw/elearning/material/1335344125freire_pedagogy_of_the_oppresed.pdf

Harmon, W.Q. (2014). 'Cremation Abolished: Government Inaugurates New National Cemetery'. *Liberian Observer*, 30 December 2014. http://www.liberianobserver.com/news-development/cremation-abolished

Hewlett B.S. and R.P. Amola (2003). 'Cultural Contexts of Ebola in Northern Uganda. *Emergency Infectious Disease*, 9(10): 1242-1248.
https://wwwnc.cdc.gov/eid/article/9/10/02-0493_article

Hope, A. and Timmel, S. (1984). *Training for transformation: A handbook for community workers.* Harare: Mambo Press. (New edition from Intermediate Technology Publications, London 1999).
http://www.developmentbookshelf.com/doi/book/10.3362/9781780446271

Kirsch, T. D., H. Moseson, M. Massaquoi, T.G. Nyenswah, R. Goodermote, I. Rodriguez-Barraquer, … and D.H. Peters.. (2016). 'Impact of interventions and the incidence of Ebola virus disease in Liberia-implications for future epidemics'. *Health Policy and Planning*, 9(0): 1-10.
https://academic.oup.com/heapol/article-abstract/32/2/205/2568849

Kutalek R, S. Wang, M. Fallah, C.S. Wesseh and J. Gilbert (2015). 'Ebola interventions: Listen to communities'. *Lancet Global Health*. 3 (3): e131.
http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)70010-0.pdf

Lewnard, J.A., M.L. Ndeffo Mbah, J.A. Alfaro-Murillo, F. Altice, L. Bawo, T.G. Nyenswah and A. P. Galvani (2014). 'Dynamics and control of Ebola virus transmission in Montserrado, Liberia: A mathematical modelling analysis'. *The Lancet (Infectious Disease)*, 14(12): 1189–1195.
http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(14)70995-8/abstract

Liberia Institute of Statistics and Geo-information Services (2008). 2008 Census Report.
http://www.lisgis.net/county.php?&f8991f9c121952a4b8958addf7124023=NTA%3D

Meltzer, M.I., C.Y. Atkins, S. Santibanez, B. Knust, B.W. Petersen…and E.D. Ervin (2014). Estimating the future number of cases in the Ebola epidemic—Liberia and Sierra Leone, 2014-2015. *Morbidity and Mortality Weekly Report*, 63(3): 1-14.
https://www.cdc.gov/Mmwr/preview/mmwrhtml/su6303a1.htm

Misean Cara (2017). *Missionary Approach to Development, Conceptual Framework*. Dublin, Misean Cara.
www.miseancara.ie

MSF [Médecins Sans Frontières] (2015). 'An Unprecendented Year: Médecins Sans Frontières' response to the largest ever Ebola outbreak, March 2014 to March 2015'. MSF's Final Ebola Response Accountability Report, June 2015.
https://www.msf.org.uk/sites/uk/files/ebola_accountability_report_final_july_low_res.pdf

MSF (2014). 'Ebola: MSF handing over activities as outbreak is contained in Lofa county, Liberia'.
https://www.msf.ie/article/ebola-msf-handing-over-activites-outbreak-contained-lofa-county-liberia

Pandey, A., K.E. Atkins, J. Medlock, N. Wenzel, J.P. Townsend… and J.E. Childs (2014). 'Strategies for containing Ebola in west Africa'. *Science*, 346: 991-995.
http://science.sciencemag.org/content/346/6212/991.full

Rivers, C.M., E.T. Lofgren, M. Marathe, S. Eubank, B.L. Lewis (2014). 'Modelling the Impact of Interventions on an Epidemic of Ebola in Sierra Leone and Liberia'. *PLOS Currents Outbreaks,* 2014 Oct 16 .
http://currents.plos.org/outbreaks/article/obk-14-0043-modeling-the-impact-of-interventions-on-an-epidemic-of-ebola-in-sierra-leone-and-liberia/

Samaritan's Purse (2014). Ebola Response Fact Sheet, Situation Report, 24/07/2014. http://www.samaritanspurse.ca/rss/disaster-relief/africa/ebola-response-fact-sheet.aspx#.Vh00kDYo5FE

Sanci, L. (2001). Adolescent Health Care Principles. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.

Shanahan, F. and N. Peddle (2015). 'Prioritizing Psychosocial Support for People Affected by Ebola in Sierra Leone', Policy Paper, Recommendations to the Ebola Recovery Pledging Conference, New York City, July 10th 2015. https://www.ucc.ie/en/media/academic/appliedpsychology/handbooks/PSSPolicyPaperPledgingConferenceFinal07-07-15.pdf

UNDP [United Nations Development Programme] (2014). 'Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience'. *United Nations Development Program*, Human Development Report 2014. http://hdr.undp.org/en/content/human-development-report-2014

Van Bortel, T., A. Basnayake, F. Wurie, M. Jambai, A.S. Koroma, A.T. Muana, K. Hann, J. Eaton, S. Martin and L.B Nellums (2016). 'Psychosocial effects of an Ebola outbreak at individual, community and international levels', *Bulletin of the World Health Organisation*, *Policy and Practice*, 94(3): 210-214. http://www.who.int/bulletin/volumes/94/3/15-158543/en/

World Health Organisation (2017). 'Ebola Virus Disease, key facts'. http://www.who.int/mediacentre/factsheets/fs103/en/

World Health Organisation (2016). 'Ebola Virus Disease'. World Health Organisation Situation Report, June 2016. http://apps.who.int/iris/bitstream/10665/208883/1/ebolasitrep_10Jun2016_eng.pdf

World Health Organisation (2015a). 'Factors that contributed to undetected spread of the Ebola virus and impeded rapid containment'. Emergencies, Preparedness, Response: Ebola Virus Disease Outbreak. January, 2015. http://www.who.int/csr/disease/ebola/one-year-report/factors/en/

World Health Organisation (2015b). 'Liberia: a country – and its capital – are overwhelmed with Ebola cases'. Emergencies, Preparedness, Response: Ebola Virus Disease Outbreak. January 2015. http://www.who.int/csr/disease/ebola/one-year-report/liberia/en/

World Health Organisation (2015c). 'Global Health Observatory Data Repository' (density per 1000, by country). http://apps.who.int/gho/data/node.main.A1444?lang=en

World Health Organisation (2014). 'EBOLA STRATEGY: Ebola and Marburg virus disease epidemics: preparedness, alert, control and evaluation'. August 2014. http://apps.who.int/gho/data/view.main.92100

World Health Organisation (1997). WHO recommended guidelines for epidemic preparedness and response: Ebola haemorrhagic fever (EHF). Geneva: WHO. http://apps.who.int/iris/bitstream/10665/63806/1/WHO_EMC_DIS_97.7.pdf

Wilkinson, A. and M. Leach (2014). 'Ebola: Myths, Realities and Structural Violence'. *African Affairs*, 114 (454): 136-148. https://academic.oup.com/afraf/article-abstract/114/454/136/2195203

Williams, W. and M. Mark (2015), 'Families left haunted by Liberia's Ebola crematorium'. *The Guardian*, 23/1/2015. https://www.theguardian.com/world/2015/jan/23/-sp-liberia-ebola-crematorium