



Keeping the Faith

The Role of Faith Leaders in
the Ebola Response



Faith is not simply a patience that passively suffers until the storm is past. Rather, it is a spirit that bears things – with resignations, yes, but above all with blazing, serene hope.

Corazon Aquino,
Political leader and
President of the Philippines, 1986-92

Cover Photo:

Sheik Ibrahim Sesay, Chief Imam of Pipe Line Coal Farm Mosque in Freetown, who delivered psychosocial training to faith leaders, organised by a Christian Aid partner
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Back Cover Photo:

Psychosocial training for faith leaders at Methodist Mende Church in Freetown - the training was organised by the Council of Churches in Sierra Leone, with support from Christian Aid's Disasters Emergency Committee funds
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The report was designed by Anthony Neal of CAFOD

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Contents

Acknowledgements	5
Acronyms	6
Glossary of Terms	7
Executive Summary	8
Geographical distribution of new and total confirmed cases of Ebola	12
Timeline of the spread of Ebola and the response of faith leaders	13
1 The purpose of the study and approach	15
1.1 Introduction	15
1.2 Purpose of the study	15
1.3 Methods and approach	15
1.4 Structure of the report	16
2 Background to the engagement of faith leaders in the humanitarian response	17
2.1 The historical context of faith and development	17
2.2 Faith leaders as an important part of locally-led humanitarian response	17
2.3 The context of religious tolerance in Sierra Leone and Liberia	18
2.4 The rise of inter-faith initiatives in Sierra Leone and Liberia	19
3 The impact of the Ebola outbreak and the engagement of faith leaders in the EVD response	20
3.1 The historical context of the Ebola outbreak	20
3.2 The rapid spread of Ebola and engagement of faith leaders in the EVD response	21
4 Promoting behaviour change to reduce transmission of the virus	25
4.1 Replacing messages of fear with messages of hope	25
4.2 Safe and dignified burials	30
4.3 Identifying the added value of an inter-faith approach	32
4.4 The role of women faith leaders in behaviour change and social mobilisation	33
4.5 The challenges presented by traditional beliefs	35
5 Addressing stigmatisation by strengthening acceptance of those who have recovered	36
5.1 Stigmatisation driven by ignorance	36
5.2 Role-modeling acceptance	37
6 The provision of assistance to those affected by the EVD outbreak	38
6.1 Leadership of community-based responses in the initial stages of the outbreak	38
6.2 The provision of relief items	38
6.3 Assistance to those placed in quarantine	39
7 Counselling and psychosocial support to the victims and survivors of Ebola	41
7.1 Support needs for those affected at the time of the Ebola outbreak	41
7.2 Mediation of disputes within and between communities	42
7.3 Longer-term trauma and the psychosocial impact of the EVD outbreak	42

8	The participation of faith leaders in the humanitarian system	44
	8.1 The participation of faith leaders in humanitarian coordination and leadership	44
	8.2 Partnership between faith leaders and humanitarian organisations	46
	8.3 Facilitation and support of faith leaders by FBOs and CBOs	46
9	Reflections on the role of faith leaders in the Ebola response	49
	9.1 How did change happen?	49
	9.2 Why did change happen?	50
	9.3 Reflections from the research	52
10	Conclusion and recommendations	54
	10.1 Conclusion	54
	10.2 Recommendations on the engagement of faith leaders in response and recovery efforts	55
	Annex 1: Methodology	56
	Endnotes	58



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The participation in the study of faith leaders, government representatives and national and international members of the humanitarian community is testament to the interest and commitment that exists to maximising the potential of faith leaders in the current response and in the future.

Andy Featherstone
Author and lead researcher

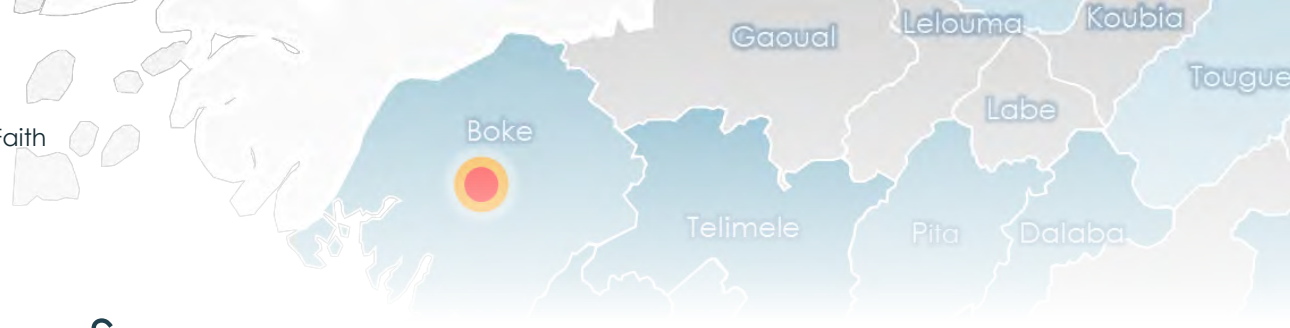
Acronyms

ADB	African Development Bank
AEL	Association of Evangelicals of Liberia
AJLC	Access to Justice Legal Centre
CAFOD	Catholic Agency for Overseas Development
CBO	Community-based Organisations
CCSL	Council of Churches of Sierra Leone
CDC	Centre for Disease Control
CHRISTAG	Christian Action Group
CRS	Catholic Relief Services
DERC	District Ebola Response Centre
DFID	Department for International Development
EU	European Union
EVD	Ebola Virus Disease
IRCL	Inter-Religious Council of Liberia
IRCSL	Inter-Religious Council of Sierra Leone
IRW	Islamic Relief Worldwide
ISLAG	Islam Action Group
JLI	Joint Learning Initiative on Faith and Local Communities
KAP	Knowledge, Attitudes and Practices
MCSL	Methodist Church of Sierra Leone
NEHADO	New Harvest Development Organisation
NERC	National Ebola Response Centre
NGO	Non-governmental Organisation
PPE	Personal Protective Equipment
RADA	Rehabilitation and Development Agency in Sierra Leone
UN	United Nations
UNICEF	United Nations Children's Emergency Fund
UNMEER	United Nations Mission for Ebola Emergency Response
WHO	World Health Organisation
WHS	World Humanitarian Summit
WV	World Vision

Glossary of Terms

A glossary of terms used in this report is provided below. Meanings and explanations of the terms are given on the right-hand side of the table.

Term	Meaning
Behaviour change	Behaviour change is a research-based consultative process for addressing knowledge, attitudes and practices. It provides relevant information and motivation through well defined strategies, using a mix of media channels and participatory methods. Behaviour change strategies focus on the individual as a locus of change. ¹
Community-based organisation (CBO)	CBOs are civil society, non-profit organisations that work to promote the development of their local community. Their actions may include community planning, community action and mobilisation, the promotion of community change and influencing.
CHRISTAG and ISLAG	CHRISTAG and ISLAG were formed in 1987 with support from the Ministry of Health in Sierra Leone and UNICEF to undertake social mobilisation activities to promote child immunisation in the country and have since been involved in basic education, water and sanitation, family planning and HIV/AIDS prevention. ISLAG and CHRISTAG are working together with the support of Focus1000 to address the Ebola outbreak.
Ebola Virus Disease (EVD)	Ebola virus disease (EVD), formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. The average EVD case fatality rate is around 50%. ²
Faith-based organisation (FBO)	For the purposes of this study, a faith-based organisation is defined as either a national or international organisation that has a religious character or mission. Please note that during the study, where FBOs are led by faith leaders, they are referred to in the text as FBO staff.
Faith leader	For the purposes of the study, a faith leader is a person who is recognised within the Christian and Muslim religions as having authority.
Joint Learning Initiative on faith communities (JLI)	The JLI is a group of more than 70 multi-sector and international partners which seeks to understand better and improve the quality, effectiveness and impact of partnerships between local faith communities and other development and humanitarian actors. ³
Knowledge, attitudes, practices (KAP) study	A KAP survey is a representative study of a specific population to collect information on what is known, believed and done in relation to a particular topic. ⁴
Psychosocial support	For the purposes of the report, the term 'psychosocial support' is assistance that is provided for the ongoing psychological and social problems of Ebola survivors, their partners, families, caregivers or responders.
Social mobilisation	Social mobilisation is a process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular development objective through dialogue. Social mobilisation seeks to facilitate change through a range of players engaged in interrelated and complementary efforts. ⁵
Stigmatisation	Stigma related to Ebola refers to derogatory attitudes, beliefs, and behaviours directed toward people living with the diseases and those presumed to be infected. ⁶
Traditional beliefs	For the purposes of the report, the term 'traditional beliefs' includes the range of traditional religions, traditional healers and secret societies that are active in Sierra Leone and Liberia.



Executive Summary

Introduction and Approach

With its focus on faith leaders, this study uses the Ebola outbreak in Sierra Leone and Liberia to explore the relationship between humanitarianism and religion and seeks to provide evidence, in real time, of the role of faith leaders in the Ebola response. It offers recommendations for how faith leaders can support the recovery efforts of the affected countries and it contributes to a discussion on the broader role of faith in humanitarian response.

Method	Description of research methods
Literature review	A literature review was undertaken to examine the role of faith leaders in humanitarian response (23 documents) and their specific role in the Ebola outbreak (54 documents), in addition to background documents on the broader outbreak, humanitarian response and recovery (44 documents), and inter-faith humanitarian response in Liberia and Sierra Leone (9 documents).
Key informant interviews	Key informant interviews and focus group discussions were conducted in Sierra Leone (Western Area, Bo district and Kenema district) and Liberia (Montserrado and Bong County) with faith leaders (33 interviews), NGOs and UN agencies (31 interviews), government representatives (10 interviews), donor agencies (4 interviews).
Faith leader survey	A formal survey and additional focus group discussions were undertaken in Western Area, Bo and Kenema districts by a team of two enumerators. This was largely targeted at village-level faith leaders (92 interviews with faith leaders).
Focus group discussions	18 focus group discussions were conducted in Bo and Kenema districts in Sierra Leone and in Montserrado and Bong counties of Liberia (with community members (176 people)).

Findings of the research

Faith leaders play an important role in communities...

Faith plays an important role in people's lives in Liberia and Sierra Leone where the majority of the people are practising believers and faith leaders enjoy significant trust and respect.

But there was a significant delay in engaging them at the start of the outbreak...

In the initial weeks after the Ebola outbreak, there was a lack of information about the disease and as a consequence, the response of faith leaders was mixed. As the outbreak spread, draconian measures were taken which went against cultural values and religious practices and which resulted in denial of the disease and hostility towards those who were seeking to contain it. Many of those with Ebola chose to remain with their families and burials were undertaken in secret. As a consequence the disease continued to spread.

Once they became involved, faith leaders played a transformational role...

Faith leaders used religious texts to interpret biomedical messages on the control and prevention of Ebola.

"Lofa County had been a hot-bed of Ebola-denial and it was difficult to get health staff in to assist. The Imam and the local chief worked together using messages from the Quran and the Bible to discuss behaviour change with the communities. This paved the way for health staff to get access to the County."

SENIOR UN STAFF MEMBER, MONROVIA, LIBERIA

By faith leaders accompanying burials and by conducting modified religious practices, communities began to comply with the urgent need for safe and dignified burials.

Because people trust them, when they started participating in the revised burial practices, people knew they could trust it and resistance ended. The participation of religious leaders was a game changer."

UN STAFF MEMBER, SIERRA LEONE

By preaching acceptance of Ebola workers and survivors and by role-modelling it in religious services, faith leaders helped to drive out the stigma that was destroying community coherence.

“Stigmatisation is a very serious social problem when it comes to the Ebola virus, as used to be the case with HIV. We have challenged HIV stigma and are now doing the same with Ebola. Those who have survived the virus find it difficult to be accepted back into their communities, so our ministers are preaching that people should accept their brothers and sisters, while still observing health guidelines.” CHRISTIAN FAITH LEADER, FREETOWN, SIERRA LEONE⁷

While the assistance they provided was often modest, it was frequently among the earliest and provided much-needed support to those affected by the disease, those placed in quarantine or those who had survived Ebola.

“Religious leaders were the first ones to provide assistance to us.” BANJO COMMUNITY MEMBER, MONTSERRADO COUNTY, LIBERIA

In the absence of adequate services, medical practitioners turned to faith leaders to support the huge unaddressed need for counselling and psychosocial support.



A Burial team in Kambia district, Sierra Leone.

How and why change happened

By replacing messages of fear with messages of hope

Through the use of religious texts and with the leadership of the faith community, biomedical messages which at first appeared harsh and which brought fear were given religious context and delivered with compassion in a way that provided hope and encouragement. It is the holistic way in which faith leaders were able to engage with people from both a technical and religious perspective that enabled changes in both the hearts and minds of communities that were being asked to sacrifice practices that they knew and trusted.

“Faith leaders have reach into every part of the country and they are highly trusted by community members.”

By shaping the attitudes and transforming the practices of local community members

The embeddedness of faith leaders in the community allowed them to form meaningful relationships and networks that have their roots in the trust and respect that people have for them. Their community leadership role permitted them to shape opinion and behaviour.

GOVERNMENT
COORDINATION STAFF
MEMBER, BO DISTRICT,
SIERRA LEONE

Once faith leaders had been engaged and understood the risks associated with some religious practices, they took measures to adapt them and then modelled the changes that were required. The lesson here is the importance of local engagement and ownership in humanitarian response.

Attribute	Description
Values	Faith leaders were highly motivated to support their communities and did so out of a spirit of compassion.
Access	The access that faith leaders had to communities, even in the most remote parts of the countries, was unparalleled.
Trust	The effectiveness of faith leaders in responding to Ebola relied in large part on the trust that community members had in them, which stemmed from their shared beliefs.
Long-term presence	Interviews highlighted staff turnover in NGOs and in government. In contrast, religious leaders were unique in occupying long-term leadership positions. While this has played a role in garnering the trust and respect of community members, it also provides faith leaders with a unique perspective on development of their communities.
Knowledge of communities	Faith leaders had a deep knowledge and love for the communities in which they lived. During interviews, they spoke passionately about those who had been lost to the disease and played a key role in modelling acceptance back into the communities for those who had recovered.

Reflections from the research

The value of adopting a holistic approach to emergencies

One of the most important lessons from the Ebola response is the importance of going beyond traditional response types for non-traditional crises. Ebola could not be addressed by the secular humanitarian system and neither could it be brought under control as a consequence of the actions of faith communities alone: it was both of these, plus traditional leaders, working together, that offered the potential to improve the situation significantly.

The essential role played by faith leaders in social mobilisation and behaviour change

The confidence that initially existed in adopting a purely medical approach to the Ebola virus disease (EVD) outbreak was misplaced; health facilities, treatment units and case management were important but they missed an essential element which was the need to mobilise communities to change behaviour and in many cases neither health staff nor the government were well placed to do this. Instead, the local community itself was best placed to effect change, and faith leaders, as trusted and respected members of communities, played an important role as agents of social change.

The effectiveness of an Inter-faith approach

In approaching the task of working together in Sierra Leone, Christian and Muslim faith leaders established an important ground rule: to focus on the issues that united them against the virus. This permitted a conversation that prioritised how to address the Ebola outbreak and allowed them to find similarities in their religious texts in how to promote behaviour change.

The coherence in the messaging between the two major religions and the unity that was demonstrated in how the messages were delivered provided an important platform for change.

The value of engaging with faith leaders as part of two-way communication with communities

The international humanitarian system has historically been weak in engaging local communities in the provision of assistance. The engagement of faith leaders in the Ebola response as community representatives in two-way discussions permitted the contextualisation of behaviour change messages. The response offers a rare example of power being shifted from the international to the local level and serves as an important example for humanitarian response elsewhere.

“Association with Muslims has been strengthened as a result of Ebola. The church cannot make change on its own... at a social level the inter-faith movement is a powerful tool to aid community development.”

CHRISTIAN FAITH
LEADER,
BO DISTRICT, SIERRA
LEONE

Conclusion and priority recommendations

The response offers some important lessons, not least the added value that came from seeking to respond to crises in a holistic manner. But faith leaders should not be considered merely as behaviour change agents to be used in times of crisis; with the number of people affected by conflict and disaster escalating at an alarming rate and with the World Humanitarian Summit less than a year away, there is growing consensus on the importance of local engagement in response and resilience. Many of the skills and capacities that faith leaders have demonstrated in the response to the Ebola outbreak have important value in placing people at the forefront of these important tasks which present an exciting opportunity for the future.

