

Responding to Crisis

An overview of the response of the
Missionary Sisters of the Holy Rosary to
the Ebola Virus Disease crisis in Sierra
Leone, 2014-2015

October 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 Sierra Leone. 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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Executive Summary

This report seeks to give an account of the responses implemented by the Missionary Sisters of the Holy Rosary (MSHR) in Sierra Leone to the 2014-2016 Ebola epidemic, based on qualitative data from interviews with survivors and extensive focus group discussions with the Sisters who led their organisation's response.

As the crisis unfolded during 2014 and 2015, the Sisters took action in the various settings in which they worked: their two girls' secondary schools in Bo and Kenema, their counselling centre and pastoral centre, and additional outreach work carried out in rural communities and in liaison with other agencies such as local hospitals and health centres. Much of this work was concerned with countering false rumours and beliefs about Ebola with correct information and guidance on how to limit its spread and look after those affected. Another part of the work was the giving of practical help, such as cleaning and hygiene materials, and also food to those most in need. Finally an important element was psychosocial counselling to help people who had lost family members overcome fear and desperation and rebuild hope for the future.

The findings suggest that the various strategies used by the Sisters were effective because of the way they all contributed to an integrated approach. Their work to change attitudes and question false rumours linked with their work to provide correct information and practical advice. Both of these contributed to changes in behaviour and practices, which were in turn helped by the provision of hygiene equipment and cleaning materials. Meanwhile early detection led to increased chances of survival for those suffering from Ebola. Practical material support to families while in quarantine, and psychosocial support and counselling, helped them and their families find ways through the ordeal.

The Missionary Sisters' approach thus embodies many of the key characteristics of the Missionary Approach to development as understood by *Misericordia*, 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.

List of Acronyms

CPC	Counselling and Peace Centre
CHO	Community Health Officer
EVD	Ebola Virus Disease
HTC	Haemorrhagic Treatment Centre
MSF	Medecins Sans Frontieres
MSHR	Missionary Sisters of the Holy Rosary
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

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, Misesan Cara designed and carried out this research study to explore the mechanisms leading to behaviour changes achieved by the EVD outreach and awareness activities carried out by the Missionary Sisters of the Holy Rosary (MSHR) in Sierra Leone.

The Missionary Sisters of the Holy Rosary is a women's missionary religious order founded in Ireland in 1927, which first came to Sierra Leone in 1948. During the civil war (1991 to 2002), they accompanied refugees fleeing to neighbouring Guinea, but returned to Sierra Leone after the war to participate in healing and re-building the country. They are currently engaged in a number of areas including girls' education, trauma counselling, and women's empowerment, all of which have received financial support from Misesan Cara. When the Ebola crisis struck in 2014, Misesan Cara supported their integrated emergency response programme, which encompassed elements of sensitisation, counselling, practical training, distribution of emergency supplies and equipment, and support for Ebola patients and their families.

This report is structured in six sections. After this introduction, Section 2 provides a general overview of the 2014-2016 Ebola Crisis in West Africa. Section 3 describes the scope and focus of this research, and outlines the research methodology used. Section 4 discusses the role of the Missionary Sisters of the Holy Rosary in Sierra Leone, both before and during the Ebola crisis. Section 5 sets out the main findings of the research: First the main issues that had to be tackled in responding to the crisis, both rumours and false beliefs, and the harmful practices often linked to these; then the strategies adopted by the Missionary Sisters, and their effectiveness in contributing to the containment and prevention of Ebola. Finally section 6 reflects on some of the insights to be found in and lessons that can be learnt from the foregoing analysis. A number of annexes give greater detail on the findings in tabular form.

2. 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 half 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 across West Africa 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).

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



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

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 (2015) 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. Before the crisis, due to recent and lengthy civil wars in all three of the most affected countries, health systems and national infrastructure were particularly lacking, and population distrust of the state and state institutions 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, 2015).

3. Research focus and methodology

3.1 The scope and focus of the research

This research focused on the intervention of one Misesan Cara member organisation, the Missionary Sisters of the Holy Rosary, drawing mainly on the Sisters’ own accounts of their experiences in 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.

various different contexts in which they worked. The Sisters who contributed to this study worked in secondary schools in Kenema and Bo, the Counselling and Peace Centre in Bo, the Pastoral Centre, also in Bo, and through a number of community outreach initiatives in Freetown.

