Misean Cara Learning Brief No. 2018/01

Missionary Responses to Ebola Virus Crises

Learning from the Missionary Sisters of the Holy Rosary's effective responses to the EVD crises in Liberia and Sierra Leone 2014-2016

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Mission Support from Ireland

Introduction

The Ebola Virus Disease (EVD) epidemic which struck West Africa in 2014 presented unprecedented challenges for the international humanitarian response. Learning from the successes and failures of the response effort is important for designing future crisis interventions.

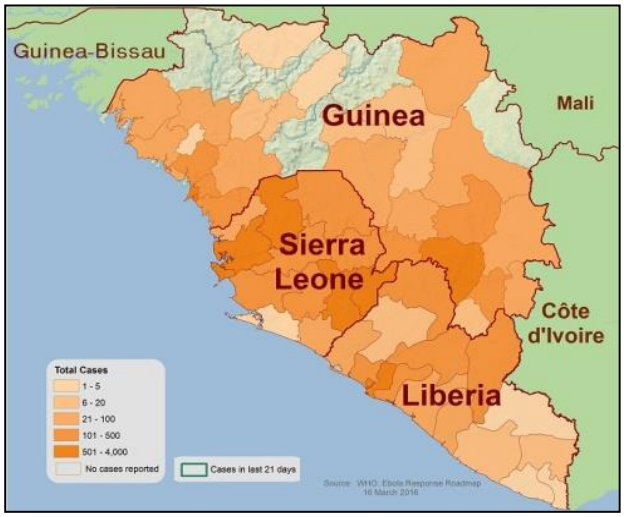
Previous research on Ebola in West Africa suggested that human behaviour is a major factor in determining the spread of the disease. Understanding and influencing changes in behaviour at individual and community level can thus be an important factor in its prevention and containment.

The studies reported in this Learning Brief focus specifically on the work of the Missionary Sisters of the Holy Rosary (MSHR) in Liberia and Sierra Leone during the Ebola crisis from 2014 to 2016. Misean Cara staff members travelled to both countries in 2016 to gather data on the Sisters' Ebola response initiatives from multiple sources. The data sets were analysed and reports written up in 2017 (Misean Cara 2017a, 2017b). This Learning Brief synthesises the findings and conclusions from both studies.

Background

Ebola Virus Disease (EVD) in West Arica

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. (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 this period, the epidemic comprised 28,616 reported cases leading to 11,310 deaths, representing a case-fatality rate of 40% (WHO 2016). It was the largest EVD epidemic to date by a significant margin.

The Missionary Sisters of the Holy Rosary

MSHR is a women's missionary religious congregation founded in Ireland in 1924, which began its African missionary work in Nigeria in 1928. During civil wars in Liberia and Sierra Leone from 1995-2006, the Missionary Sisters worked with refugees from both countries in UN refugee camps in neighbouring Guinea. When the conflicts ended and people returned to their homelands, the Sisters accompanied them and established educational, health and community support projects in both countries which continue to the present. Thus when Ebola struck in 2014, the Sisters were already present in the local communities, with established networks and support systems.

Social Empowerment through Learning Liberia (SELL)

The MSHR's response to Ebola in Liberia was delivered mainly through SELL, a local NGO which the Sisters had set up in 2006.

SELL's approach is based on Paolo Freire's Critical Pedagogy (Freire, 2007) and also draws on the *'Training for Transformation'* approach (Hope and Timmel, 1984) using community drama as a key methodology. It encourages behaviour change by presenting a problem through short dramas, facilitating discussion on the content of the drama, encouraging critical reflection on the issue raised, and inspiring suggestions for solutions. Community members gain awareness through interaction and participation, and come to develop their own understanding of the problem. Thus learning is internalised, and proposed solutions are culturally appropriate and locally owned. Since its founding SELL has worked throughout Lofa County promoting adult literacy, and through this raising awareness and building solidarity on a range of issues including children's rights, land rights, and prevention of gender-based violence. As a result, when Ebola first appeared in 2014, SELL was known and accepted in local communities. Thus they were able to reorientate their established approach to the new priority of raising awareness and encouraging behaviour change in response to the EVD epidemic.