Priority recommendations:

For international organisations, government and donors

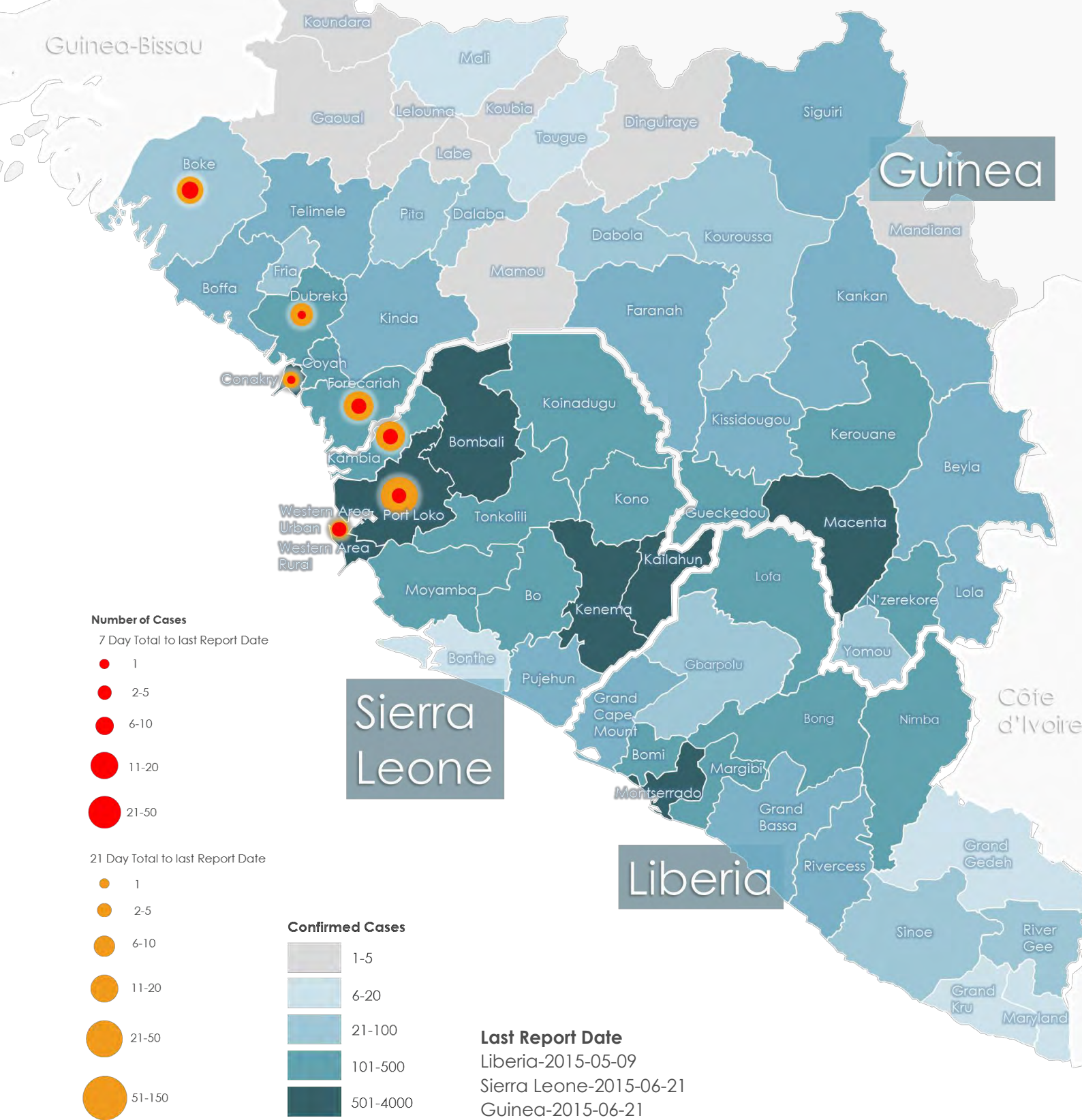
- **Include faith leaders in planning for recovery and in health emergencies:** While faith leaders were considered to be instrumental in promoting positive change during the Ebola response, there was a significant delay in engaging them at the start of the outbreak. Given their embeddedness in communities and their unparalleled knowledge of local-level needs, it is essential they are proactively engaged in planning processes for recovery.
- **Engage faith leaders in restoring health systems:** Faith leaders are well placed to draw on their respect within communities and a shared agenda in strengthening the health and well-being of their communities.
- **Strengthen faith literacy among humanitarian staff and undertake research:** Many relief and development staff have a narrow view of faith and the role of faith leaders and communities, particularly at field level. All humanitarian agencies should take advantage of the growth of literature on how to engage with FBOs and train their staff accordingly. The capacities of faith leaders are largely unmapped and their overall impacts uncharted. Further research should be undertaken to address this.
- **Avoid instrumentalisation of faith leaders:** There is a risk that the success of faith leaders in promoting behaviour change may lead to them being seen as a means to an end and used as passive actors to address social ills. Yet the changes they promoted came out of dialogue and a shared agenda which should serve as a blueprint for future engagement.

For faith-based organisations (FBOs)

- **Provide technical support:** FBOs should continue to build capacity and provide technical support to faith leaders as they respond to the Ebola crisis and recovery including in psychosocial support, addressing stigma and behaviour change. FBOs should support faith leaders to be empowered to respond to future EVD outbreaks and other disasters.
- **Strengthen inter-faith dialogue:** FBOs should work across denominations and faiths to catalyse and strengthen inter-faith dialogue and ensure consistency and accuracy of messages delivered by faith leaders. This could also incorporate pooling resources, undertaking cross-learning visits, coordinating activities and monitoring progress.
- **Facilitate national-level engagement:** Faith leaders should be supported to continue their engagement with national-level processes such as recovery plans and the rebuilding of health systems. If FBOs are unable to connect them directly to these processes, they should engage with agencies who may be better placed to do this, such as humanitarian international NGOs.

For faith leaders

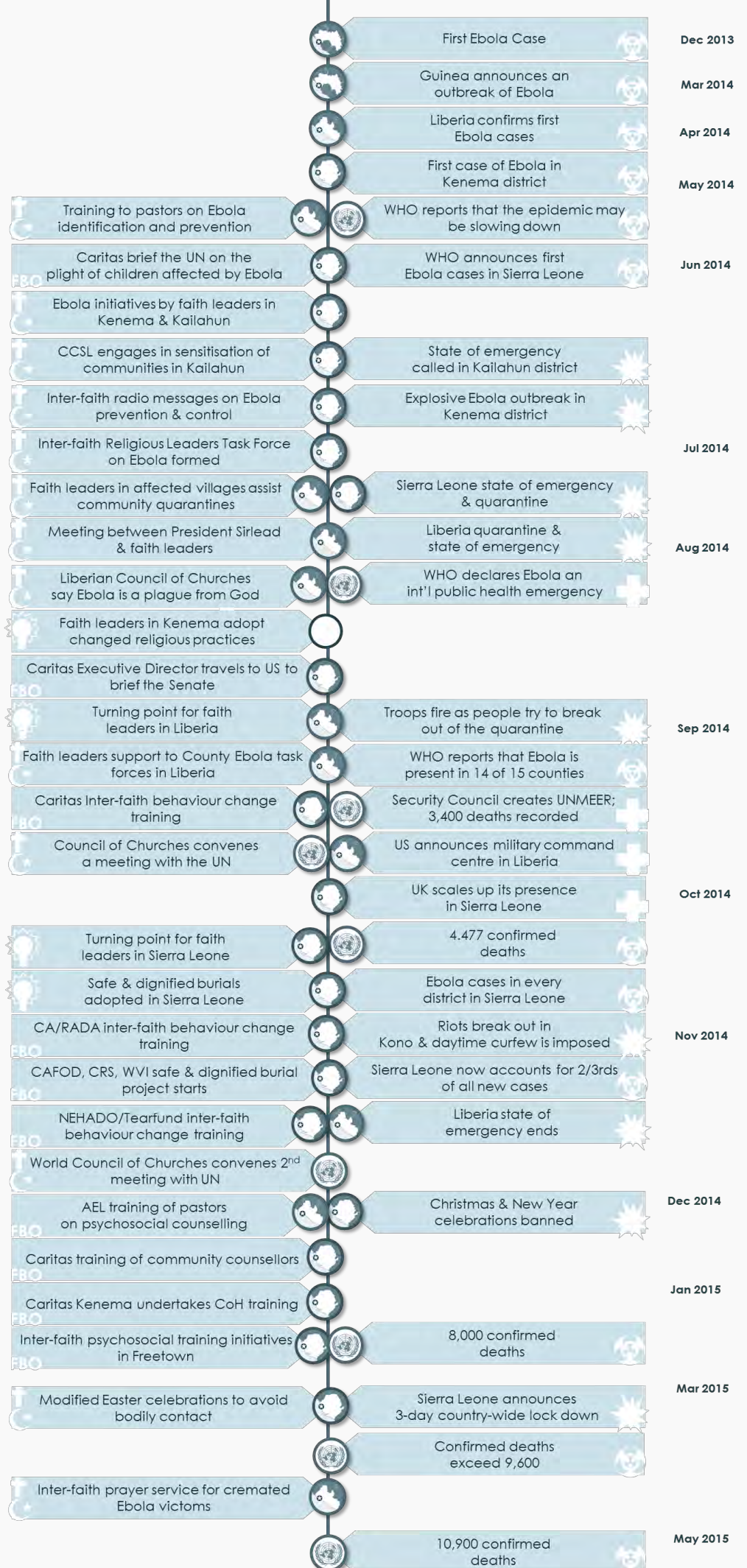
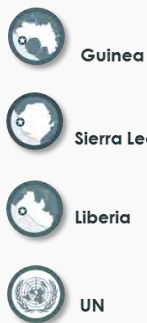
- **Support the Ebola response:** The continued engagement of faith leaders to maintain momentum on changing behaviour, facilitate psychosocial support to survivors and affected families, address stigma and discrimination, and support vulnerable groups is critical.
- **Catalyse community engagement:** As health systems are reestablished, faith leaders should play a key role in advocating for, and engaging communities in, health-related programmes. It is important that women are proactively engaged in this and suitable conditions are established to enable their involvement.
- **Build resilient communities:** Faith leaders should continue to play a critical leadership role in supporting communities' capacity to prepare for and respond to uncertainty, shocks and stresses.⁸



Geographical distribution of new and total confirmed cases of Ebola⁹

Timeline of the spread of Ebola and the response of faith leaders

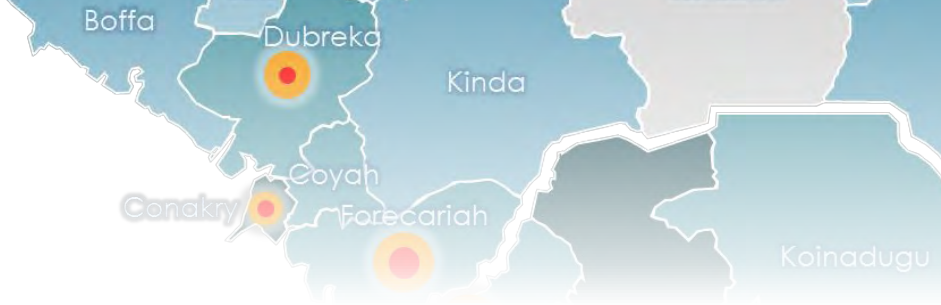
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Psychosocial training for faith leaders at Methodist Mende Church in Freetown - the training was organised by Council of Churches in Sierra Leone, with support from Christian Aid's Disasters Emergency Committee appeal funds.



Introduction, purpose of the study and approach

1.1 Introduction

Faith leaders and faith-based organisations (FBOs) have a long history of responding to crises in West Africa and have played a key role in addressing the Ebola virus disease (EVD) outbreak in Sierra Leone, Liberia and Guinea. Faith plays an important role in people’s lives in each of these countries, where the majority of the population are practising believers. They listen to their faith leaders and often come to places of worship for reliable information. The messages of the faith leaders can resonate with their congregations and, where government lacks capacity and when NGOs are no longer present or unable to reach remote communities, the faith leaders will remain.

With its focus on faith leaders, this study uses the Ebola outbreak to explore the relationship between humanitarianism and religion and seeks to provide evidence, in real time, of the role of faith leaders in the Ebola response. It offers recommendations for how faith leaders can support the recovery efforts of the affected countries and it contributes to a discussion on the broader role of faith in humanitarian response.

1.2 Purpose of the study

The research, which is commissioned by an inter-agency, inter-faith group comprising CAFOD, Islamic Relief Worldwide, Christian Aid and Tearfund, seeks to provide an evidence base on the role of faith leaders in addressing the Ebola outbreak, particularly in relation to social mobilisation, physical assistance, stigmatisation and psychosocial support. It aims to contribute joint learning from the Ebola outbreak on the critical elements of effective community mobilisation and participation in relation to the role of faith leaders and provides input into the broader work of the Joint Learning Initiative on Faith and Local Communities (JLI) in advance of the World Humanitarian Summit (WHS).

1.3 Methods and approach

The study was undertaken by an international researcher working with a national research team in Sierra Leone and Liberia with the support of the commissioning agencies.¹⁰ The research methods used for the study are summarised in the table below (see Figure 1). The methodology is outlined in greater detail in the Annex.

Figure 1: Summary of research methods

Method	Description
PRIMARY	
Key informant interviews	Key informant interviews in Sierra Leone (Western Area, Bo and Kenema districts) and Liberia (Montserrado and Bong Counties) with faith leaders (33 interviews), NGOs and UN agencies (31 interviews), government representatives (10 interviews), donor agencies (4 interviews).
Faith leader survey	A formal survey and additional focus group discussions were undertaken in Western Area, Bo and Kenema districts by a team of two enumerators. This was largely targeted at village-level faith leaders (92 interviews with faith leaders).
Focus group discussions	18 focus group discussions were conducted in Bo and Kenema districts in Sierra Leone and in Montserrado and Bong counties of Liberia (176 people).
Additional input	The research in Sierra Leone also drew from the interviews and focus group discussions undertaken by Anne Street of CAFOD during an initial scoping visit to Kambia in the Northern Province of Sierra Leone.
SECONDARY	
Literature review	A literature review was undertaken to examine the role of faith leaders in humanitarian response (23 documents) and their specific role in the Ebola outbreak (54 documents), in addition to background documents on the broader outbreak, humanitarian response and recovery (44 documents) and inter-faith humanitarian response in Liberia and Sierra Leone (9 documents).

1.4 Structure of the report

Section 1 provides an introduction to the study, and outlines its purpose and the approach that was used. Section 2 analyses the context to the engagement of faith leaders in humanitarian response and describes the historical role that faith leaders have played in resolving crises in Sierra Leone and Liberia. Section 3 provides background to the Ebola outbreak in West Africa. Sections 4 to 8 present the findings of the study on the role of faith leaders in promoting behaviour change, addressing stigmatisation, providing physical assistance and offering counselling and psychosocial support to the victims and survivors of Ebola. They also outline the role of NGOs in facilitating the work of faith leaders during the response. Section 9 presents a series of reflections on the research and section 10 concludes the study and makes recommendations for faith leaders, FBOs and international organisations, governments and donors.



©CAFOD/LOUISE NORTON

A burial team engaging with faith and community leaders in Kambia, Sierra Leone as part of Caritas Makeni's safe and dignified burials programme.



Background to the engagement of faith leaders in humanitarian response

This section analyses the nexus between faith and humanitarianism and outlines the historical role of faith leaders in responding to crises in Sierra Leone and Liberia as background to their role in the EVD response.

2.1 The historical context of faith and development

There has been a resurgence of interest in faith and development in recent years. In 2007 the Director of the World Bank recognised that “*we cannot fight poverty without tending to people’s spiritual dimension and its many manifestations in religious institutions, leaders and movements*”.¹¹ The acknowledgement that local faith communities represent a significant proportion of civil society capacity and in many contexts are vulnerable themselves to humanitarian crises has led to greater efforts by secular NGOs and UN agencies to engage FBOs and faith communities in what some consider to be the dawning of a “*post-secular age*”.¹² In addition to being recipients of humanitarian assistance, there is also recognition of the contribution that FBOs make to international development and humanitarian response; in 2007 the World Health Organisation (WHO) estimated that FBOs cover about 40% of the healthcare services in Africa,¹³ and in 2012 in his *Dialogue on Protection Challenges on the theme of Faith and Protection*, the United Nations High Commissioner for Refugees underscored “*the valuable contributions that faith organisations and communities make to the protection of refugees and the displaced*”.¹⁴ Recent research undertaken by UNICEF which shows that it works with religious communities in 102 out of 149 countries further underlines the importance of the contribution.¹⁵

As a consequence of the resurgence in engagement, there have been a number of efforts to try to strengthen partnership between the humanitarian system and faith communities. Prominent among these has been the effort of the UK’s Department for International Development (DfID) under the former Secretary of State for International Development, Andrew Mitchell, to develop a set of Faith Partnership Principles.¹⁶ At an inter-agency level, the Joint Learning Initiative on Faith and Local Communities (JLI), a group of more than 70 multi-sector and international partners, has sought to understand better and improve the quality, effectiveness and impact of partnerships between local faith communities and other development and humanitarian actors.