The research aimed to build a better understanding of:

- The rumours and false beliefs that contributed to the spread to 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 (a) counter rumours and false beliefs, and (b) encourage safer behaviour and preventative practices;
- How the different strategies contributed to prevent the spread of Ebola and bring the crisis to an end, both as response strategies in their own right, and as elements in an integrated, holistic response.

3.2 Research methodology

Data was collected using the following qualitative methods:

- Key informant interviews with two local women who themselves had survived the Ebola epidemic, but who had lost family members, and also with a (male) doctor who had worked in hospitals and Treatment Centres throughout the crisis and who himself had contracted and survived EVD during the crisis.
- Full day focus group with seven members of the Missionary Sisters of the Holy Rosary who had been instrumental in the Congregation's various projects in Sierra Leone (schools, counselling centre, outreach centre etc.) during the crisis. During the course of the day, participants undertook the following activities:
 - Discussion of the context and overview of the MSHR's interventions.
 - Creation of a time-line of the crisis as it developed, and the corresponding actions undertaken by MSHR at each stage.
 - Listing and detailing of all the issues they considered dangerous in encouraging the spread of Ebola or hindering its containment. These included beliefs, myths and rumours; and also practices: both traditional practices, and new ones developed in response to the current situation.
 - Ranking exercise to identify and prioritise to what extent these issues contributed to the spread of Ebola, or hindered containment.
 - Further discussion of the most significant issues, exploring how each one was addressed, and with what outcomes; then ranking these outcomes according to how effectively each one contributed to bringing the epidemic to an end.

4. The Missionary Sisters of the Holy Rosary in Sierra Leone

4.1 The MSHR in Sierra Leone, before and after the Civil War

The MSHR is a women's missionary religious order founded in Ireland in 1927, which began its African missionary work in Nigeria the following year. The Sisters are now active in nine African countries as well as Brazil and Mexico.

The Holy Rosary Sisters first came to Sierra Leone in 1948 with a mission to bring education, especially to women, and to provide health care to mothers and children and the population in general. They did this in Freetown, Kenema, Bo, Pujehun and further afield, living and working peacefully with both Christians and Muslims. During the civil war which engulfed the country from 1991 to 2002, hundreds of thousands were forced from their homes and became refugees in neighbouring Guinea, where the Holy Rosary Sisters moved with them. When the war came to an end, the Sisters returned with the people to begin the task of rebuilding. They currently are engaged in:

- The Holy Rosary Counselling and Peace Centre (CPC) in Bo, specialising in trauma release, healing management, counselling and empowerment.
- A women's bakery in Kintom, Freetown.
- A women's empowerment project in Bo and surrounding communities.
- Holy Rosary Senior Girls' Secondary School, Kenema.
- Queen of the Rosary Girls' Secondary School, Bo.
- A Pastoral centre in Bo.
- St Mary's Technical and Vocational School.

Misean Cara has supported the following MSHR projects and activities in Sierra Leone since 2011:

Table 4.1: Misean Cara's support to the Missionary Sisters of the Holy Rosary, 2011-2017

Areas of work supported (Misean Cara Project Portfolios)	Year	MC Funding (€)
Holy Rosary Girls' Secondary School, Kenema	2011-2014	224,170
Queen of the Rosary Girls' Secondary School, Bo	2012-2015	273,188
Freetown Montessori Programme (evaluation)	2012	4,155
Empowering community-based women's groups through agriculture and business planning for self-reliance (Bo)	2013-2015	29,996
Sex Education and Awareness Campaign " <i>Fullness of Life</i> ", Port Loko, Moyamba, Western Rural District and urban slums	2014-2017	68,250 ³
Ebola response programme, Sierra Leone	2014-2015	30,000
Total:		629,759

³ An further \$20,000 has been approved for the third year of this project going into 2018.

4.2 The MSHR and the Ebola crisis

“We had eight students who died of Ebola, we had more than 24 parents who died, and one teacher ...So all of these girls were now under our care, we had to support them. We did psychosocial counselling with them”.

“All the auxiliary staff they teamed up and they came to help, and when we had supplies they helped me to reach out to the communities”.