Research questions

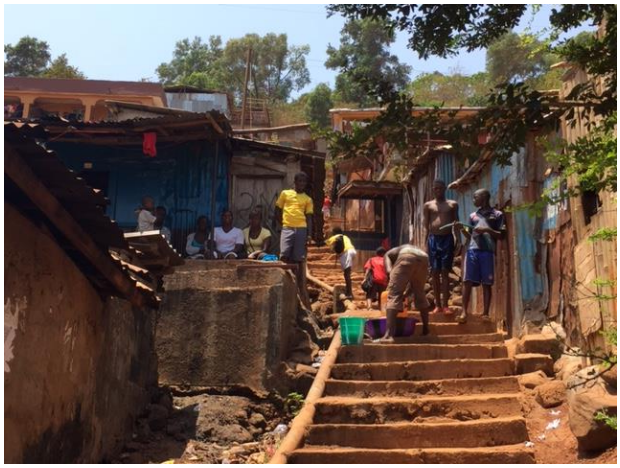
The research was designed to gather and analyse evidence from a variety of sources that would help build a better understanding of:

In Liberia

- SELL's approach to awareness-raising, and the key issues addressed in the communities.
- How community members changed their beliefs and behaviour in relation to these issues.
- Mechanisms leading to change; i.e. why did the communities listen to the awareness information provided, and change their behaviour as a result?

In Sierra Leone

- The rumours and false beliefs that contributed to the spread of Ebola and hindered its containment;
- The high-risk practices and behaviours that persisted in communities, partly due these rumours and beliefs;
- The strategies used by the Sisters to counter rumours and false beliefs, and to encourage safer behaviour and preventative practices;



Ebola survivors, Freetown Sierra Leone

Research methodology

Data was collected using a range of qualitative methods including:

- Key informant interviews.
- Focus group discussions: In Sierra Leone with members of the MSHR; In Liberia with the SELL Coordination Team and facilitators, and community members affected by the crisis.
- Observation of the SELL Critical Pedagogy approach in action.

(For a full account of the research methodology, see the full reports: Misean Cara 2017a, 2017b).

Findings

Key issues

Participants identified the key issues across three broad categories:

1. Denial of EVD as a real medical condition

In Liberia, facilitators noted that EVD denial and belief in myths and conspiracy theories were the first issues they had to tackle when they 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, hospitals, ambulances, and even NGO workers spreading awareness messages.

> "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."
>
> *Female community member, Kolahun*

Among the myths and false beliefs most frequently mentioned were:

- Belief that Ebola was being spread from the hospital or treatment centre. This caused people to fear going to the treatment centre, and to flee from ambulances that came to take sick people 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.
- There was a related belief that the chemicals used in preventative measures to spray houses and ambulances were themselves poisoned and their use would cause Ebola, and that wells and water pumps had been poisoned with Ebola.

Another set of false beliefs were those that attributed a supernatural cause to Ebola, particularly the belief that it 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. Others

preferred to take the sick to traditional healers, leading to increased risk of further infection.

2. Rejection or low uptake of preventative and treatment-seeking behaviours

Even after the myths and false rumours had been shown up as such, the harsh reality of the situation still gave rise to 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.

> "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*

3. Social and psychological impact of Ebola on individuals, families and communities

An important part of the MSHR's approach in both countries was provision of psychological support to individuals and families who had come through the Ebola crisis. Facilitators drew attention to a number of social issues causing stress and trauma in communities. The 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.

> "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*

Community members, in speaking of the changes in their wellbeing brought about through psychosocial support, 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 Sisters' approach had helped them overcome this fear and confusion and generally improved their psychological wellbeing.

Evidence of change

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, facilitators claimed that EVD had eventually been accepted as a real medical condition in all of the communities where they worked. In Liberia over half of the community members consulted stated outright that they had come to believe EVD was real because of SELL's awareness intervention. In addition, all claimed to have adopted at least one preventative behaviour.

Adoption of preventative and treatment-seeking behaviours

All participating community members reported the adoption of at least one preventative and/or treatment-seeking behaviour within their community.

Improving hygiene and sanitation: This was the most widely reported change. Every community member reported that they had begun washing their hands, and all mentioned using the buckets provided for hand washing. Improved sanitation was widely reported, including the use of pit latrines. Facilitators confirmed that hand washing, despite no previous culture of it, was widely adopted in every community they worked in.

> "We heard Ebola was killing people on the radio but nobody explained it to us… Some others told us about prevention but stayed very far from us."
>
> *Female community member, Voinjama*

Reduction of high-risk physical contact (contact with symptomatic individuals or the deceased): Most community members reported reduced high-risk physical contact and/or increased referral to health or burial teams. This included referral of sick people to the hospital, treatment centre or clinic, and ceasing physical contact with symptomatic individuals.