An important part of the discourse on faith and development has been the issue of inter-faith – or work between people of different faiths. While in an age of growing religious intolerance there is a compelling justification to strengthen understanding between faith communities, practical models of putting religious difference aside (without compromising the individuality of beliefs) continue to be rare; not every faith community has sufficient harmony within itself to extend this to others and it has often proved difficult for faith leaders to contain opposition and to explain the basis for partnership. However, where inter-faith dialogue and understanding has taken root, there is evidence to suggest that it offers a foundation for successful collaboration that goes far beyond the spiritual and can achieve important social development and humanitarian outcomes.¹⁷

2.2 Faith leaders as an important part of locally led humanitarian response

Underpinning the resurgence of interest in faith-based humanitarian response has been an acknowledgement of weaknesses in the ways that the international humanitarian system works with national organisations and people affected by crises. There is broad agreement that the international humanitarian system is over-stretched and yet when new crises occur, the first reaction is often to look at the international response despite compelling evidence that it is local and national organisations that respond in the first days, that have the best contextual knowledge of relevant approaches to protecting lives and livelihoods and have the greatest commitment to staying long after the immediate crisis has passed.¹⁸

This dilemma is one of many that will be discussed during the World Humanitarian Summit in Istanbul in April 2016, the aim of which is to bring the global community together to commit to new ways of working together to save lives and reduce hardship around the globe. In the consultation process prior to the Summit, there has been growing consensus on the importance of a shift in power from the international to the national with the adoption of “*an ecosystem approach to humanitarian response where local and international civil society work coherently according to the principle of subsidiarity*”¹⁹ which the faith community can make an important contribution to.

While there is now a greater appreciation of the role of FBOs in humanitarian response, the actions of faith leaders, the subject of this study, remain on the boundaries of humanitarian consciousness; their capacities are largely unmapped and their overall impacts uncharted. They are often inadequately represented at the planning and coordination table and their scalability remains unexplored. As a result, development and humanitarian actors do not always understand their motivations and contributions. However, when talking about civil society, it is impossible to ignore the important role that faith and by extension, faith leaders, play for the billions of people (estimated to be more than 84% of the world population) who identify with a religious group.²⁰

2.3 The context of religious tolerance in Sierra Leone and Liberia

Sierra Leone is a deeply religious country although estimates of the percentage share of the different beliefs vary; while official sources suggest that 78.9% of the country is Muslim and 20.9% is Christian,^{21,22} other sources suggest that Islam accounts for 60% of the population with Christianity accounting for 20–30%.²³ Traditional beliefs account for the remaining 20–30% of the population.²⁴ The variability in the figures are indicative of the degree to which religious beliefs in Sierra Leone are flexible and accommodating; one can go to a Christian church on Sunday, for example, and still make a sacrifice to one's ancestors for good fortune. Likewise, Muslim rituals may appear to dominate in some areas, yet these can become mixed with indigenous ideas or customs. As a consequence of this religious flexibility, Sierra Leone is also one of the highest-ranking countries for inter-religious tolerance in the world; inter-faith marriage is common, provision is made for both Muslim and Christian prayers to be said in public gatherings and the religions have worked together to address issues of common good in society.

Liberia is similar to Sierra Leone in this respect and has a broad spectrum of faiths and religious beliefs, with Christianity and Islam practised alongside traditional beliefs. While the data in Liberia is less recent, the 2008 census indicated that 85.5% of the country was Christian while 12.2% of the population was Muslim.

As a consequence of the prominent role of religion in both Sierra Leone and Liberia, faith leaders are generally held in high regard and play a very visible role in daily life. During the research in Sierra Leone, the capacities of faith leaders were discussed in a series of focus group discussions²⁵ with very similar feedback received from each of the discussions, as shown in the word cloud in Figure 2. Trust, respect and honesty were words that were frequently used to describe faith leaders who were also singled out for their leadership skills. In Liberia, faith leaders occupy a similar position in society and are considered by many to be just and honest.

Figure 2: Attributes of faith leaders



2.4 The rise of inter-faith initiatives in Sierra Leone and Liberia

There are two main inter-faith groups that are active in Sierra Leone, the Inter-Faith Council and the Inter-Religious Council. The former comprises two action groups: the Islamic Action Group (ISLAG) and the Christian Action Group (CHRISTAG). These were formed in 1987 with support from the Ministry of Health and UNICEF to undertake social mobilisation activities to promote child immunisation in the country. The initiative was instrumental in increasing immunisation of children against six vaccine-preventable diseases, from 6% in 1986 to 75% in 1990.²⁶ The Action Groups have since been involved in basic education, water and sanitation, family planning and HIV/AIDS prevention and after the war merged to form the Inter-Faith Council, an umbrella body responsible for coordination and advocacy on matters involving religious leaders.

The Inter-Religious Council (IRCSL) was founded in 1997 during Sierra Leone's rebel war. After supporting dialogue with both parties to the conflict, the Council supported the President to meet with the rebel group, the Revolutionary United Front, for peace negotiations and they later attended the Lomé peace talks as informal mediators. In so doing, they *"earned the respect of civil society, the parties to the conflict and the international community"*.²⁷

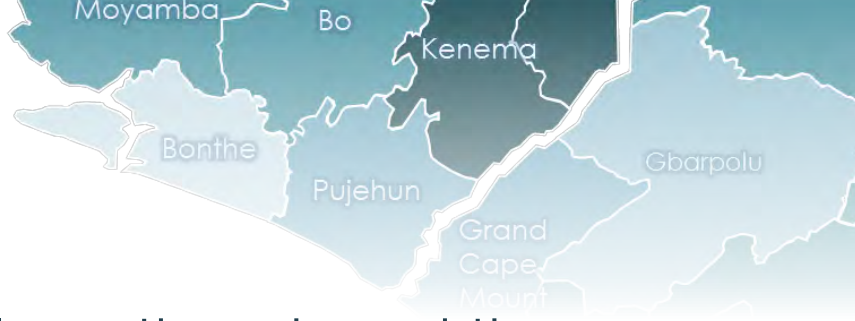
A similar inter-faith platform was created in Liberia in 1984 following the violence directed at Muslims in Nimba County when the Liberian Council of Churches and the National Muslim Council of Liberia collaborated in the formation of the Inter-Faith Mediation Committee. Its goal was the eradication of religious and ethnic tensions through cooperative dialogue and engagement with the warring factions. It was later re-organised into the Inter-Faith Council of Liberia and then the Inter-Religious Council of Liberia (IRCL) in 2001.²⁸ The inter-faith group involved itself in disarmament and repatriation initiatives for displaced persons before the 1997 Presidential elections and mediation efforts in 2002 that paved the way for the Accra peace talks. When these were disrupted the Inter-Religious Council supported the adoption of a ceasefire which ultimately contributed to the Comprehensive Peace Agreement of 2003.

It is this powerful mix of religious observance, tolerance and inter-faith intervention, particularly in times of crises that has positioned faith leaders to play an authoritative role in the Ebola response and one which offers numerous lessons both for West Africa and for the world.



©NEHADO/SAMA SANDIE

Faith based leaders in Kenema, Sierra Leone receive psychosocial training from Tearfund partner NEHADO.



The impact of the Ebola outbreak and the engagement of faith leaders in the EVD response

This section provides background to the Ebola outbreak, its transmission across West Africa and its impact and gives an overview of the initial engagement of faith leaders in responding to the disease.

3.1 The historical context of the Ebola outbreak

Although there have been 35 previously documented outbreaks of Ebola previously (of which 23 affected humans) since EVD was first identified in 1976,²⁹ the cultural and geopolitical context of West Africa, coupled with fragile systems in the post-conflict countries created the environment for such a catastrophic outbreak. The first case of the virus has been traced to Meliandou in Guinea, with the death of a child probably infected from a bat in December 2013. Ebola appeared again in January 2014 in the border area between Guinea, Sierra Leone and Liberia, but poor communications and political and cultural resistance coupled with a lack of health infrastructure and specialist medical knowledge hampered the full recognition of the extent of the outbreak. By early May 2014, many responders had concluded the epidemic was burning itself out. However, a failure to trace contacts and a lack of active case

finding allowed the epidemic to quietly build up. The massive flare up of cases occurring from May and June onward caught many local as well as international organizations by surprise and in many cases unprepared (see figure 4 for an overview of the cumulative number of ECD cases and deaths).

The exponential spread of EVD in West Africa that followed the initial outbreak has been widely attributed to weak health systems, traditional beliefs (see figure 5), mistrust of western medicine, dangerous caring and burial practices, intense movement of infected people within countries and across borders. The outbreak also stands apart from other previous events by being predominantly urban-based rather than rural in nature.

Figure 3: Cumulative number of confirmed EVD cases and deaths in Sierra Leone, Liberia & Guinea³⁰

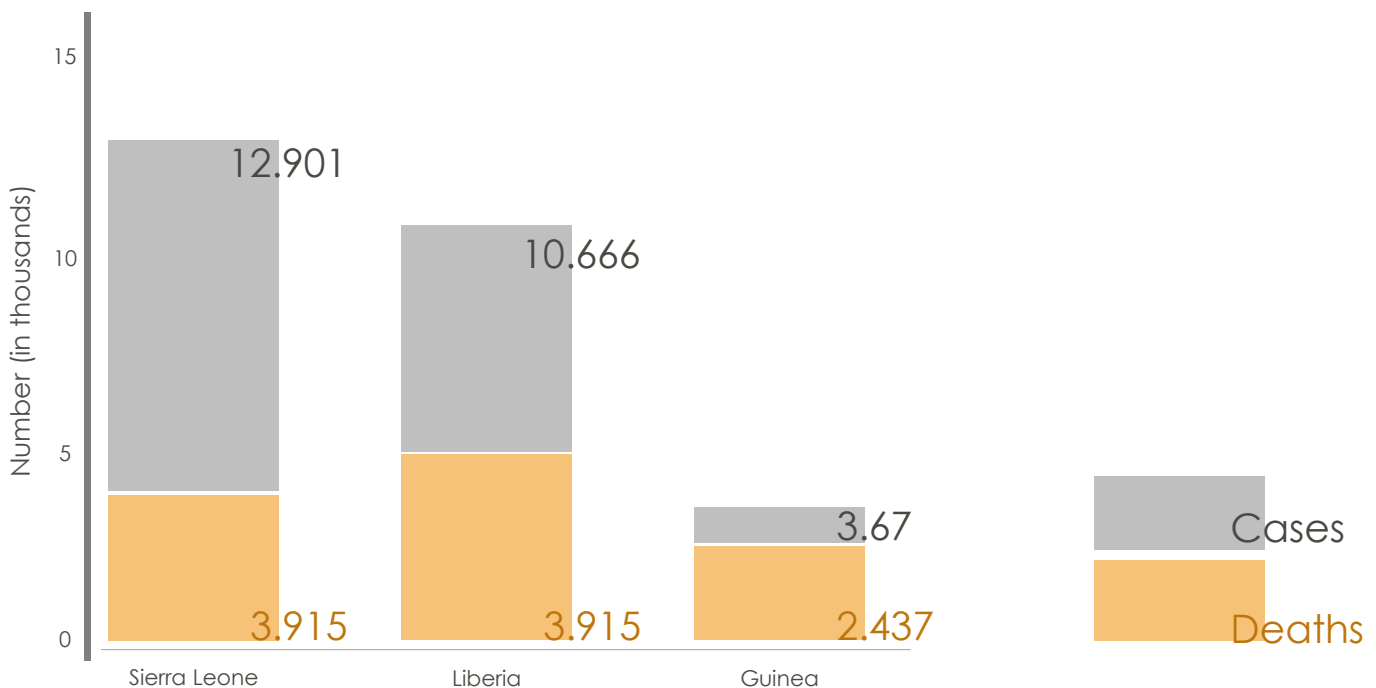


Figure 4: Traditional beliefs and disease transmission

When discussing the issues of faith, culture and disease transmission and burials in West Africa, it would be remiss to overlook the importance of traditional religions, traditional healers and secret societies (termed traditional beliefs in the research), which all play an extremely important role in determining the behaviour of communities, particularly in rural areas. Throughout West Africa, people interpret and respond to disease in line with “*longstanding local frameworks*”³¹ based on regional history, social institutions and experience. While organised religion may be pre-eminent in some parts of Sierra Leone and Liberia, this is far from being the case in many parts of both countries where social ills or disease outbreaks are widely considered to arise because of a fault which has been committed by the individual or his/her ancestors or as a consequence of sorcery or witchcraft by others. Remedial action would not be medical, but would involve a traditional healer or herbalist. The same beliefs are applied when someone dies where the destiny of the spirit and the situation of the surviving family members are determined by the observance of specific burial rites, which plays an essential role in shaping community behaviour after a death.

While the research focused on Islam and Christianity and the role that the organised religions played in mobilising and convincing communities to change behaviour, discussions also touched on the role of traditional beliefs in confounding efforts to promote health-seeking behaviour, which is discussed in Section 4.5.

3.2 The rapid spread of Ebola and engagement of faith leaders in the EVD response

As Ebola reaches Freetown and Monrovia, religious and cultural practices are banned

In Sierra Leone, the first cases of Ebola were thought to have been in late-May 2014 when 14 people returned from a funeral of a traditional healer who had been treating suspected cases in Guinea. By the end of the month there had been five deaths and by September, Ebola had reached Freetown. Initially the President made and announced decisions to control the outbreak by deploying police and military to support health workers, passing a law against hiding those suspected of having the virus with two years in jail and there was an initial reliance on the Paramount Chiefs to enforce new laws to reduce the spread of the disease which affected religious practices such as banning large gatherings.

Liberia confirmed its first two cases of EVD on March 30 2014 and by mid-June it had spread to Monrovia. The declaration of a 90-day state of emergency in August was made alongside preventative measures, including the closure of schools, the closure of markets in affected areas, and restrictions on social gatherings and movements between counties. As the numbers affected continued to rise, the Government of Liberia adopted an increasingly command and control approach which included quarantines and burials and for a short while cremations were sanctioned which was against cultural practice. As the situation grew worse, local-level task forces were established to try to reinforce government messages about behavior change and to provide rudimentary care to those who contracted the virus.



Participants in a Freetown mosque at a session arranged by a Christian Aid partner, the Council of Churches in Sierra Leone, to train faith leaders in how to provide psychosocial support to community.

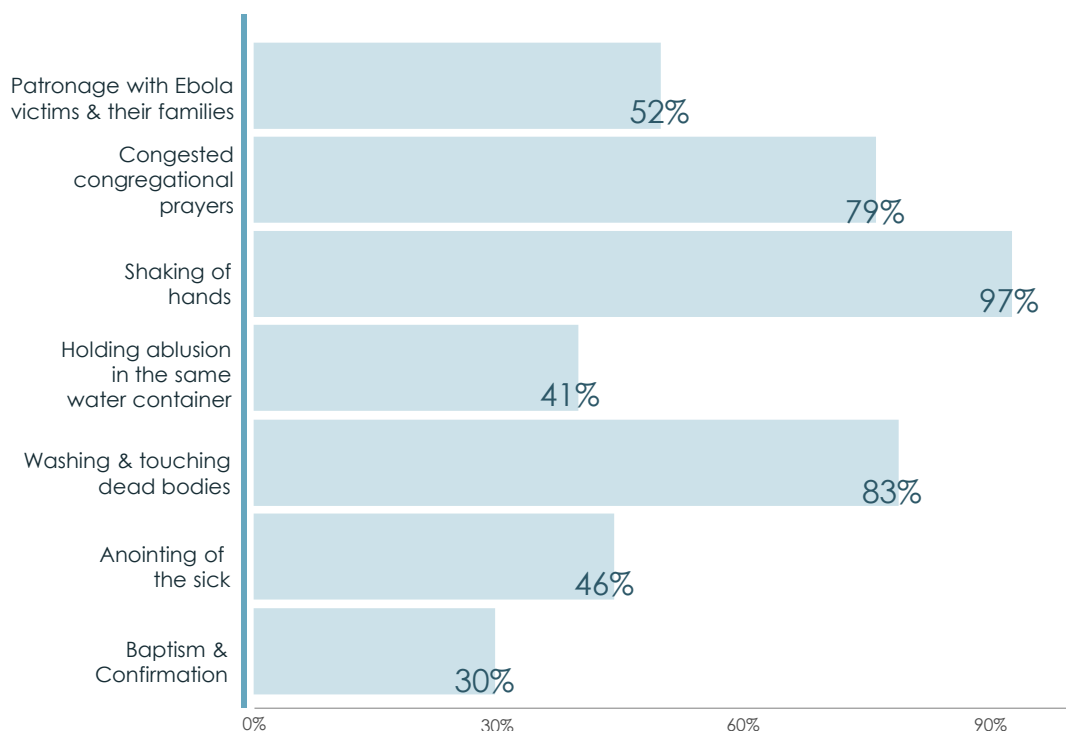
Denial of the medical basis of Ebola by some faith leaders in the early stages of the outbreak

In the months immediately after the outbreak, some faith leaders played a role in perpetuating misinformation about the virus and in promoting their own particular brand of stigma; when the Liberian Council of Churches unanimously agreed in July 2014 that “*God is angry with Liberia*” and that “*Ebola is a plague. Liberians have to pray and seek God’s forgiveness over the corruption and immoral acts (such as homosexuality, etc.) that continue to penetrate our society.*”³² Then a dangerous precedent was set. While their proposal for the nation to stay indoors for three days to fast and pray was a sensible response for a disease that is transmitted through bodily contact, when illness is seen as punishment, the ill are seen as punished and so the declaration had the effect of stigmatising sufferers and may have caused others to distance themselves from them.