Missionary Sister, Holy Rosary Girls’ Secondary School, Kenema

“Some families, their family members died, some people were left hopeless, without any help. And some areas were quarantined, because when Ebola comes in an area like this, so what the government will do is come and quarantine that area. So I bought food and sent it to them.”

Missionary Sister, Bo.

“When the school closed, we organised an Ebola workshop for the teachers in the school, because we all have to be on the alert for what was happening to our students wherever they were, and also the teachers wherever they were. So we were keeping in contact with each other. No teacher died from Ebola, but they lost family members; one staff member lost six members of his family”.

Missionary Sister, Queen of the Rosary Girls Secondary School, Bo.

In the course of the research, the Sisters created a time-line of the Ebola crisis as they experienced it. By this means they were able to recap the evolution of the crisis in Sierra Leone, side by side with a summary of their own activities in responding to the crisis and supporting those most affected. The following table is based on the Sisters’ hand-written timeline prepared during the research process. The columns on the right show the range of activities undertaken by the Sisters in different locations and settings: their two girls’ secondary schools in Bo and Kenema, their counselling centre and pastoral centre, and additional outreach work carried out in rural communities and in liaison with other agencies such as local hospitals and health centres.

Table 4.1: Timeline of 2014-2016 Ebola Crisis in Sierra Leone as experienced by the Missionary Sisters of the Holy Rosary

Date	National overview	Missionary Sisters of the Holy Rosary's response actions			
		Schools	Counselling and Peace Centre (CPC)	Pastoral and other centres	Outreach in community and hospitals
2014					
March	First case recorded in neighbouring Guinea				
13 March	Archdiocesan Lent Pilgrimage in Freetown. As part of a public awareness campaign, Ministry of Health officials addressed the crowd for 1½ hours on Ebola risk, symptoms, hygiene etc.				
May	First case in Sierra Leone confirmed in Kailahun district (where borders of Sierra Leone, Liberia and Guinea meet). Patient was a middle aged woman who was a traditional birth attendant recently returned from Guinea. Ebola spread to her family and those who participated in the burial ritual, and through them to neighbouring communities.	Networking with parents, past pupils, Health and Education Ministry staff to prevent Ebola in the school. Ebola sensitization workshops for staff and students.	Offering Counselling services. Training CPC staff on psychosocial counselling.		Distributing food to communities.
June	People did not believe it was Ebola and tried various treatments. One woman visited the Community Health Officer (CHO) in Daru. The CHO contracted Ebola and was brought to a Haemorrhagic Treatment Centre in Kenema. People in Kenema began believing Ebola was real when the CHO died in the HTC. Kenema town put under quarantine for 21 days.	Instruction on personal and community hygiene.		Training workshops on skills to avoid Ebola.	Distributing food to hospital staff.
July	MSF set up an Ebola Treatment Centre in Kailahun. Dr Sheikh Khan died after being transferred from Kenema for treatment at the MSF Centre in Kailahun. The same day, President Ernest Koroma declared a state of emergency and declared a public curfew. All public schools were closed. Dr Khan was publicly buried in Kenema because many still thought his death was a false rumour.	Ebola sensitisation workshops.	Training for centre staff on trauma release	Using radio broadcasts to teach skills to avoid contamination.	Distributing food to communities. Distributing food and clothing to quarantined Ebola patients in Kenema.
August	Many families fled from Kailahun through the bush to Kenema; some went to relatives in Bo who sheltered them, hiding their deaths and the spread of Ebola. Check-points set up on roads to check temperatures and wash hands. Church adjusted funeral ceremonies to help people do their grieving within the constraints of the government's non-contact and safe burial procedures. 29 Aug Health Minister Miatta Kargbo sacked.		Computer training for young people (all schools were closed) Offering food to those who came to the CPC	Composed "Ebola Prayer" for the region. Pastoral centre used to distribute food and hygiene items ("Ebola soap" etc.) (Circular sent to Sisters in the region to close down all their activities).	Hygiene and food supplies to quarantined communities. (Continued...)