Traditional burial practices: Though this was the issue facilitators deemed most significant, it was the change least reported by community members. Facilitators observed 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.

Ebola survivors, Voinjama, Liberia

Seeking medical treatment: Facilitators also noted the challenge of getting people to refer their sick for testing and treatment, due to fear of conditions in the treatment centres, and 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 centre. Facilitators responded to this by accompanying symptomatic individuals to the treatment centres and bringing back information to their families.

Reduction in general physical contact (contact with non-symptomatic people): This included shaking hands and general social contact, receiving injections in the pharmacy, and public gathering in the market place. Over half the community members reported reduced physical contact, stating that they had stopped shaking hands, hugging, or touching generally. Facilitators noted that this was an issue due to the importance of hand-shaking in Liberian culture. However, they 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.

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*

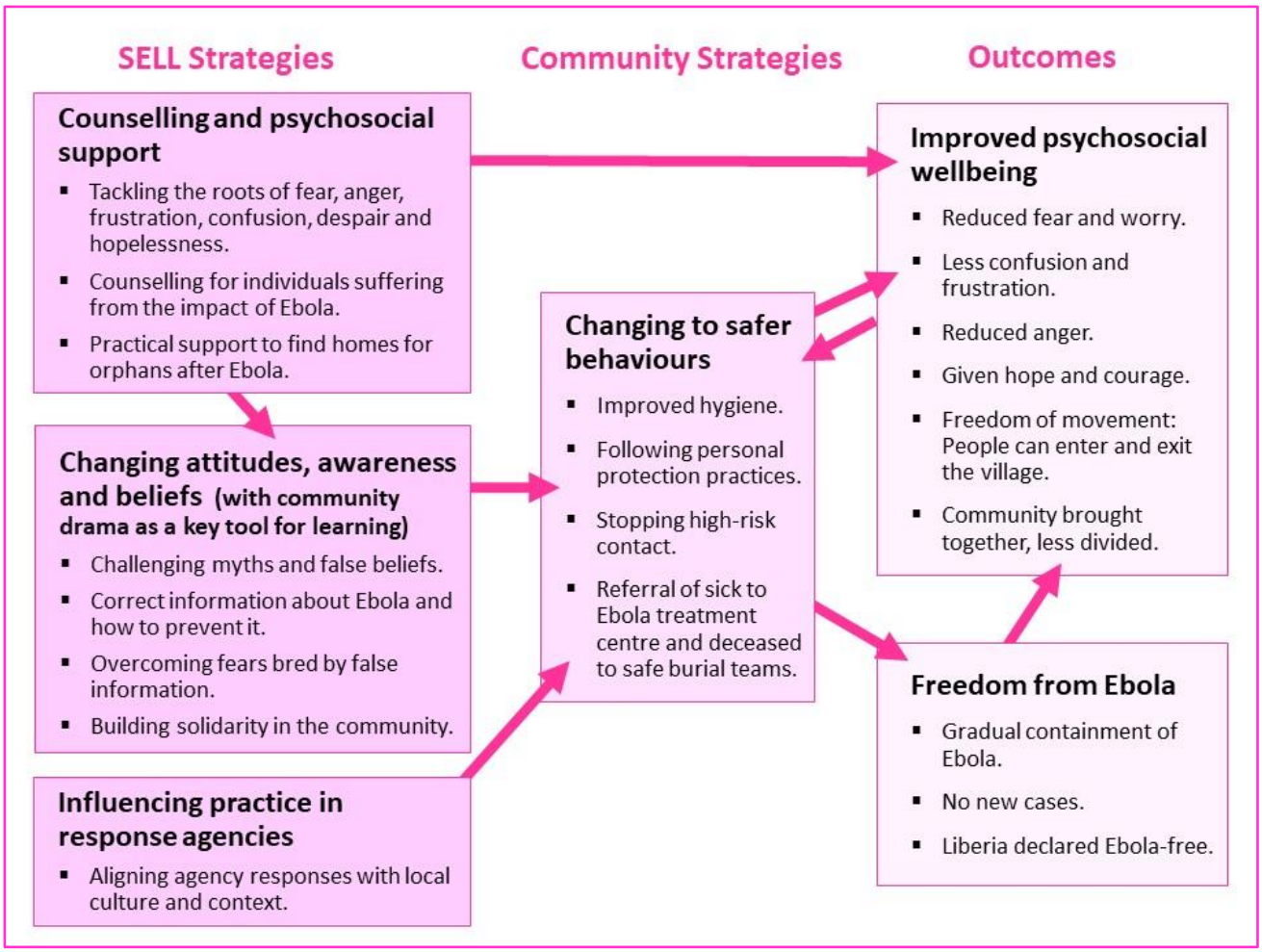
An improvement in psychosocial wellbeing was reported by 80% of the participants. The fact that SELL's interventions helped overcome fear, worry, confusion etc. was fundamental to the programme's success with containment and prevention of Ebola. As discussed above, denial of the *reality* of Ebola was an important factor in people's failure to seek medical treatment, and thus contributed to the spread of EVD and continuing fatalities. However, when people learnt about 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 the Missionary Sisters' psychosocial approach recognised and responded to these fears, more people were able to overcome their fear 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.