There are also many stories of early attempts by faith leaders seeking to heal those with Ebola by laying hands on those infected and spreading the virus to their congregations as a consequence; a church in Liberia lost eight members of its congregation to the disease and some estimates suggest that over 40 pastors died of Ebola.³³ In the same way, before messages about the risks inherent in washing dead bodies had been contextualized and understood, Muslim burial practices were causing a significant increase in Ebola transmission rates. As part of the study, a survey was undertaken of 92 faith leaders in Western Area, Bo and Kenema districts of Sierra Leone which identified key religious practices which prior to changes that were made, contributed to the spread of EVD (see figure 5) which confirms the risks inherent across many religious practices. The survey also showed the willingness of faith leaders to make changes to these practices in order to reduce the possibility of transmission.

Figure 5: Faith leader perceptions about religious practices that contributed to the spread of EVD

What religious practices do you think contribute to the spread of EVD? Please select all answers that apply (92 respondents)



A call to action by faith leaders as the virus spreads

As Ebola continued to spread through towns and cities in the West African nations, faith leaders began to mobilise against the virus. In the hardest hit areas where the situation was rapidly spiraling out of control many leaders across both of the faiths contracted the disease themselves which led to greater acceptance that change was necessary. At the same time, there was a concerted effort from across faith communities, FBOs, community-based organisations (CBOs) and inter-faith groups in Sierra Leone and Liberia to take action which positioned faith leaders and the broader faith community in a far stronger position to play a lead role in the response. Many faith leaders set aside practices which spread the virus and started to engage in promoting messages about the importance of behavior change.

“Before... we the religious leaders pray[ed] for the sick by laying hands. It has changed. Now when someone is sick, we call the health team.”

CHRISTIAN FAITH LEADER, BANJO COMMUNITY, MONTSERRADO COUNTY, LIBERIA³⁴

At the international-level, there were calls to recognise the capacities of the faith community and to strengthen engagement between what was considered to be a largely secular and biomedical health response with a community-owned response in which faith leaders could use their position of trust and respect within communities to combat the spread of the virus and support those that had been affected. The World Council of Churches convened a meeting of Christian aid organisations and UN Agencies at the end of September 2014 to learn from each other and strengthen the collective response to the EVD outbreak. During the meeting, David Nabarro, the UN Secretary General's Special Envoy for Ebola highlighted the important role that faith-based organisations could play:

“To formulate an effective response it is important to empower women, traditional healers and health workers without putting them at a risk..[C]hurches and faith-based organisations have a massive role to play in dealing with emotional, psychological and spiritual aspects of people's lives, engaging them on questions of life and death.”³⁵

It was these three inter-connected factors - of local action by faith leaders, collective action by national inter-faith groups, and support from national and international organisations - which assisted in galvanising individual and collective action from faith leaders which has subsequently played an important role in turning the tide on the Ebola outbreak.



To help prevent the spread of Ebola in the future, Caritas staff come to Big Fanti Town, Liberia, right outside Buchanan, to promote better hygiene and distribute hygiene kits.



©TEARFUND/MAIRO RETIEF

Distribution of food and other essentials to treatment centres outside Freetown, Sierra Leone.



Promoting behaviour change to reduce transmission of the virus

This section presents the findings of the study on the role of faith leaders in promoting behaviour change. It documents the important role they played in offering messages of hope and in advocating for and facilitating safe and dignified burials. It documents the contribution made by inter-faith initiatives and highlights the role played by women faith leaders. The challenges to progress that were presented by traditional healers and secret societies in both Liberia and Sierra Leone are briefly discussed.

4.1 Replacing messages of fear with messages of hope

Messages about Ebola in the months after the outbreak in Sierra Leone were extremely negative; rather than messages about Ebola being a disease that is best treated through swift hospitalisation and care, the pervading narrative about Ebola was that it was a malevolent force spread through touch and for which no cure could be found. Rumours emerged that the medical teams were bringing Ebola to remote villages and that Westerners were collaborating with powerful locals to create excuses to snatch the ill for use in cannibalistic rituals. Given that the medical teams who evacuated the sick wore personal protective equipment (PPE) that hid their eyes, covered their skin and rendered them alien-like, these rumours resonated with traditional beliefs and struck fear within communities. In Sierra Leone, these rumours were mixed with concerns that the disease was politically manipulated in favour of different political groups, while in Liberia there were initial accusations that it was a manmade disease and an attempt by the government to generate funds from the international community.

“By saying that there was no cure for the disease, the initial messages given by the government pushed Ebola underground.”

MUSLIM FAITH LEADER, BO DISTRICT, SIERRA LEONE

As a consequence, the epidemic triggered widespread fear and the challenge of reducing its transmission became a far greater task as it first required the rebuilding of trust in control efforts. There were many instances of people not presenting for care early and also of people hiding from humanitarian teams who they feared would spread the virus to them.

The fact that many of the precautions needed to prevent the spread of Ebola conflicted with deeply rooted West African cultural practices, particularly those related to burial, was another impediment to making faster progress. In its Practice Paper on *Engaging Local Communities in the Ebola response*, the Institute of Development Studies is scathing in its criticism of initial efforts to control the spread of the outbreak:

“When people doubted the existence of Ebola they were repeatedly told through media, that ‘Ebola is real’. Such messages did nothing to engage with people’s suspicions that the outbreak was a political or financial ploy concocted by governments or foreigners with ulterior motives... The persistence of an approach that individualises responsibility for stopping Ebola by scapegoating fictitious selfishness or supposedly traditional medical superstitions, while failing to deliver concrete support for people infected and affected, seriously limits the possibility of engaging with sceptical publics.”³⁶

Once governments and those mandated to coordinate the response started to accept the limitations of their approach to combating the disease, it became clear that safer practices need to be adopted without changing people’s core beliefs and that, rather than developing messages at the international and national level, they needed to be religiously and culturally adapted to make them effective (see Figure 6). The importance of localising behaviour change messages is underlined in a 2014 Lancet article which suggested that correcting information “*using standardised advice for non-standardised situations may not be effective. Action and advice must be locally practical, socially acceptable, as well as epidemiologically appropriate.*”³⁷

Figure 6: What the Quran and the Bible say about health-seeking behaviour³⁸

The need to seek medical care

Islam has commanded the sick to seek medical cure and make use of physical means that would help eradicate the disease which includes the taking of medicine. The Prophet (PBUH) said, *“O you servants of Allah. Seek cure [from your illness] for Allah has not made a sickness without making medicine for it...”* (Tirmidhi 2038).

The Bible makes repeated reference to the need to seek medical attention or healing, particularly in the New Testament where people (including the blind, the lame, lepers etc) sought healing from Jesus, as they had faith in his power to heal. (See also Leviticus 13:3, the book of Acts, the Gospels, Paul’s letters.)

Contact with bodily fluids

Islam confirms that epidemics spread through body contact such as shaking hands. It therefore forbids close contact with infected people, in order to avoid transmission of diseases that may endanger lives. Sahih Muslim tells of a delegation from Thaqif coming to the Prophet (PBUH) to seek his allegiance and there was a leper among them. The Prophet (PBUH) sent word saying, *“We have accepted your allegiance” i.e. do not come to us. I cannot shake hands with you because leprosy is contagious and could transfer through body contact* (Sahih Muslim: 2231).

The Bible is clear that those with infectious skin diseases or discharges may infect others: *“If a descendent of Aaron has an infectious skin disease or a bodily discharge, he may not eat the sacred offerings until he is cleansed, any crawling things that make him unclean, or any person who makes him unclean, whatever the uncleanness may be. The one who touches any such thing will be unclean until evening. He must not eat any of the sacred offerings unless he has bathed himself with water...”* (Leviticus 22:4-6. See also Numbers 5:1–5; 19:11–16).

Handwashing

Islam commands the regular washing of hands. In Sahih Muslim, the Prophet (PBUH) said, *“If any one of you awakes from sleep, let him wash his hands three times before inserting them into the container, for he does not know where his hands slept”* (Sahih Muslim: 278).

In Christianity, hands are associated with healing, warding off evil and blessing. Cleanliness is also associated with purity and godliness... Water treatment, sanitation and the safe disposal of faeces are all mentioned in the context of disease prevention (Deuteronomy 23:12; Leviticus 11:1-47, 15:1-33; Numbers 19:3-22, Matthew 15:1-2; John 2:6; and Psalms 26:6).

It is impossible to determine how long the negative messages were in circulation but in Sierra Leone it was not until the third-quarter of 2014 that the narrative started to change and the initiative was taken to train faith leaders about the EVD and how to prevent transmission, including by New Harvest Development Organisation (NEHADO), a partner of Tearfund. While the faith community understood the importance of culturally appropriate messages, initially they were also guilty of offering mixed messages:

“In the early months of the response, there were too many mixed messages coming from faith leaders; we called a meeting and challenged them to look at the Bible and Quran to find messages that related to the transmission of the disease, presentation at clinics, control of the virus and the management of dead bodies.”

NATIONAL NGO DIRECTOR, FREETOWN

It was not until the disease had reached its peak towards the end of 2014 that there was greater coherence in messaging, with significant adoption of The Channels of Hope (CoH) methodology. Devised by World Vision and originally used as a tool to promote behaviour change for HIV and AIDS, the methodology was revised so that it was relevant to Ebola (see Figure 7) and a growing number of FBOs and CBOs used this and similar methodologies as a basis to engage faith leaders as champions of change.

The CoH training facilitated an exploration of Biblical and Quranic texts to identify links with the situation. This was done in a participatory way through the training, with Christian and Islamic scholars being asked to identify and share supporting messages. Feedback suggests that some of the messages were easier to locate than others and it took time to develop them in such a way that they could be used to support behaviour change. Some of the tools that were developed by Christian FBOs were initially not considered as inclusive for use with Muslims but they were strengthened with time. Staff working for CAFOD’s partner, Access to Justice Law Centre (AJLC), spoke of laying the foundations of the public health messages with faith messages. A chief Imam in Kambia district described the Muslim texts as providing the ‘evidence’ to support the public health messages.³⁹ In one rural community outside Kenema, training participants felt that the training took away the confusion because they were given the holy texts as explanation.

Interviews in Liberia revealed that as the virus spread, the inter-faith response was spearheaded by the Inter-Religious Council of Liberia (IRCL) and relatively quickly, faith leaders began to speak with greater unity. While there was a range of different initiatives to ensure coordinated messages, one of the more significant initiatives was led by UNICEF which had previously partnered with the Inter-Religious Council of Liberia. A set of messages were agreed and then disseminated through the different faith leaders.

“Lofa County had been a hot-bed of Ebola-denial and it was difficult to get health staff in to assist. The Imam and the local chief worked together using messages from the Quran and the Bible to discuss behaviour change with the communities. This paved the way for health staff to get access to the County.”

SENIOR UN STAFF MEMBER, MONROVIA, LIBERIA

Figure 7: Channels of Hope for Ebola

Channels of Hope is a World Vision (WV) methodology that mobilises faith leaders to respond to development issues in their immediate environments. In response to the Ebola crises, WV applied its experience and developed a curriculum focused specifically on Ebola. The curriculum draws on a range of material including sacred scriptures, scientific information and messages, case studies, personal experience and interactive activities to remove religious and social barriers that result in the spread of Ebola. It also addresses the stigma and the psychosocial and spiritual challenges that affected individuals face. The programme equips faith leaders to promote accurate and responsible messages about Ebola and helps them to respond with compassion and care for affected people.⁴⁰

The independent knowledge, attitudes, practices (KAP) study undertaken in Bong, Lofa and Montserrado Counties in Liberia emphasises the important role played by religious leaders, particularly in Lofa County in the remote north of the country, who were considered by many to be the first points of contact in the community as well as the leader of prevention activities:

“As an Imam, I don’t only pray for my people, I encourage them to keep washing their hands, [saying that] they should not touch sick people and dead bodies. In the morning, I walk [around] the community to see whether people have Ebola buckets in front of their houses. Those who don’t have, I tell them to get one and at times I recommend them to the Red Cross to provide for them...”

MUSLIM FAITH LEADER, LOFA COUNTY, LIBERIA⁴¹

Despite the progress that was made, there continued to be some religious leaders who clung onto their denial of the virus. These tended to be Christian leaders who had been slow to believe that the EVD outbreak was a medical rather than a spiritual condition, or Muslim leaders in remote villages who were poorly acquainted with Quranic doctrine and as a consequence struggled to accept the basis for behaviour change. However, interviews across a range of faith leaders at district, chiefdom and village level suggest that communication between faith leaders at different levels was broadly effective and focus group discussions with communities suggest that there was the same respect for the leaders at national level as at village level, which serves to underline the important role that can be played by faith leaders.

“We called the leaders to sensitise them. All of the traditions were changed but we knew this was our duty. We had lots of meetings... but we researched the Quranic references. We needed to ensure that there was understanding as we had to accept the changes.”

FOCUS GROUP DISCUSSION AT THE DISTRICT IMAM’S OFFICE, BO DISTRICT, SIERRA LEONE

The ripple effect that occurred through engaging with senior and influential leaders across the faiths to promote change in the cities and towns, and from there cascading the same messages to counties and

chiefdoms and then to villages, achieved significant coverage across much of the two countries.

The challenge of reaching urban communities

Once Ebola had started to reach the large urban areas such as Freetown and Monrovia, the limitations of traditional approaches to community mobilisation became more evident, given that many people spent most of the day in offices or behind gates in locked compounds. While radio played a role in reaching these groups, the religious institutions were equally if not more important particularly given the predilection for face-to-face communication to prompt behaviour change. Workers, the middle classes and the elites would all attend Friday prayers and Sunday services and it was *khutbas*⁴² and sermons that were instrumental in passing on Ebola-related transmission and behaviour-change messages.

“Social mobilisation can often only target the poor as they are the ones who are available to listen. Those who work or the rich are often missed. Religious leaders can reach these people in Friday prayers or Sunday services.”

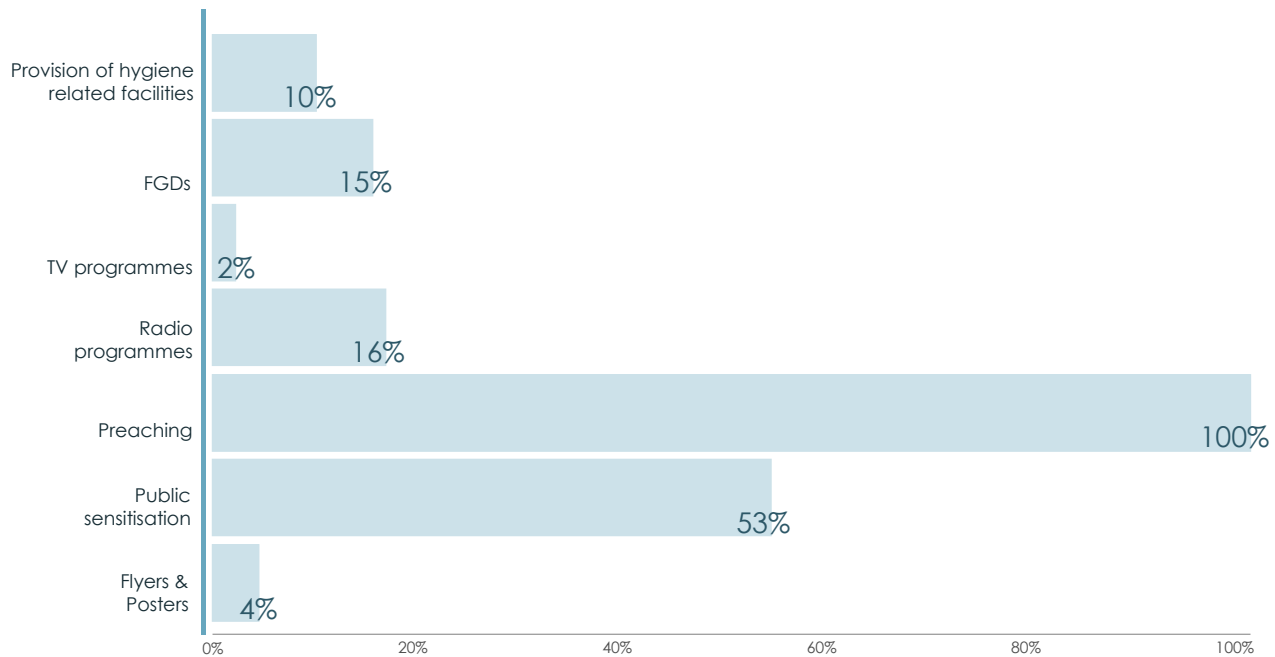
SOCIAL MOBILISATION OFFICER, INTERNATIONAL NGO, FREETOWN

The faith leaders survey undertaken in Western Area, Bo and Kenema districts shows that while religious services were the primary vehicle for communicating messages and for mobilising communities, an array of other means were also used (see Figure 8). Depending on the context of the outbreak, different approaches offered advantages and in the early days after the outbreak in Kenema, in June and July 2014, radio slots proved to offer the coverage that face-to-face communication was unable to reach.