Date	National overview	Missionary Sisters of the Holy Rosary's response actions			
		Schools	Counselling and Peace Centre (CPC)	Pastoral and other centres	Outreach in community and hospitals
Sept.	Government closed all pharmacies so people could only seek treatment through hospitals. Travel passes, requiring a medical check, needed if travelling from a quarantined area. All burials had to be done by "Burial Teams".	Distribution of food relief to staff, students and families affected.	Grassroots sensitisation in villages. Offering computer services to those who needed them.	Offering accommodation and cooked food.	Established community base to distribute food, soap, clothing etc.
October	Government opened more Treatment and Holding Centres. Health workers demanded increased salaries because of risk, rejection by neighbours and eviction by landlords.	Provided counselling for teachers whose families were affected by Ebola. Sensitisation for junior staff. Provided stipend to school staff who were without salary.			Sensitisation training of young people and community members. Training workshops on Ebola prevention. Distributing food to communities.
Nov.	Red Cross arrived (from Spain, Canada, USA and UK) and took over the Treatment Centre in Kenema; began giving proper burials with records and marking of graves, and allowed families to see dead relatives before burial. Traditional leaders in the East of the country introduced local by-laws with fines for: <ul style="list-style-type: none"> - touching anyone; - hiding illness; - taking in a visitor without informing the chief. 	Sensitisation of parents, teachers and pupils			Distributing water and drinks to Ebola patients in hospital Distributing food, drinks, toiletries and hygiene materials to affected communities
Dec.	Last Ebola cases recorded in East. No Christmas celebrations in many churches.				
2015					
January	Government started giving money to people who reported illness to Ebola Response Teams and Chiefs.	Keep QLS clean. Operating a "Good Health Unit" in the school.	Leadership training for young people. Offering counselling where needed.		Distributing food and drink, clothing and prevention materials to communities.
March	Government announced new support to schools and no school fees for 2 academic years (1 calendar year).	Promoting good practices in personal and community hygiene.	Psychosocial counselling to families of survivors.		Ebola sensitisation. Distributing food to communities. <i>(Continued...)</i>

Date	National overview	Missionary Sisters of the Holy Rosary's response actions			
		Schools	Counselling and Peace Centre (CPC)	Pastoral and other centres	Outreach in community and hospitals
April	Schools and other public places reopened but with preventative measures enforced: <ul style="list-style-type: none"> - temperature checks; - hand washing - close by 6.00 pm. Ministry of Education distributes hygiene materials from UNICEF to schools	Psychosocial support training and counselling Sensitisation on hygiene and cleanliness for teachers. Supply of food and hygiene materials to orphans, survivors and care-givers.	Offering counselling. Grassroots sensitisation in villages.		Networking with Social Welfare and Ministry of Health on data collection. Counselling for survivors.
May	Ministry of Education started training teachers in psychosocial counselling; each school had to send 2 teachers on the course.	Provision of basic needs to student survivors and parents.		Psychosocial trauma release workshop for teachers.	Collection of data on survivors. Family tracing and medical assistance for orphans.
June	Ministry announced 2 school years to be merged into one calendar year.	Medical care to students and teachers.			Organising vocational training for young people.
July					Launched radio programme with students.
August				Organising doctors, nurses, and pharmacists to treat survivors.	Distributing food, clothing, toiletries and Bevimix health drink for children.
October	Because of lingering cases in the North, schools there did not open till October.		Psychosocial training in villages. Counselling.		Post-Ebola food and medical support for orphans and survivors.
Nov. <i>07 Nov.</i>	President declares end of state of emergency and Sierra Leone "Ebola free".			Spiritual activities, including Bible-sharing workshops and prayer.	Psychosocial workshop with Ebola survivors Supplying food and hygiene materials to care-givers.
2016					
March	WHO declares no further cases of Ebola in Sierra Leone.				

5. Findings

Table 5.1: Most dangerous rumours and practices relating to Ebola, as ranked in importance by MSHR (summary of complete ranking table shown in Annex 1)

Description	Outreach		Schools		Total score	%
	Free-town	Bo	Bo	Kenema		
Rumours						
1. Ebola is caused by Witchcraft.	32	8	2	20	62	15%
2. Political conspiracy to reduce opposition population, especially in the East.	15	11	2	8	36	9%
Other rumours	9	23	9	9	50	11%
Sub-totals:	56	42	13	37	148	35%
Practices						
1. Not disclosing death until after the body had been washed (led to Ebola spreading in villages).	21	20	7	5	53	13%
2. Denial for first 6 months until a significant well-known person died (Government closed all pharmacies so that all treatment must be provided through hospitals).	15	22	4	2	43	10%
3. Poor sanitation and hygiene practices; including not washing hands.	10	14	6	8	38	9%
4. Hiding illness (of self or other family members): Relatives hid sick people and later covered up their deaths.	11	14	5	4	34	8%
5. Traditional burials involving washing of bodies and sprinkling of water (especially of influential people, as it was believed that this could help one acquire the dead person's wisdom).	7	19	5	0	31	7%
Other practices	0	49	20	4	73	18%
Sub-totals:	64	138	47	23	272	65%
Total	120	180	60	60	420	100%