The Missionary Sisters' intervention strategies as mechanisms of change

In Sierra Leone, the Missionary Sisters of the Holy Rosary responded to Ebola with a number of strategies according to the varied circumstances in which they worked. However, the effectiveness of these strategies was greatly enhanced through the Sisters' integrated approach. In particular, their work to change attitudes and question false rumours, linked with provision of correct information and practical advice.

Both of these contributed to changes in behaviour and practices, and were further helped by the provision of hygiene equipment and cleaning materials. Meanwhile improved nutrition led to increased chances of survival for those suffering from Ebola, and psychosocial support and counselling helped them and their families find ways through the ordeal.

In Liberia the Sisters' main strategy was through their already established SELL programme. Though this involves an integrated and holistic approach where different elements are interconnected and reinforce one another, it is useful to think of the 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 visualises the relationship between the elements of the SELL approach, and the resulting changes.



Conclusions

Previous studies of the international community's response to the West African Ebola crisis 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.

The findings of Misean Cara's studies reported here are based on the analysis of extensive qualitative data from different stakeholders, including members of the affected communities.

In Sierra Leone, the Sisters' response to the Ebola crisis can be understood as a journey that they undertook in order to accompany the people among whom they lived and worked as they struggled to find pathways that would lead them safely through the crisis and onwards to the rebuilding of lives and communities. By travelling alongside the people in this way, the Sisters gave hope and built trust where previously there had been neither.

In Liberia, where the SELL programme was already established and could be adapted to respond to new challenges, it can be concluded that:

- The MSHR's strategies were 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, the Missionary Sisters 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 were

directly related to specific aspects of this approach, including:

- **The use of community drama** as an awareness-raising and collective learning tool, particularly in enabling people themselves to expose false beliefs and scare stories for what they were; and giving people a greater sense of belief in and ownership of the solutions agreed on, which in turn increased the likelihood of sustained behaviour change;
- **Repeated home visits** in affected communities, which were 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 psycho-social 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 the MSHR and had **learnt to trust** them based on experience with earlier projects;

These findings provide compelling evidence of "what works", and in so doing further highlight the importance of context-appropriate community engagement through integrated psychosocial 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, 2017c).

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 approach described above.

Recommendations

Although these studies considered two context-specific responses to the Ebola crisis, many of the lessons learnt can be effectively put to use in other emergency or humanitarian crisis situations. The following recommendations are presented for consideration:

1. **Recognise the principle of human dignity:** Human dignity is a core value in every culture, not just in West Africa. 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 a 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 are very valuable; particularly persistence in the face of initial rejection.
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.

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About Misean Cara

Established in 2004, Misean Cara is an international and Irish faith-based missionary development movement made up of 91 member organisations working in over 50 countries. We work with some of the most marginalised and vulnerable people in developing countries. Adopting a human rights focus, we support communities addressing basic needs in the areas of education, health, and livelihoods, as well as advocating for economic, social, cultural, civil and political rights. At times of humanitarian crisis, the trusted and long-term presence of missionaries in affected communities also allows for rapid, efficient and targeted responses.

Misean Cara and our members work collectively and individually through the missionary approach to development. This framework is based on five values: respect, justice, commitment, compassion and integrity. Together, these establish the basis for the approach of missionaries to good development practice.

Our Strategy 2017-2021 identifies five goals:

- Uphold the right to quality education
- Uphold the right to better health, clean water and sanitation
- Uphold the right to sustainable livelihoods
- Uphold and advocate for human rights
- Enhance and promote the missionary approach to development.

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Further expressing our desire to reach the most vulnerable and marginalised, the Strategy will see Misean Cara bringing a particular focus to bear on targeting five groups: women, children, refugees, displaced people and people with disabilities.