“Soon after Ebola reached Kenema, the Resident Minister paid for slots on 3 community radio stations for religious leaders to sensitise the public...the Kenema Christian Council and the Council of Imams spoke with one voice to address the outbreak.”

INTER-RELIGIOUS COUNCIL MEMBER, KENEMA DISTRICT, SIERRA LEONE

Figure 8: Means used by faith leaders to communicate messages about the EVD



Towards an assessment of effectiveness

Feedback from those outside of the religious community on the role of faith leaders in promoting behaviour change was extremely positive. Government representatives and Ebola coordination staff underlined the trust and respect that were afforded to faith leaders which meant that they were extremely well placed to engage with communities about the need to modify behaviour to reduce the transmission of EVD.

“Faith leaders have reach into every part of the country and they are highly trusted by community members.”

GOVERNMENT COORDINATION STAFF MEMBER, BO DISTRICT, SIERRA LEONE

“Government is not trusted and many politicians have been discredited and so they can only go so far in promoting change. The vast majority of Liberians are either Christians or Muslims and so if you want to have a big audience it is the obvious place to start!”

SENIOR NGO STAFF MEMBER, MONTSERRADO COUNTY, LIBERIA

Focus group discussions in Freetown, Bo and Kenema underlined the legitimacy that faith leaders had in the towns and villages where they were lived and attributed community members’ decision-making about changing their behaviour to their interventions.

“At first we did not have confidence that Ebola was real, because of the numerous mixed messages we had about the disease - political game, money making and the reduction of the South-eastern population. It was the faith leaders who preached to us that Ebola is real. They gave us examples of stories in the past from the Quran and Bible... They also convinced us to trust what the government says and take all medical precautions and advices such as no body contacts, spacing people in mosques and churches.”

FOCUS GROUP DISCUSSION, KALLIA VILLAGE, KAKUA CHIEFDOM, BO DISTRICT, SIERRA LEONE

During the focus group discussions, community members were asked to compare the effectiveness of faith leaders with that of the NGOs and government, the responses from which underlined the benefits of faith leaders' embeddedness in the community. Independent KAP studies undertaken in Sierra Leone and Liberia underline the importance that community members attached to the messages received from faith leaders (see Figure 9).

4.2 Safe and dignified burials

The governments of Sierra Leone and Liberia both responded to the EVD outbreak by imposing bans and fines for burying, sheltering or treating suspected patients and corpses. Resistance to response teams and the continuation of traditional burials were undoubtedly assisting the transmission of the disease as burials became known to be 'super spreading' events; for example, the May 2014 funeral of a traditional healer in a remote village in Sierra Leone was reportedly responsible for an estimated 365 deaths that were subsequently traced back to a single funeral.⁴³

In Liberia, in August 2014 the government ordered the corpses of those who died from Ebola to be cremated due to the large number of deaths, an order which was extremely unpopular with communities. The practice was relaxed in December 2014, when the government allowed people to return to the practice of burying their dead, albeit with the instruction that bodies should not be touched. Compulsory cremation was said to have led to people refusing to send family members to Ebola treatment centres and burying them covertly at home instead.



Acting a drama of Ebola affecting villagers, in Oblela village, Liberia.

Figure 9: What knowledge, attitude and practice studies tell us about the role of faith leaders

In Sierra Leone, a series of knowledge, attitudes, practices (KAP) studies were undertaken jointly by Catholic Relief Services, UNICEF and Focus1000. In the first study, for which data was collected in August 2014, 41% of participants had received information about the virus from a church or mosque, which was second to radio through which 88% of survey participants had received information on Ebola. By the third survey, which was undertaken in December 2014, the percentage of those receiving information from religious venues had increased to 47%. This percentage was far in excess of that of many government sources including the Ministry of Health, traditional leaders and the government of Sierra Leone. It is noteworthy that the surveys do show significant regional variations, with twice as many people in the eastern districts (Kenema and Kailahun) receiving information from churches and mosques than in the north (Port Loko and Kambia).

A similar KAP study undertaken in Liberia in March 2015 (towards the end of the outbreak) suggests that churches and mosques were less important as information sources, with healthcare professionals and the Ministry of Health and Social Welfare among the most preferred and trusted sources of information.⁴⁴ However, this is contradicted by an earlier KAP study which focused on Bong, Lofa and Montserrado counties, published in January 2015, which described "*chiefs and religious leaders in the community... as the driving force of the community task force groups. These leaders were often the first people to be contacted when there was an Ebola-related issue and many respondents cited good leadership as a reason why they had fewer Ebola cases than before and fewer cases than other counties*".⁴⁵

Initially, the revised burial practices in Sierra Leone lacked religious and traditional rituals and dignity, and served as a powerful incentive against communities seeking the involvement of burial teams. The handling of dead bodies and use of mass graves has influenced negative attitudes towards seeking treatment. A series of 15 community and family interviews undertaken by the Centre for Disease Control (CDC) highlighted the outrage felt by communities at these burial practices which were considered “*undignified and unacceptable*” as bodies were being “*buried in unmarked graves, often with multiple bodies in the same grave*”.⁴⁶ Similar feedback was given to the research team during the study:

“The implementation of safe burial practices was considered to be un-religious and there was opposition to offering up bodies to people dressed like men from the moon. Before we introduced dignity to the procedure, people had gone to ground and were burying their loved ones secretly.”

INTER-RELIGIOUS COUNCIL MEMBER, BO DISTRICT, SIERRA LEONE

Many families wanted direct involvement by themselves and by religious or traditional leaders in determining the treatment of their relatives’ bodies. There was widespread concern within communities about the disappearance of both sick people who had been removed by health teams and corpses removed by burial teams. Adequate community engagement in burials was essential in the overall response. Denial, fear, panic, traditional practices and people avoiding medical help contributed to the exponential rise in the

number of cases and deaths. Efforts to engage affected communities to address the challenges of burials were slow but the feedback received was clear: it was impossible to reconcile Ebola control measures with religious and traditional customs.⁴⁷

“For Muslims, to change the practice of washing the body before burial needed an Imam to promote behaviour change.”

INTERNATIONAL NGO SOCIAL MOBILISATION STAFF MEMBER, FREETOWN

There was a breakthrough in Sierra Leone in early October 2014 with the revision of the Standard Operating Procedure (SOP) for burials which importantly included a provision allowing the families to come to the cemetery to observe the burial, and permitted them to invite an imam or minister to pray with the families at a safe distance. The WHO burial protocol was similarly amended the same month to “*encourage the inclusion of family and local clergy in the planning and preparation of the burial, as well as at the burial event itself, giving specific instructions for Muslim and Christian burials*”.⁴⁸ These changes were underpinned by the engagement of religious scholars in linking the required behaviour changes to Biblical and Quranic texts (see Figure 10)

Figure 10: The use of the Quran and the Bible to promote behaviour change for burial preparations⁴⁹

It is the right of a dead Muslim to be washed and buried before *Janazat* prayer is offered for him/her. However, in an unusual situation such as the Ebola epidemic, where washing or touching the dead body could put lives at risk, the Quran provides a warning: “*And do not throw yourselves into destruction*” (Al Baqarah: 195). In fact corpses are not always washed in Islamic burial preparations: Muslims who die as martyrs on the battlefield fighting for the cause of Islam are buried with their clothes and bloodstains, with no washing and no *Janazat* prayer. Similarly, the bodies of Muslims who die in a fire and by drowning are usually not washed before burial, because they, like victims of plagues, are considered as having the status of martyrs.

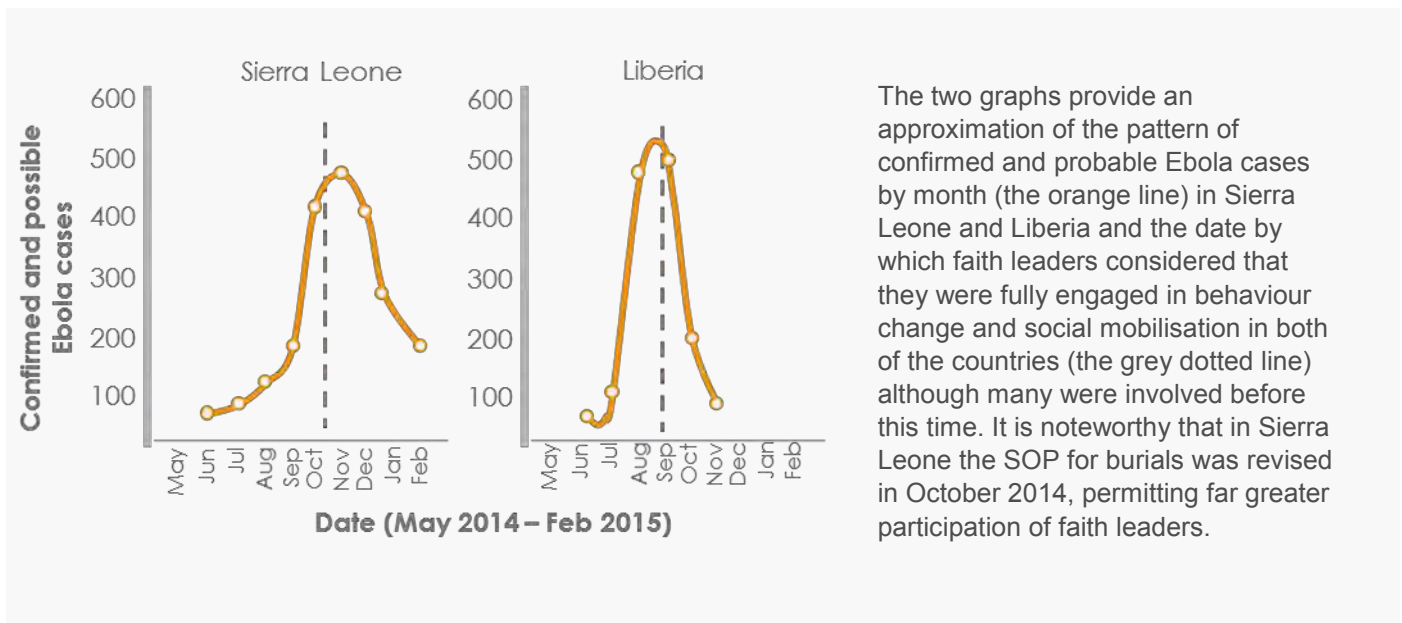
In the Bible, the Old Testament warns about the risk of infections passing from dead bodies to those who touch them: “*Whoever touches the dead body of anyone will be unclean for seven days. He must purify himself with water on the third day and on the seventh day; then he will be clean. But if he does not purify himself on the third and seventh days, he will not be clean. Whoever touches the dead body of anyone and fails to purify himself defiles the Lord’s tabernacle...*” (Numbers 19:11–13). “*He will also be unclean if he touches something defiled by a corpse*” (Leviticus 22:4). (See also Numbers 5:1–5.)

A study on improving burial practices undertaken by the CDC concluded that treating the bodies with greater respect and permitting religious practices will “likely reduce Ebola virus transmission because deaths would be more likely to be reported and bodies more likely to be buried safely by burial teams”.⁵⁰ There were similar reports from Liberia where religious leaders partnered with health teams and the community task forces to communicate messages about the importance of changing burial practices in which it was concluded that “community and religious leaders were instrumental in making this change in burial rites possible”.⁵¹ The pattern of transmission of the disease in both Sierra Leone and Liberia adds weight to this, suggesting as it does that cases only started to reduce once faith leaders were engaged in social mobilisation and behaviour change and once protocols for burials had been changed (see Figure 11).

Towards an assessment of effectiveness

The incorporation of ‘dignity’ to the ‘safe burial’ standard operating procedure (SOP) and the engagement of religious leaders in Sierra Leone in February 2015 was considered by many of those interviewed to have been instrumental in turning the tide in ensuring bodies were disposed of in a safe way and with due respect for religious practice.

Figure 11: Ebola cases in Sierra Leone and Liberia and the participation of faith leaders in the response⁵²



“Before Ebola, religious leaders were involved in 95% of burials [in Sierra Leone]. Because people trust them, when they started participating in the revised burial practices, people knew they could trust it and resistance ended. The participation of religious leaders was a game changer.”

UN STAFF MEMBER, SIERRA LEONE

A recent CAFOD evaluation, undertaken in May 2015, suggests that one of the main contributions of the CoH methodology had been in changing traditional burial practices.⁵³

4.3 Identifying the added value of an inter-faith approach

The historical engagement of the Inter-Religious Council in peacebuilding and mediation in Sierra Leone offered significant potential for a combined faith response to the Ebola outbreak. Following a government appeal to the Inter-Religious Council, a Religious Leaders’ Ebola Response Task Force was established in Freetown in July 2014 which worked through the media to disseminate messages on Ebola control and prevention. Concurrently with this, the NGO Focus1000 re-instated a separate inter-faith platform comprised of a Christian Action Group (CHRISTAG) and an Islamic Action Group (ISLAG), which were supported to replicate themselves throughout the country at district and chiefdom level, as well as in many villages. There was a palpable feeling from all faith leaders who participated in the study that they were much stronger together than they were apart.

The two graphs provide an approximation of the pattern of confirmed and probable Ebola cases by month (the orange line) in Sierra Leone and Liberia and the date by which faith leaders considered that they were fully engaged in behaviour change and social mobilisation in both of the countries (the grey dotted line) although many were involved before this time. It is noteworthy that in Sierra Leone the SOP for burials was revised in October 2014, permitting far greater participation of faith leaders.

“The church [in Sierra Leone] was initially dormant in its Ebola response; a few tried to take action but it was fractured. Then we began to get organised and partnered with our Muslim brothers.”

CHRISTIAN FAITH LEADER, BO DISTRICT, SIERRA LEONE

In Liberia the picture was different: the Inter-Religious Council of Liberia was called by the president at a relatively early stage after the outbreak. At a meeting which included five of the most senior Christian and Muslim leaders, the president outlined the importance of a collaborative response which set the tone for what followed:

“All of the senior faith leaders gathered and we recorded a radio message for all Liberians. We overcame the divisions that existed and used our voices to unite the people behind the government’s response.”

FAITH LEADER, MONROVIA, LIBERIA

With the focus of efforts to change negative behaviour focused on both Christians and Muslims, there was significant benefit from religious leaders adopting a single voice which sent a powerful message to people of both faiths and none. In Liberia the Inter-Religious Council convened a ten-person team tasked with addressing bad practice within the faith community – wherever it existed. In Sierra Leone there was a similarly unprecedented level of collaboration between leaders, including ‘pulpit swaps’ which were considered to be particularly influential:

“The voice of a sheik in the church was more powerful than the host reverend. This was an interesting lesson for me.”

CHRISTIAN FAITH LEADER, BO DISTRICT, SIERRA LEONE

Many faith leaders were convinced that the inter-faith work offered a platform with significant potential for the future.

“Association with Muslims has been strengthened as a result of Ebola. The church cannot make change on its own... At a social level the inter-faith movement is a powerful tool to aid community development.”

CHRISTIAN FAITH LEADER, BO DISTRICT, SIERRA LEONE

Given the considerable interest in inter-faith initiatives, it is noteworthy that the results of the survey conducted with 92 faith leaders in Sierra Leone show that only a minority of religious leaders participated in inter-faith activities: 18% indicated that they had been frequently involved in inter-faith activities, 20% had been involved on occasions and 62% had not been involved in them. This suggests that more can be done to strengthen support for inter-faith work in the future, particularly if it is considered to be effective in achieving positive societal change.