5.1 Beliefs and rumours

“In the unreached areas – these are in the hinterland, very far away – the first thing that we did was to educate them on the importance of accepting that Ebola had come, because they were under denial at this time, and they were running away if they saw anyone from the town. So our psychosocial workers went to prepare the people, that was before we started our distribution.”

Missionary Sister, Bo

Analysis of participants' responses showed 9 issues under the category of rumours and beliefs, which between them received 35% of the votes; and 12 issues under the heading of harmful practices, which received 65% of the votes. The two are closely related, however, since in many cases the harmful practices were motivated by underlying beliefs, or sustained by rumours that were circulating in the communities.

The Sisters recognised these beliefs as false and potentially harmful, and many of their actions (described in the following section) were directed at countering and changing such beliefs. Of the many beliefs and rumours mentioned, two were considered particularly dangerous:

- *Ebola is caused by witchcraft:* This was a severe problem as there was evidence that over 70% of the population believed in witchcraft, and so witchcraft was widely accepted as an explanation of Ebola without question. This then affected people's responses (see "Harmful practices" below); for example persuading them to go to a witch doctor rather than a medical professional. Not only did witch-doctors become a focus for cross-infection, but some of their solutions, such as herbs that induced diarrhoea, or group treatments, only served to encourage the spread of the disease.
- *Ebola is part of a political conspiracy to reduce the population opposed to the government in the east of the country:* This belief led people to avoid government-run health facilities that could have helped them, and fed the already widespread denial of the reality of Ebola. In addition it exacerbated the already high level of political and inter-tribal tension throughout the country, a consequence of the civil war of the 1990s. Though less prevalent, various other myths about the government's involvement in Ebola were mentioned, for example: "The government is keeping Ebola going in order to win international donor funding"; "Instead of treating sick people, Government hospitals are injecting them so they die quickly"; and "The Government is killing people in connivance with foreign bodies in order to sell their blood".

Other myths included supposed "cures" for Ebola, such as eating bitter cola, or getting up early and bathing in, or drinking, salt water. There was also a belief that Ebola was a "Kenema disease"; that is, it was only a problem in the East of the country. Finally some believed it was a curse sent by God to punish the people for their transgressions.

5.2 Harmful practices

The most harmful practices were considered to be:

- *Not disclosing the death of a family member until after performing the traditional washing ritual with the remains:* There was a strong belief in the importance of this washing ritual, and people were not prepared to abandon it. Since it was known that the Ebola virus remained active on the surface of the body for some time after death, adherence to this ritual was a driver for the spread of Ebola.
- *Denial of the reality of Ebola:* For at least six months, many people refused to accept the reality of the Ebola outbreak. It was not until well-known public figures began to die that the reality was widely accepted. The persistent denial encouraged the spread of Ebola as people simply carried on with their daily routines, including, for example, close physical contact with sick relatives, sharing food and utensils with sick people, and eating "bush meat" (wild animals such as bats and monkeys, known to host the Ebola virus).
- *Poor sanitation and hygiene practices:* Regular hand-washing was not part of the local culture. Many did not have access to toilets, and the few toilets available were used by large numbers of people. Most people did not have access to the materials needed for proper cleaning and disinfection.

- *Families hiding the illness of family members, and later hiding bodies and not disclosing deaths:* This was due largely to fear of what would happen if loved ones were taken away to a Treatment Centre. In many cases (in the early stages) they were never heard of again. A contributing factor was the stigmatisation of households known to be affected by Ebola; and fear of this prompted people to hide cases of Ebola within their family. This led to many people dying, whose lives could have been saved if they had been diagnosed and treatment sought earlier.
- *Traditional burials:* The traditional burial practice often involved the washing of the dead person and then the sprinkling of the water used. There was a traditional belief that through this practice others could acquire the wisdom of the dead person, which made this particularly dangerous following the death of a respected or influential elder.

Other harmful practices included the use of traditional healers or witch doctors; eviction of sick people from their homes, which led to them wandering from place to place; affected families fleeing through the bush to be hidden by relatives in neighbouring communities; people making false reports of Ebola against those they had a feud or disagreement with; and medical staff accepting bribes to give false reports so that families could perform dangerous rituals.

Annex 2 contains a table giving the full list of beliefs and practices identified, and their ranking by the research participants.

5.3 Strategies and results

Following the identification and ranking of harmful beliefs and practices, the most significant of these were considered in more detail, as the Sisters discussed their responses to each one, and the results of the different actions or strategies used. In this section, beliefs and practices are discussed together, in the order of importance attributed to them by the participants.

5.3.1 Belief in witchcraft as the cause of (and thus most likely cure for) Ebola

Strategies:

The main strategy to address belief in witchcraft was sensitisation, working alongside local health service officials. It involved both workshops and informal communication, as well as a variety of media: Radio talks, flyers, T-shirts, bill-boards and banners. It involved meetings with traditional leaders or village chiefs, going to meet people where they were (as far as was possible whilst respecting government-imposed isolation zones and restrictions on movement), and explaining what was happening, especially those who still believed it was witchcraft. An important part of the sensitisation was the need to counteract the fear and misunderstanding caused by the initial government message that Ebola had no cure. People who heard this message preferred to go to a witchdoctor than go to hospital to die alone.

All sensitisation materials, such as posters and leaflets, were checked and vetted by the Ebola Task Force before use, to ensure correct and coherent messages were being given. The Sisters also used posters provided by UNICEF.

Results:

The sensitisation work eventually led to greater awareness, and changes in attitudes and behaviours, e.g. washing hands and avoiding body contact. This brought increased trust in medical help and reduced reliance on traditional healers and witchcraft.

Some people were willing to let go of traditional beliefs because of their trust in the Sisters; they recognised that in the past the Sisters had always been trustworthy, had stood up for their welfare and had never let them down. The fact that the sisters stayed with the people throughout the crisis

had a big impact. They also pointed out that Ebola was not an issue of culture, and modern medicine offered the best solutions.

5.3.2 Not disclosing death to the authorities, until after ritual washing

Strategies:

This was a critical issue, as it led to people secretly leaving the bodies of deceased relatives in the street (usually some way from their homes to avoid detection or stigma). As well as the ongoing sensitisation work described above, the Sisters contacted elected councillors and appealed to them to take action to address this issue. The issue was also addressed through psychosocial training and counselling. (It was noted that the failure to have bodies removed to safe burial was not always the families' fault. If someone died at home of unconfirmed Ebola, families had to pay 250,000 Le for a swab test, and if they could not do this, the burial team would not respond to their call).

Results:

People were touched by the Sisters' advocacy on their behalf, and responded by stopping the practice of ritual washing and instead calling the Ebola response team. In general they became more conscious of health and hygiene issues. The Government also became more active in deploying people to carry out inspections. Eventually the Government radio issued an appeal to people to stop dropping leaving the remains of the deceased in the street.

5.3.3 Denial of the reality of Ebola

Strategies:

At the start of the crisis, the Sisters themselves received training, by Caritas among others. As well as the sensitisation programmes, involving workshops, radio, and banners, they worked with children and young people to raise awareness through community drama activities, and children in schools were trained as "carriers of learning". Training was also organised for care-givers, either directly or by networking with other groups active in this area.

Results:

This strategy led to very high awareness among children, and through them to gradual acceptance of the reality of Ebola throughout the communities. People began washing hands without prompting, and there was increased use of hygiene and sanitary equipment, such as Veronica Buckets.⁴

5.3.4 Poor sanitation and hygiene

Strategies:

As well as general sensitisation, people were given specific guidance on hygiene practices: For example, they were encouraged to dig and use rubbish pits, and to de-congest their houses. Practical assistance and supplies were provided, like soap, disinfectant, buckets and aprons. Incinerators were built in schools and community centres, wells were bored and some toilets built (previously it would have been common for 100 people or more to depend on a public toilet in urban areas).

⁴ A Veronica Bucket is a bucket with a tap near the bottom, which makes it easier for people to wash their hands properly in situations where there is no running water, or water is scarce.