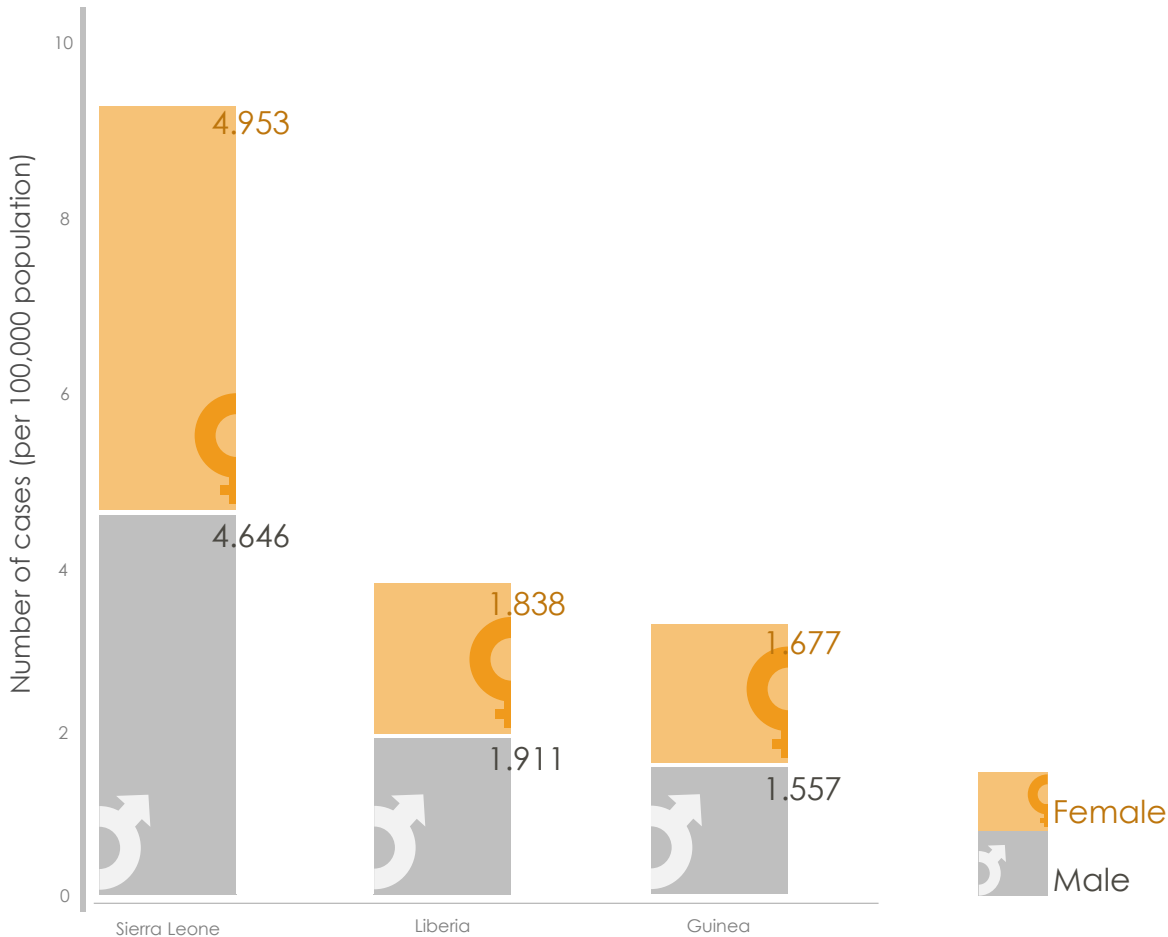
4.4 The role of women faith leaders in behaviour change and social mobilisation

There has been widespread concern that women have been disproportionately affected by the virus, given their role as frontline care-givers, cross-border traders, nurses and mothers within the disease-stricken communities. The number of female Ebola cases is greater than that of men in Sierra Leone and Guinea (see Figure 12), and its impact has had greater consequences for women in all three countries in terms of gender-based violence and exploitation. The United Nations Development Programme has documented “high levels of psychological trauma among children and women, increased violence against women and girls, early pregnancies, and early marriage”.⁵⁴ The closure of schools in particular and the displacement of families has exposed girls to sexual exploitation and sexual violence.



Member of a decontamination crew, Kambia, Sierra Leone. Decontamination crews are responsible for cleaning the ambulances and support vehicles with strong chlorinated water. They work in protective clothing, in a cordoned off area of the fleet management site. After cleaning the vehicles they carefully peel off their protective clothing and place in a pit to burn.

Figure 12: Cumulative number of confirmed EVD cases by gender in Sierra Leone, Liberia & Guinea⁵⁵



Prior to the Ebola outbreak, there were female faith leaders in Sierra Leone and Liberia, particularly in some of the Christian denominations. A national NGO, Rehabilitation and Development Agency in Sierra Leone (RADA), which is a partner of Christian Aid, had also begun to work with faith leaders to champion women’s empowerment and had established a network of leaders shortly before the Ebola outbreak was confirmed; this was a valuable resource and was later used to support the response. Despite this, women of both faiths tended to be under-represented in many of the behaviour change training programmes.

Female church leaders received training and in turn relayed those messages to their congregations. In Monrovia, the Catholic Religious Sisters played a key role in training healthcare personnel as well as coordinating community-based education and social mobilisation. Where there was a lack of female leaders, senior members of congregations or women’s groups were incorporated into training initiatives to discuss and promote behaviour change.

One female faith leader in Freetown talked of the efforts that were taken to include women in the church but also of the challenges of involving them in initiatives to train faith leaders on Ebola transmission and prevention:

“We had wanted to include more women in the training but it is sometimes difficult for them to stay at hotels without family members because of negative perceptions which act as a barrier to their attendance... It is also harder to include them in the evenings because of the family responsibilities that they have.”

FEMALE FAITH LEADER AND FBO COORDINATOR, FREETOWN

At the community level, women are influential in shaping and influencing attitudes and behaviour. Within the Catholic church, the Catholic Women's Association is pivotal, while in Protestant communities the parish council often has strong female leadership and in some churches, such as Pentecostal churches, there are women pastors. In Muslim communities the chair lady or 'mami queen' of the Mosque can play a vital multiplier role in reinforcing sensitisation messages on Ebola although, with a few exceptions, the majority of the Muslim leaders who were trained tended to be male. While there is limited information about the specific ways in which women used the training, CAFOD's recent evaluation of its work with faith leaders notes that *"the women who were involved demonstrated their particular niche in the response, in going house-to-house to do sensitisation and talking specifically to other women and supporting them in practices around caring for sick children, or in speaking specifically with women's groups in their places of worship."*⁵⁶

4.5 The challenges presented by traditional beliefs and secret societies

While the governments of both Sierra Leone and Liberia requested the support of organised religions in the Ebola response, it took much longer to acknowledge the importance of the traditional religions and secret societies for successful behaviour change and longer still to engage them in the battle to defeat Ebola. Poro (male) and Sande (female) secret societies hold great power over many adults and exist in parallel with Christianity and Islam; many people both subscribe to an organised religion and belong to a secret society. While some secret society leaders did attend the CoH training, and there is evidence to suggest that their attendance did lead to behaviour change, the fact they did not relate to Biblical or Quranic texts used in the training could be seen as limiting its potential as a behaviour change tool. There is certainly significant evidence to suggest that in both Sierra Leone and Liberia traditional religions and secret societies were less successfully engaged and therefore less effective in changing behaviour.

There was also concern that some of the successes in changing behaviour among those practising Christianity or Islam might have been undone by the failure to instill similar changes within secret societies. For the people who are members of both groups, burial ceremonies are jointly undertaken, with secret societies taking responsibility for burials once the religious rites had been completed. Before the burial teams had nationwide coverage, there was a risk that some of the positive changes that religious leaders had helped bring about may have been undone by the secret societies:

"Where a community member has both a religious belief and is a member of a secret society, in the event of a death, the religious ceremony is observed after which the body is handed over to the secret society to undertake its own rites."

SENIOR FBO STAFF MEMBER, KENEMA DISTRICT, SIERRA LEONE

Initial efforts by both governments sought to contain the activities of secret societies' virus-spreading practices, particularly during burials. In June 2014, Liberia placed a moratorium on Poro and Sande activities and in August 2014 a partial ban was placed on the activities of secret societies in the north of Sierra Leone.⁵⁷ However, in the same way as early efforts to contain the virus were considered to be irreligious, which served to push Muslim burial practices underground, there have been similar reactions to these moratoria, prompting a sustained campaign to stop negative practices.

In contrast to their engagement with Christian and Muslim leaders, it has been more difficult for both the government and other interlocutors to find ways to engage with the secret societies. It was not until April 2015 that Focus1000, which has been one of the NGOs that has spearheaded engagement with faith leaders, convened a meeting with the Sierra Leone Indigenous Traditional Healers Union to seek to brainstorm ways to maintain progress against Ebola and to elicit pledges to support coordinated efforts to address the outbreak. Recent transmission of the virus suggests that there is still work to be done: in the most recent National Ebola Response Centre update, at least two of the new cases in Sierra Leone are linked to the activities of traditional healers⁵⁸ and the resurgence of Ebola in Liberia appears to be the consequence in part of a herbalist's activities.⁵⁹ The failure to find a means of promoting behaviour change – even in the short term – within the traditional belief system and secret societies currently represents one of the most significant threats to addressing the Ebola outbreak in West Africa.



Addressing stigmatisation by strengthening acceptance of those who have recovered

This section presents the findings of the study on the role of faith leaders in addressing stigmatisation through their words and deeds.

5.1 Stigmatisation driven by ignorance

In Liberia, in the early weeks of the outbreak, the lack of medical services and proper isolation facilities forced communities to adopt extreme isolation measures for community members suspected of having Ebola. In effect, suspected cases, whether they were individuals or whole villages, were isolated and often left to die. Just as clinics treated every illness as a suspected Ebola case, communities did the same and were even more draconian in their isolation of the sick. In Sierra Leone, the measures taken were less extreme but the trauma of those who were placed in quarantine was the same in both countries; there were reports of too little food being provided, of a lack of clean water and the constant threat of death or having to cope with the deaths of family members or friends.

Stigmatisation of Ebola survivors was also a constant in both countries. Stigma in the context of Ebola occurred for a number of reasons including poverty and lack of education, combined with cultural practices which influenced attitudes, beliefs and behaviours with respect to disease transmission. In Kenema town, a whole street was stigmatised because it had been badly affected by the virus. If people mentioned that they were from the area, they would be turned away from shops and people would refuse to associate with them. In some places, survivors would be branded as ‘witches’ for surviving. Those who had recovered from the disease were not the only ones to suffer stigma but those who had assisted people with Ebola were similarly ostracised from communities. A CBO staff member who assisted in the response spoke of having to leave her house before daylight and return after darkness each day to avoid her neighbours who were concerned that she was putting

herself and the community at risk. Stigmatisation has affected people’s livelihoods and their relationships and has also caused psychological problems.

However, in the same way that religious texts have been used extensively as means of promoting changed behaviour to prevent transmission of EVD and for the burial of dead bodies, they were also a powerful tool for addressing stigma (see Figure 13).

Lessons learned from experience of addressing HIV and AIDS-related stigma suggests that it is essential to provide communities with accurate information, but that the impact of this is heightened by using “*members of a community who are highly respected and who may have the ability to mobilise people to work for a common goal*”.⁶⁰ In this respect, faith leaders have played a critical role in addressing stigmatisation by working with communities that have received Ebola survivors to communicate culturally relevant and accurate messages about EVD coupled with religious references about compassion. Long-standing Christian Aid partner, the Methodist Church of Sierra Leone (MCSL), used its existing community health and HIV networks to challenge Ebola stigmatisation. The organisation trained ministers to promote good hygiene and safe burials, and to encourage communities to respond to Ebola survivors with acceptance, not rejection.

Figure 13: What the Quran and Bible say about stigmatisation

Victims of epidemics must not be stigmatised, for what has happened to them is not their fault. Allah said: “No blame or sin is there upon the blind, nor is there blame or sin upon the lame, nor is there blame or sin upon the sick.” As for those who die of the epidemic, they are considered in Islam as martyrs, for the Prophet (PBUH) said: “(Death from) plague is martyrdom for every Muslim” (Bukhari: 5732).⁶¹

The Bible has always condemned all forms of stigma. This is evident in numerous Biblical stories, including the parable of the Good Samaritan who came to the aid of the man abandoned on the road to Jericho (Luke 10:30–37).⁶²

“Stigmatisation is a very serious social problem when it comes to the Ebola virus, as used to be the case with HIV. We have challenged HIV stigma and are now doing the same with Ebola. Those who have survived the virus find it difficult to be accepted back into their communities, so our ministers are preaching that people should accept their brothers and sisters, while still observing health guidelines.”

CHRISTIAN FAITH LEADER, FREETOWN, SIERRA LEONE⁶³

A second Christian Aid partner, Network Movement for Justice and Development (NMJD), has used faith leaders as part of its community-based teams to ‘welcome’ Ebola survivors back into their villages and considered that they played an important role in disseminating messages of acceptance.

“Faith leaders were very keen to participate and have played a key role. Trust is important for counsellors... and they are held in high regard and so have been able to play a very powerful role.”

NMJD STAFF MEMBER, KENEMA, SIERRA LEONE

By early-2015, the community sensitisation had begun to yield positive results, with growing acceptance of many of those who had survived the disease. Several of the focus group discussions in Liberia were attended by survivors who spoke of the trauma of having to cope after they had returned to their communities; most had had their houses and belongings burned during the process of decontamination after they had contracted the disease and so had lost everything. However, they had now been accepted back into communities and were mingling with others. In focus group discussions conducted in some of the worst-affected villages in the Western Area, Bo and Kenema districts, community members spoke of the role played by faith leaders in promoting acceptance and the difference this had made to community perceptions:

“Faith leaders visited survivors and counselled them; this made us believe that the disease was no longer with them and we started encouraging them. They also preached against discrimination.”

FOCUS GROUP MEMBER, HANGA VILLAGE, NGOWA CHIEFDOM, KENEMA DISTRICT

While many survivors had been accepted back into their communities, there are still certain livelihood practices that they are unable to engage in, such as food preparation and selling snacks, and so many have lost their means of generating income and it will take time for them to fully recover.

5.2 Role-modelling acceptance

Some efforts to address stigma have focused on separating out those who are being stigmatised and while this may be necessary for the purposes of targeting support, the act of ascribing a positive label can in itself exacerbate differences and in so doing can reinforce the stigma.

Faith leaders often took a more sensitive approach to role-modelling acceptance of Ebola survivors back into communities by welcoming them into their churches and mosques; rather than reinforcing the difference of those who had survived, there were many examples given of when they focused on unity within communities:

“In the mosque there are no special spaces for different people; there’s no prioritisation and so everyone is treated equally – even Ebola survivors. We give messages of hope about ‘life after Ebola’ and preach that people should sympathise with survivors as they are our brothers.”

MUSLIM FAITH LEADER, BO DISTRICT, SIERRA LEONE

“On Friday I went to the Central Mosque with all of the survivors for a thanksgiving service. I did not put them in a group but dispersed them among the members.”

MUSLIM FAITH LEADER, KENEMA DISTRICT, SIERRA LEONE

Focus group discussions with communities affected by the EVD outbreak in Sierra Leone underlined the importance that community members attached to these efforts and also suggested that they made an important contribution to strengthening acceptance of those who had recovered and were seeking to return to normal life.



The provision of physical assistance to those affected by the EVD outbreak

This section documents the range of physical assistance that has been provided by faith leaders during the different stages of the Ebola response, starting in the initial stages of the outbreak and continuing throughout the relief phase.

6.1 Leadership of community-based responses in the initial stages of the outbreak

Given the trust and respect afforded to faith leaders by their communities, when the EVD outbreak started to spread, people looked to them to provide assistance. In Liberia in August 2014, some of the worst-affected counties were quarantined and in September, community-led task forces were launched in which faith leaders often played a lead role.

“Thanks to the community task force, religious leaders and community leaders are the driving force [for] this initiative.”

CHRISTIAN FAITH LEADER, BANJOR COMMUNITY, MONTSERRADO, LIBERIA⁶⁴

Community members spoke of traditional chiefs and faith leaders working together to galvanise local action to identify the sick and to organise rudimentary quarantine. These locally initiated and locally managed facilities played an important role in reducing transmission of the virus, particularly in Liberia where the spread was far more rapid than it was in neighbouring Sierra Leone.

“A local task team was created to identify and quarantine patients. The Imam had skills in community mobilisation and played a lead role.”

FOCUS GROUP MEMBER, BANJO COMMUNITY, MONTSERRADO COUNTY, LIBERIA

Leadership of such a complex response brought with it significant challenges particularly in having to make decisions about the use of quarantine for suspected Ebola cases, which divided communities and was fiercely opposed by many. It was the respect and trust that people had for faith leaders that allowed them to play this role and often they did so at some cost to their position within their communities. A lessons-learned document reported that quarantines such as these *“[had] been most effective not at a district or individual level, but at a community level, orchestrated by local and religious leaders.”*

This approach was considered far more effective than earlier efforts to enforce segregation by the security forces and was considered crucial to minimise violations of quarantine; it was also more effective in facilitating the tracing of contacts and discovery of new cases.⁶⁵

6.2 The provision of relief items

In and of themselves, faith leaders had limited resources to support those in need of assistance although from the early days after the outbreak, there were collections for those who had been affected with a focus on ensuring that places of worship had buckets and soap so that religious gatherings were as safe as possible. Initial fundraising efforts by faith institutions were piecemeal which resulted in the provision of small-scale assistance, but these were essential given the flight of better-funded international organisations from large parts of the country once the outbreak started to spread. Under these difficult circumstances the assistance provided by faith leaders was often the first to arrive and despite it often being small-scale, it was welcomed.

“Religious leaders were the first ones to provide assistance to us.”

BANJO COMMUNITY MEMBER, MONTSERRADO COUNTY, LIBERIA

In one of the worst-affected villages in Bo district of Sierra Leone, the community listed all of the support they had received from faith leaders which had started to arrive in July 2014 at the same time as the outbreak spread to Bo and before many of the international organisations had organised themselves to provide assistance:

“Reverend Father Charles provided rice for us and Reverend Kainwo provided cooked food for us. Faith leaders put buckets in the churches and mosques and advised us about precautions to take to avoid Ebola.”

FOCUS GROUP MEMBER, KALLIA VILLAGE, KAKUA CHIEFDOM, BO DISTRICT

It is not possible to make generalisations about the quantity and quality of the assistance that was provided by faith leaders as it was reliant on a diverse set of factors which included fundraising capacity and links to FBOs. However, there did appear to be a difference in the support provided by Christian and Muslim leaders; while in time, many of the Christian denominations were supported by well funded international partners and sister churches from overseas, the Muslim faith leaders most often relied on the generosity of their local supporters although some assistance was also received from national and international organisations. Assistance was provided in advance of faith leaders being engaged in behaviour change initiatives, which came several months later; the need for assistance was self-evident and faith leaders were motivated by compassion for those who were affected.

A survey undertaken in Sierra Leone and Liberia by Plan International in December 2014 underlines the importance of the assistance received from faith groups in both Liberia and Sierra Leone, reporting that religious institutions were a significant source of help, especially in urban areas. In Liberia, assistance received from churches and mosques was ranked second only to NGO assistance (the survey shows that approximately 10% of respondents listed churches as having provided assistance) and third after government-provided assistance in Sierra Leone (the survey shows that approximately 11% of respondents listed churches as having provided assistance). The same survey recorded approximately 24% of respondents in Liberia and 21% of respondents in Sierra Leone as having received little or no help.⁶⁶ In a context where almost one quarter of those in need of assistance received nothing, the support provided by churches was considered to be of significant value.

6.3 Assistance to those placed in quarantine

As the Ebola virus spread throughout Sierra Leone and Liberia and areas came under quarantine, local markets ceased functioning and communities struggled to meet their basic needs. However, for those who had Ebola or were quarantined with Ebola sufferers, the situation was often dire, with severe shortages of food and water and no access to other members of the community who themselves feared contracting the disease. In such circumstances, faith leaders often played a leading role both in helping to organise communities but also in the provision of support to those who were quarantined.

“We raised funds from the members and provided food to those suffering in quarantine via the Ebola Task Force in the heat of the outbreak.”

MUSLIM FAITH LEADER, KENEMA DISTRICT, SIERRA LEONE

As systems to manage the outbreak were strengthened, the services provided to those placed under quarantine improved. Even then, however, those in quarantine often lacked the basic necessities and it was these groups who were frequently assisted by faith leaders and FBOs. In addition to the provision of material assistance, faith leaders also played an important advocacy role as the theory about the services provided to those under quarantine was often far better than reality. In such situations, faith leaders lobbied community leaders, service providers and the government on the importance of ensuring that adequate support was provided:

“We realised that some of what was being said about the situation of those in quarantine was not true; when we visited them, there was a lack of two-way communication. There was a role for faith leaders to advocate to the government as an intermediary.”

NATIONAL NGO STAFF MEMBER WORKING WITH FAITH LEADERS



©CAFOD/POPPY HARDEE

Members of Caritas Makeni burial team, Kambia district, Sierra Leone.



Counselling and psychosocial support to the victims and survivors of Ebola

This section presents the findings of the study on the provision of counselling by faith leaders, their engagement in mediation of disputes and the contribution they made to addressing longer-term trauma through the provision of psychosocial support.

7.1 Support needs for those affected at the time of the Ebola outbreak

In addition to material needs, but far more difficult to address, are the emotional and social needs within communities, particularly for those people in the hardest hit areas of Sierra Leone and Liberia. A disease that can only be stopped when people stop all physical contact with their sick loved ones has a terrible impact on the emotional wellbeing of family members.⁶⁷

Several studies in the rapidly growing field of religion and health have indicated that belief in a loving God, along with the support of being part of a social network whose members care for one another, leads to positive physical and mental health outcomes, including lower rates of depression and anxiety and greater overall happiness.⁶⁸ In the context of an illness for which early medical messages said there was no cure, spiritual resources offering hope, optimism and connection were considered to be especially helpful to those suffering from Ebola. While it is not possible to attribute health outcomes to the messages of hope that were given by faith leaders, there can be little doubt that they provided comfort and relief.

"It is the poor who are the church's priority. This disease makes ordinary human kindness impossible – like putting your arm around someone who is crying. The key to survival is to keep our humanity intact in the face of this deadly Ebola virus, and as a church we are finding ways to do this with our communities."

CHURCH LEADER, GBARNGA COUNTY, LIBERIA⁶⁹

In addition to providing comfort to people who attended church services and worshipped at mosques, faith leaders also provided independent witness to the running of treatment facilities that were often crudely constructed and short-staffed. In such situations, the presence and support of faith leaders and their congregants were often the only support that Ebola-sufferers received beyond that of the medical staff. Stories such as the one transcribed below show the solidarity that was demonstrated by a small number of people:

"We visited the Holding Centre every day to give people hope. There were three tents; the first was called the 60:40 where they took people who might survive, the second was the 50:50 tent and the third was where they took people who they expected to die. There was one woman who was in a terrible condition in the third tent but we shouted to her, 'Mariam, you're not going to die,' and we tried to encourage her. She was lying on the ground on a piece of sheeting and was too weak to speak or move but she was able to move her hand. We called the staff and demanded they put her on a mattress and treat her with dignity. We came each day to encourage her and one day we arrived and she wasn't there and we were concerned but then we saw her in the 50:50 tent. She was released from the holding centre some days later."

FAITH LEADER IN BO DISTRICT, SIERRA LEONE

While the impact of support such as this is not possible to determine, it is likely that the acts of kindness and solidarity such as this were deeply appreciated by those who survived Ebola.

7.2 Mediation of disputes within and between communities

Communities have been considerably damaged by disputes that have come about as a result of the EVD outbreak. Many of the interviews in both Sierra Leone and Liberia highlighted the increase in divisions within and between communities for a variety of reasons which included the abandonment of community members or their loved ones and suspicion about families hiding suspected cases which added to the distrust. Such feelings were particularly evident in urban areas which had a high incidence of Ebola where accounts included extreme examples of families being boarded up in their houses without food or water, and communities being divided into Ebola and non-Ebola sections, with suspects being denied access to the village well and other facilities.⁷⁰ There was animosity and disputes between members of the public and hospital workers, burial teams and social mobilisers as rampant mistrust spread in the wake of Ebola.

“The first Ebola case arrived in Kenema on 25th May from Kailahun and was admitted into the Lassa fever isolation unit.⁷¹ As the number of referrals increased, health staff began to die and then it spread to the town. At first people thought that it was the health workers that brought the virus to Kenema and the hospital was stoned on several occasions.”

MINISTRY OF HEALTH STAFF MEMBER, KENEMA DISTRICT

There were frequent disputes between those placed under quarantine and the health staff who were tasked with supporting them. Faith leaders were often able to play a mediation role as well as making up for shortfalls in the assistance provided.

“There was often an air of hatred between health workers and those that were quarantined. Religious leaders were considered neutral... and mediated between the two.”

FAITH LEADER, FREETOWN

7.3 Longer-term trauma and the psychosocial impact of the EVD outbreak

Beyond the pain and anguish suffered by those who contracted Ebola, there is a longer-term trauma for those who have recovered and have had to come to terms with the debilitating medical conditions which often accompany the recovery. Many also suffered stigma at the hands of friends and family who were fearful that the disease may somehow be passed on. For many Ebola survivors, there is also a need to live with painful memories of having to watch loved ones die beside them in quarantine and the struggle of having to come to terms with life without family members. There have been large numbers of orphans in countries that have limited facilities to provide adequate care for them and the stigma associated with the disease can be acute: this too has also been a source of trauma. An International Medical Corps report documents in detail the psychological problems faced by Ebola survivors (see Figure 14) which indicates the significant scale of the challenge of providing appropriate support given the dearth of specialist assistance that is available. The mental health system in Sierra Leone is poorly equipped to deal with large numbers of people seeking mental health support and there is only one psychiatric hospital in Freetown and limited non-specialised support in the districts.⁷²

While faith leaders recognised the role that they could play in this important area of service, there was also some concern that training for such a specialist task was being inconsistently applied:

“While some have the skills or have received training, many [faith leaders] have limited experience, particularly those in the villages.”

CHRISTIAN FAITH LEADER, BO DISTRICT, SIERRA LEONE

Figure 14: Psychological problems of Ebola survivors⁷³

- **Fear:** Many described being fearful about how to interact with other people, especially those stigmatising them and discriminating against them. Fear over the future and what will happen.
- **Frustration/anger:** Feel anger towards the healthcare providers for not treating them humanely. Feel angry at being abandoned and not being supported now they are at home.
- **Helplessness:** Feeling like there is no hope and there is no help.
- **Problems related to thinking and concentrating,** ruminating on how things could have been different, forgetfulness, worry.

Efforts to fill the gaps in training and to top up skills in counselling and the provision of psychosocial support have been numerous but they have also often been piecemeal. This makes it difficult to determine the extent to which they have been coordinated in such a way as to provide a nationwide safety net. While there are examples of professional training by qualified faith-based organisations such as the Christian Health Association in Montserrado in Liberia and the Catholic Seminary in Bo town in Sierra Leone, there have also been many other initiatives that have sought to train and empower faith leaders to provide support and it is unclear how effective some of the training initiatives have been and the extent to which they have been based on professional standards of care and support. Despite this, feedback from government medical staff suggests that faith leaders have played an important role in providing psychosocial support:

“Being able to meet people’s psychological needs requires training and so I selected a team of those who I knew could assist which included four pastors and two imams... We would travel to communities to discuss issues of acceptance and to talk with the survivors.”
 PSYCHOLOGICAL SUPPORT NURSE, KENEMA HOSPITAL, SIERRA LEONE

In times of crisis, there is little doubt that religious community members will look to the churches and mosques to support them and there has been considerable effort to assist faith leaders in providing support to those seeking it. In Bo district, NEHADO has played an important role in bringing faith leaders together and equipping them to help them meet the demand for counselling from their congregants and the local communities.



Working with faith leaders in Sierra Leone.



The participation of faith leaders in the humanitarian system

This section discusses the ways in which faith leaders engaged with the humanitarian system in Sierra Leone and Liberia including their participation in coordination mechanisms, their partnership with a diverse range of organisations engaged in the Ebola response and the support and facilitation they received from CBOs and FBOs.

8.1 The participation of faith leaders in humanitarian coordination and leadership

The coordination of the Ebola responses in Liberia and Sierra Leone suffered from a series of challenges, the most significant of which was the need to adopt a 'command-and-control' approach to combating the disease and as a consequence they were established over time. While the UN was itself slow to mandate and deploy the United Nations Mission for Ebola Emergency Response (UNMEER), its leader Ismail Ould Cheikh Ahmed was correct both in highlighting "...a problem of coordination" in January 2015 as well as the importance of "national leadership" in addressing Ebola.⁷⁴

A common criticism of faith communities is that they frequently work outside of or on the periphery of humanitarian coordination mechanisms, either because they seek to separate themselves from coordination mechanisms or, more often, because they feel excluded from them. However, in the Ebola outbreak faith leaders played a far more visible role in coordination and leadership of the humanitarian response; in both Liberia and Sierra Leone senior faith leaders from both of the major religions were requested to mobilise their faith communities to support the Ebola response. In Liberia, the Inter-Religious Council was a member of the Incident Management System and participated in the National Task Force, the two bodies empowered with leadership of the Ebola response. In Sierra Leone, members of the Inter-Religious Council participated in the National Burial Command Centre for the roll-out of safe and dignified burials and in Kenema and Bo, and senior faith leaders were part of the Social Mobilisation Pillar of the District Ebola Response Centre and frequently attended coordination meetings. And at a local level in countless villages across Liberia, faith leaders partnered with local chiefs to lead community-based Ebola task forces.

Sierra Leone and Liberia both had nationally led coordination mechanisms (albeit heavily supported by the United Kingdom and the United States respectively) and it was only in the Ebola hot spots or in specific technical aspects of the response that the international system played a more visible leadership role. While the coordination mechanisms were themselves new, which meant that they were unfamiliar, the fact that many of them were led by nationals may have played a role in encouraging the engagement and participation of faith leaders. When asked who they coordinated with, faith leaders in Sierra Leone did not mention UNMEER or WHO, but considered NGOs as their main interlocutors with the National/District Ebola Response Centre also playing a significant role (see Figure 15). One particular example is the development of the standard operating procedures (SOPs) which presented the approach of the government towards addressing key aspects of the Ebola response in Sierra Leone. SOPs were developed for burials, quarantines and other issues of which faith leaders had a unique understanding given their knowledge and engagement with communities, and their involvement in their development was important.



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Equipment used by members of Caritas Makeni Safe and Dignified Burial team, Kambia, Sierra Leone.

Where faith leaders struggled to engage consistently was at the national level, particularly in Sierra Leone. Given that this is where many of the Ebola policies were developed, there was potential for the voice of an important change-agent and community interlocutor to be omitted and it was only after faith leaders had been engaged on the issue of burials and behaviour change towards the end of 2014 that international organisations such as UN agencies and donors began to engage with faith leaders in a more structured way. After this watershed, DfID was particularly instrumental in engaging with faith leaders on issues related to behaviour change. It is also important to acknowledge the work of some UN agencies, particularly UNICEF in both Liberia and Sierra Leone, which had historic involvement with faith leaders that pre-dated the Ebola outbreak. In Liberia, UNICEF was one of the most active supporters of faith leaders as social mobilisers and as a consequence it was swift to partner with the Inter-Religious Council to disseminate behaviour change messages across the country. Given the instrumental role that faith leaders played in the Ebola response, the limited engagement that they have had in planning for recovery is disappointing. While some have plans and proposals of their own, when asked about their participation in donor or UN agency efforts, there were no leaders who had been directly involved. Given that the recommendations made in the joint UN, World Bank, European Union (EU) and African Development Bank (ADB) recovery strategy document⁷⁵ focuses significant attention on the participation of faith leaders in the process, their lack of participation suggests that there is much work to do to move from rhetoric to reality (Figure 16).

Figure 15: Response to the survey question: 'Who engaged faith leaders in the SOPs?' (92 participants)

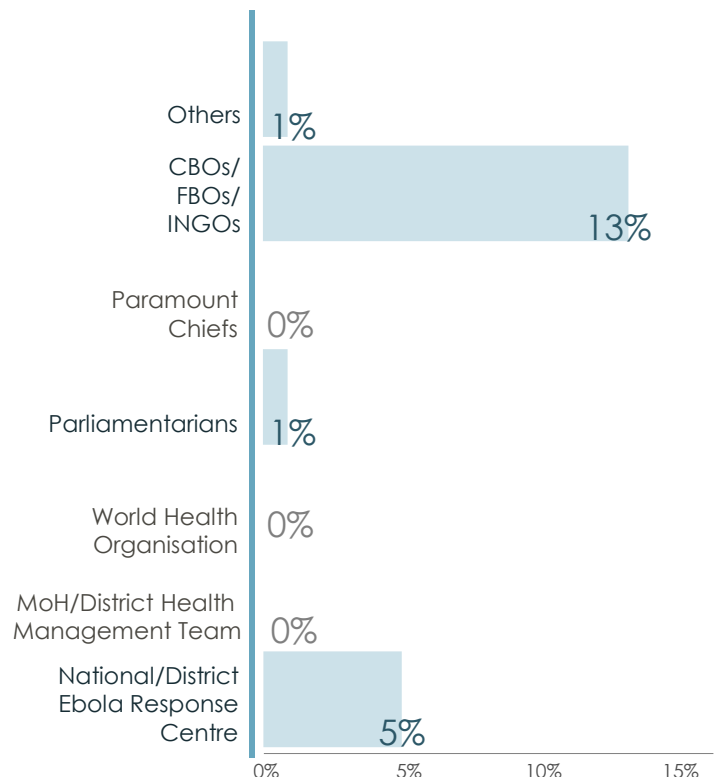


Figure 16: Excerpts from the joint UN, WB, EU and ADB recovery strategy document

- Strengthen the capacity of actors [including civil society, traditional and religious leaders] to participate in the prevention and management of conflicts and natural disasters as well as health, early warning and rapid response (page 16).
- Learn from the low levels of trust in state institutions before the epidemic which hampered the response and bring in political stakeholders, including opposition parties, civil society, religious and traditional leaders, and other groups, to help to rebuild trust and promote national consensus on the priorities of recovery strategies (page 40).
- Work with community-based organisations including traditional and religious leaders to fight stigma and tensions created by the impact of the Ebola crisis (page 67).