Results:

As people became more aware of hygiene for preventing Ebola, they began to request help with the improvement of sanitation facilities in villages. As well as helping to prevent the spread of Ebola, this led to a significant reduction in other water-borne diseases (e.g. no cholera recorded in 2016) and in infant mortality.

As people became aware of the risk of close physical contact while sharing motorbikes, this practice was stopped. Riders started wearing protective jackets and stopped sharing their motorcycle helmets.

5.3.5 Conspiracy theory myth that Government was encouraging the spread of, and benefitting from, Ebola

Strategies:

Political polarisation had remained a major problem in the country since the civil war, and there was little the Sisters could do to address this directly. They adopted a strategy of strict neutrality in all their sensitisation work; distributing supplies and offering support irrespective of people's beliefs or political affiliations; and never letting the issue of religion affect how they treated people.

Results:

Their neutral stance had an impact on many people, and helped to encourage cooperation and collaboration, bridging gaps between people on opposite sides. Their message of a just, tolerant and peaceful society was heard and understood by many.

5.3.6 Hiding illness (and subsequent death) in the family

Strategies:

As well as their ongoing sensitisation and psychosocial support work, the Sisters consistently referred sick people to hospital, giving assurances to doctors, who themselves were often scared, when people needed treatment for non-Ebola ailments. They gave money and/or medicine to people who needed it, and distributed food where it was most needed. They also supported health centres run by other groups known to them. They used prayer to give people courage and hope.

Results:

These strategies reduced fear and got more people to go to hospital, which in turn led to the saving of lives and helped reduce the spread of Ebola. Indirectly this led to a healthier, safer environment.

5.3.7 Traditional burial rituals

Strategies:

Again, sensitisation was key to addressing this issue. Here the sisters used empathy with the families they visited, showing that they understood the importance of the ritual and affirming its validity in normal circumstances, before explaining why the current circumstance required people to act in a different way for their family's safety (avoiding physical contact with the dead person).

Results:

Although it was painful for many, they eventually accepted the message and began to allow the Ebola team to bury their dead. Also, because of the Sisters' intervention, people started listening to and following the guidance they received from Government media. As a result, Ebola was eventually controlled and eliminated.

5.4. Rating the effectiveness of the results

Following their analysis of the various response strategies and the results achieved through each of these, the Sisters were asked to give an overall assessment of which strategies were the most effective in tackling the crisis. Their assessment and ranking of their strategies is shown in a table in Annex 2.

The Sisters felt the most effective strategy (21% of votes) was the improvement in hygiene and sanitation. They noted that as well as helping prevent the spread of Ebola, this improvement in hygiene led to a general reduction in water-borne diseases, such as cholera. Next were people's greater awareness (18%) or acceptance of the reality of Ebola (15%), which led to changes in attitudes, including the letting go of some harmful traditional beliefs, and consequently to changes in behaviour, such as calling the medical teams when someone fell ill. The Sisters also believed that their efforts to improve the general health of the communities they worked with had a major effect. For example by distributing food to those most in need, they were able to improve the overall level of nutrition, and thus reduce risk (16%). Finally, the Sisters noted the contribution made by their psycho-social counselling and support services to the re-integration of survivors into the community.

5.5 Shared learning with MSHR sisters in Liberia

In addition to the local strategies discussed above, the Sisters also spoke of their efforts to coordinate, share and collaborate with their colleagues in neighbouring Liberia:

- Written reports were shared with each other via the Mother Generalate.
- The MSHR development office put them in contact with Hilton Foundation in the USA. The Liberia office helped them prepare a successful funding application which brought additional support for their Ebola response work.
- The Sisters in Liberia sent additional financial support for the work in Sierra Leone.
- The Sisters in Liberia produced a written account of their experience which helped the Sisters in Sierra Leone in developing their own strategies.
- Though they tried to maintain telephone contact, telecommunication systems were very weak at the time, so this was only possible on an irregular basis.

6. Conclusions

Although this report shows that the Missionary Sisters of the Holy Rosary responded to Ebola with a number of strategies according to the varied circumstances in which they worked, it is clear that 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 their work to provide correct information and practical advice. Both of these contributed to changes in behaviour and practices, which was in turn 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.

The Sisters' response to the Ebola crisis can also 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.

The Missionary Sisters' approach thus embodies many of the key characteristics of the Missionary Approach to development as understood by Misesan Cara, particularly the long-term commitment of the 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.

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ANNEXES

Annex 1: Rumours and practices relating to Ebola

Scores show votes given in ranking exercise according to the Sisters' perception of what was most dangerous in spreading the disease in Sierra Leone.

Description	Outreach		Schools		Total score	%
	Free-town	Bo	Bo	Kenema		
Rumours						
3. Ebola is caused by Witchcraft.	32	8	2	20	62	15%
4. Government trying to reduce opposition population, especially in the East.	15	11	2	8	36	9%
5. Ebola is a Kenema disease and in only a problem in the East.	0	9	0	9	18	4%
6. Ebola can be cured or prevented by eating bitter cola.	0	11	0	0	11	3%
7. The Government is using Ebola and keeping it going to get international donor funding.	4	3	2	0	9	2%
8. Some people believed they were being punished by God.	5	0	2	0	7	2%
9. Ebola can be cured or prevented by getting up early and bathing in or drinking salt water (this led to death due to high blood pressure etc.).	0	0	3	0	3	<1%
10. Instead of treating sick people, Government Hospitals are injecting them so they die quickly.	0	0	2	0	2	<1%
11. The Government is killing people in connivance with foreign bodies to sell their blood.	0	0	0	0	0	<1%
Sub-totals:	56	42	13	37	148	35%
Practices						
6. Not disclosing death until after the body had been washed (led to Ebola spreading in villages).	21	20	7	5	53	13%
7. Denial for first 6 months until a significant well-known person died (Government closed all pharmacies so that all treatment must be provided through hospitals).	15	22	4	2	43	10%
8. Poor sanitation and hygiene practices; including not washing hands.	10	14	6	8	38	9%
9. Hiding illness (of self or other family members): Relatives hid sick people and later covered up their deaths.	11	14	5	4	34	8%
10. Traditional burials involving washing of bodies and sprinkling of water (especially of influential people, as it was believed that this could help one acquire the dead person's wisdom).	7	19	5	0	31	7%
11. Hiding the remains of loved ones who died, as this could lead to the stigmatisation of survivors.	0	12	6	0	18	4%
12. Going to traditional healers, or to church or mosque to pray for a cure (often linked to denial of reality of Ebola).	0	8	3	4	15	3%
13. Cross-contamination: Some patients contracted Ebola in ambulances and health centres. Also spraying of chlorine in ambulances in transit; combined with hyper-ventilation and fear, this led to suffocation.	0	10	5	0	15	3%
14. Sick or infected people moving from place to place (in some cases landlords evicted health workers because of fear that the house would be contaminated).	0	4	6	0	10	2%
15. Families from affected areas fled through the bush and were hidden by relatives.	0	8	0	0	8	2%
16. People made false reports that someone they had had a disagreement or feud with had Ebola, so that that person would be taken away to a Treatment Centre.	0	5	0	0	5	1%
17. Some medical staff accepted bribes to provide false reports of the cause of death; so that families could perform traditional burial rituals.	0	2	0	0	2	<1%
Sub-totals:	64	138	47	23	272	65%
Total	120	180	60	60	420	100%

Annex 2: Rating of effectiveness of results

Based on MSHR sisters' perception of which were most effective in addressing the crisis.

Results / outcomes	Freetown outreach work	Outreach in Bo	Bo school	Kenema School	Total score	%
1. Better hygiene and sanitation.	14	25	9	10	58	21%
2. Awareness leading to changes in attitudes and behaviour.	17	23	2	7	49	18%
3. Health improvements; e.g. provision of food leading to better nutrition.	11	19	7	7	44	16%
4. Acceptance of the reality of Ebola.	16	14	8	3	41	15%
5. Letting go of some traditional beliefs (e.g. not all diseases can be cured by traditional healers).	6	12	4	0	22	8%
6. Re-integration of Ebola survivors into the community through psycho-social support.	0	14	2	6	22	7%
7. Practice of calling medical teams if someone falls ill.	10	4	3	0	17	6%
8. Reduction in water-borne diseases.	2	5	3	6	16	6%
9. People began listening to Government instructions.	3	4	2	1	10	3%
Total:	79	120	40	40	279	100%