8.2 Partnership between faith leaders and humanitarian organisations

Given the context of faith and religious tolerance in Sierra Leone and Liberia, the engagement of FBOs in relief and development activities and the historical role played by faith leaders in previous crises, the role of faith in humanitarian action is well understood at a national level in both of the countries. During the years of conflict, it was common for national FBOs and faith leaders to work in close proximity to secular international humanitarian agencies and there were frequent partnerships in some of the most challenging conflict-affected parts of both countries. As a consequence, there is a level of familiarity that created an enabling environment for similar partnerships to be used to respond to the Ebola outbreak.

While the churches and mosques were among the first to respond and were supported by their national religious coordination bodies such as the Council of Churches of Sierra Leone, the Evangelical Fellowship of Sierra Leone and the Christian Health Association of Liberia, international FBOs including CAFOD and Caritas, Christian Aid, Tearfund and World Vision began the process of re-establishing or re-tooling their programme partnerships in order to support the Ebola response. While in Sierra Leone there was an initial focus on non-medical support such as social mobilisation and distribution of non-food items, in Liberia where the church has a long history of support to health services, there was a much greater focus on ensuring that health services could play a complementary role in responding to the medical needs of those suffering from EVD as well as maintaining broader health services.

Beside the FBOs, UN agencies and international organisations were slower to engage with faith leaders. The Ebola outbreak had brought about a significant change in international personnel and heralded the arrival of many new staff who were unfamiliar with the context and whose networks were far smaller than their predecessors'. Early efforts focused on launching a biomedical response and interviews with senior UN staff suggest that it was not until after September 2014 that the untapped potential of faith leaders was explored which was around the same time that a meeting between the World Council of Churches and UN agencies was convened in Geneva, which provided a platform for collaboration.

8.3 Facilitation and support of faith leaders by FBOs and CBOs

Facilitation and support of faith leaders by FBOs and CBOs has played an important role in assisting them to organise themselves. The provision of training has helped them to contextualise their knowledge and skills to make them relevant to the Ebola outbreak and support has also been provided to monitor the interventions of faith leaders.

Assistance provided to faith leaders to strengthen their organisation

A common challenge for faith leaders is in organising themselves to respond coherently at scale and this is something that NGOs have supported. While ecumenical and inter-religious umbrella movements existed in both Sierra Leone and Liberia prior to the Ebola outbreak, they initially had quite limited resources to support the mobilisation of faith leaders. Many FBOs and CBOs facilitated these groups through the provision of funding which permitted them to scale up the support they provided. Several FBOs spoke of how they had reached out beyond their existing faith partnerships (and across faiths) in order to expand their support to communities across the country. In this way, numerous ad hoc groups of faith leaders were convened, often for purposes of receiving training or to support social mobilisation initiatives. However, there were also efforts made to formalise inter-faith groups, such as by Focus1000 which provided support to Islamic and Christian action groups (ISLAG and CHRISTAG) to establish themselves across the country, with representation at district, chiefdom and even village level, although some considered that it duplicated the work of the Inter-Religious Council.

Provision of training

While some faith leaders had received significant training related to their ministry prior to the EVD outbreak, many of those who were based at village level had comparatively little training and they are also often the ones that have the least experience. As a consequence, the capacity of faith leaders to engage in social mobilisation and behaviour change varied considerably albeit with a tendency for those with least training to be based in areas where their leadership capacities were required the most – at the village level where it was often hardest to change practices and where alternative support was in short supply. It was in the area of training that CBOs and FBOs have played a valuable role and faith leaders frequently praised the valuable support that they had received, particularly for the CoH methodology which was widely disseminated.

“The Channels of Hope training which includes issues of social justice and advocacy has inspired faith leaders and has also given them greater ambition.”

CHRISTIAN FAITH LEADER, BO DISTRICT, SIERRA LEONE

Given the limited availability of government services in many rural areas of Sierra Leone and Liberia, the training and additional support given to faith leaders have provided an important safety net. As recovery efforts begin to gain pace, a decentralised approach to training that seeks to build the skills of faith leaders in rural and remote areas will be essential. While the majority of training for faith leaders has been on messaging and awareness-raising, the Sierra Leone faith leaders’ survey suggests that there is scope for strengthening capacities in two key areas where faith leaders have taken on specific additional responsibilities: psychosocial support and child protection (see Figure 17). These both require specialist knowledge and skills and, in the absence of adequate government services, it will be essential that faith leaders are supported in maintaining a safety net.

Assistance with monitoring and evaluation

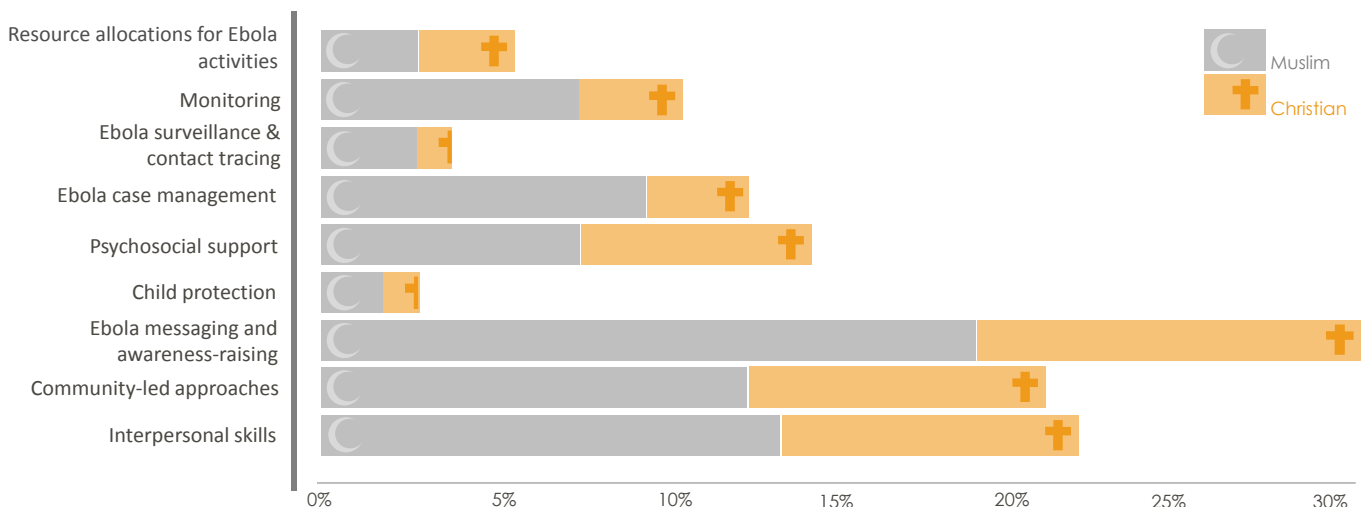
A key area of NGO support was in strengthening monitoring systems. Faith leaders had relatively limited capacity or resources to monitor their work and were often unfamiliar with the reporting regimes that were required for coordination and donor accountability purposes. Faith leaders also spoke with some candour about the limitations they had in ensuring that agreed behaviour change messages were being passed on to those attending churches and mosques, as expressed by a Muslim faith leader in Kenema:

“We have a powerful network but it requires oversight and management to ensure that messages are being replicated. We need to strengthen the monitoring of our work to ensure that adherence.”

MUSLIM FAITH LEADER, KENEMA DISTRICT, SIERRA LEONE

NGOs were able to offer support in strengthening monitoring systems and there were a number of different examples provided by FBOs and CBOs of initiatives taken to engage with faith leaders to ensure that they were contributing positively to behaviour changes and to target follow-up training where weaknesses were identified.

Figure 17: Faith leaders’ participation in training initiatives in Sierra Leone (92 participants)



“After the training we monitored those faith leaders that participated and also checked on the messages they gave with civil society members. We used the information to feed into a refresher training to ensure that we addressed any gaps.”

SENIOR FBO STAFF MEMBER, KENEMA DISTRICT, SIERRA LEONE

In seeking to work with faith leaders, FBOs stressed the importance of adopting an approach which facilitated engagement and was based on two-way discussion rather than their being treated like ‘contractors’. In championing the work of faith leaders it was recognised that there was a risk that they could be pigeon-holed as behaviour change experts rather than being considered in the wider context of the communities they were part of.



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Psychosocial training for faith leaders at Methodist Mende Church in Freetown - the training was organised by Council of Churches in Sierra Leone, with support from Christian Aid's Disasters Emergency Committee appeal funds.



Reflections on the role of faith leaders in the Ebola response

This section analyses the findings of the study to identify how faith leaders contributed to change and offers some suggestions as to the specific skills, values and capacities that faith leaders had which made them effective agents of change.⁷⁶ A set of lessons specific to the role of faith leaders in the Ebola response are also highlighted.

9.1 How did change happen?

Scriptural, technical and heart dialogue

The mix of theological, attitudinal and technical input that was offered by faith leaders meant that they were uniquely placed to enable people to engage holistically in addressing underlying beliefs and attitudes and in so doing change behaviour. Government messaging on the cruel medical realities of Ebola had sought to speak to people's intellect as a means of stimulating change and the social mobilisation that followed sought to reason with people about the need for change, but neither of these approaches created a tipping point of behaviour change; rather, these messages served to push care of the sick and traditional approaches to burials underground.

Through the use of religious texts and with the leadership of the faith community, biomedical messages which appeared harsh at first and which brought fear were given religious context and delivered with compassion in a way that provided hope and encouragement. Fundamentally, many of the messages were unchanged, but the means through which they were delivered spoke to the belief that people had in a compassionate and loving God, which provided reassurance and hope. Where Ebola control practices were considered irreligious and so were not observed, negotiation to allow the participation of religious leaders was fundamental in bringing about acceptance of the changes, as was the underpinning of prevention messages with reference to religious texts.

It is the holistic way in which faith leaders were able to engage with people from both a technical and religious perspective that enabled changes to both the hearts and minds of communities who were being asked to change longstanding and deeply felt practices which went to the heart of their identity.

Strengthening community structures and the importance of local engagement in the response

The embeddedness of faith leaders in the community allowed them to form meaningful relationships and networks that have their roots in the trust and respect that people have for them. Their community leadership role permitted them to shape opinion and behaviour. One of the implications of this was that in the early days after the outbreak, while faith leaders themselves were ignorant and lacked accurate information about the causes of the Ebola virus, many continued with practices that were detrimental to containing the spread of the virus. However, once faith leaders had been engaged and understood the risks associated with some religious practices and had been involved in identifying adaptations that were consistent with religious practices, then they were able to role-model the changes that were required. Sermons and *Khutbas* offered an opportunity to champion the changes with community members who were naturally predisposed to following the example of their leaders.

The lesson here is the importance of local engagement and ownership in humanitarian response.

Several participants in the study spoke of the "ripple effect" that occurred once senior leaders such as bishops, district imams, the Inter-Religious Council and the Supreme Islamic Council were engaged in seeking to address the Ebola outbreak which would lead to others following suit and as the ripples moved outwards from Monrovia and Freetown to the counties and the districts, so too did the changed practice and support for those affected by the disease. With a critical mass of believers who were willing to heed the example of their leaders, even those who did not believe chose to fall in line.

A lesson from this is the importance of engaging at an appropriate level of leadership; when senior faith leaders were engaged, they had far greater potential to change the practice of other leaders as well as being able to role-model the changes to their congregants.

Holding government and service providers to account

The governments of both Sierra Leone and Liberia initially engaged in dialogue with the Inter-Religious Councils as a means of galvanising the support of the faith communities to tackle the outbreak based on the historic role that they have played in past crises. This placed senior faith leaders in a position of influence as it offered them an influential advocacy platform. In Sierra Leone, they lobbied the government on issues which included safe and dignified burials and how to organise lockdowns in a way that would minimise suffering. In Liberia there was discussion on the issue of cremations which had elicited significant animosity as the practice was considered to go against commonly held beliefs. The access that faith leaders had through their ministers and imams to the districts, towns and villages that were affected by Ebola meant that they were well placed to raise issues on behalf of those who were suffering. While some faith leaders in Sierra Leone spoke of a disconnect between Freetown and the surrounding districts, the opportunity to escalate the concerns of communities was taken on a number of occasions.

As well as engaging government in Freetown and Monrovia, faith leaders at the district and country level also often raised issues with the authorities and coordinating bodies. Feedback from both government and NGO coordination staff on the engagement of faith leaders was complimentary and they welcomed the knowledge they had of communities and the reach they had to effect change as a consequence.

While the involvement of faith communities with government is often considered to be an area of weakness, for the Ebola response the historical engagement of senior faith leaders at times of national crises and the important role that they played in supporting the Ebola response gave them a significant voice with national and local government.

9.2 Why did change happen?

Values

The study found faith leaders were highly motivated to support their communities and did so out of a spirit of compassion. There were many examples given where their motivation to serve their communities placed them at greater risk from the disease, whether as a result of engaging in local-level efforts to isolate Ebola cases (most frequently in Liberia), ministering to those in quarantine or travelling to affected areas to disseminate messages to try to stop the spread of the disease. Medical staff spoke of the willingness of faith leaders to support efforts to provide counselling and psychosocial support as well as role-modelling the acceptance of Ebola survivors which has played a key role in changing attitudes towards those who recovered from the disease. Such selfless acts speak to the spirit of compassion that many faith leaders showed through their actions.

Access

The access that faith leaders had to communities even in the most remote parts of the countries was unparalleled as they were themselves members of the community. Social mobilisation staff in NGOs and UN agencies considered this to be one of their key strengths in changing attitudes and practices. In the early days of the outbreak in Lofa County in Liberia when Ebola was out of control, government health staff and NGOs trying to gain access to communities were stoned and barricaded due to misplaced fears that they were carrying the disease. Access was negotiated directly by local faith leaders from the communities who were able to strengthen understanding and acceptance. Elsewhere in remote parts of the country, faith leaders worked with other village elders and traditional chiefs to provide the first line of defence against the virus, establishing household-level community quarantine. In these contexts faith leaders often played an important liaison role between members of the community and health staff as well as overseeing the distribution of food and water which were often in very short supply.

Trust

The effectiveness of faith leaders in responding to Ebola relied in large part on the trust that community members had in them which stemmed from their shared beliefs, and the leadership vested in them. In Sierra Leone, successive KAP studies highlighted the significantly greater trust that communities placed in faith leaders than they did in the government, the Ministry of Health or health workers during the Ebola response. In focus group discussions with communities in both Liberia and Sierra Leone, trust was the most frequently cited attribute of faith leaders. Trust also played an important part in the success of faith leaders in convincing communities to change important religious and cultural practices substantially. While fear also contributed to the willingness of communities to adapt their behaviour, the failure of early efforts by the government suggests that fear alone was not sufficient to prompt change but, when they were delivered by a leader who was trusted in a way that was consistent with religious practices, then change was accepted.

Long-term presence

Many of the faith leaders who participated in the study were either born in their communities or had lived in them for many years. While interviews highlighted the change in staffing experienced by NGOs, UN agencies and in government, religious leaders were unique in occupying long-term leadership positions in the towns and villages where they lived. While this has played a role in garnering the trust and respect of community members which has been so important for promoting behaviour change, it also provides faith leaders with a unique perspective on the development of their communities; some communities spoke of their disappointment as NGOs mothballed their development programmes and evacuated their staff from at-risk locations as Ebola spread throughout the country. Faith leaders, by contrast, were integral members of their communities and they did not leave but stayed and suffered the effects of the outbreak with them. Equally important is that the community knew that faith leaders would remain with them in the future.

Knowledge of communities

At a local level, faith leaders were fervent advocates for the provision of assistance to the communities in which they were based. While some had access through their churches to relief supplies, where this was not the case, faith leaders lobbied on behalf of their communities. During interviews, imams and church leaders spoke passionately about those who had been lost to the disease and had played a key role in role-modelling acceptance back into the community of those who had recovered from Ebola. Where communities had been divided as a consequence of the transmission of the disease, faith leaders played a lead role in seeking to build bridges and bring communities back together.



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Food distribution to quarantined communities in Freetown, Sierra Leone.

9.3 Reflections from the research

Faith leaders have played an essential role in reducing the transmission of the disease, in addressing stigma, providing counselling and in offering assistance to those who required it. Many of those who participated in the study echoed the words of a senior member of the Ebola Task Force in Kenema, that *“Sierra Leone would have saved more lives and more money had religious leaders been engaged at an earlier stage of the disease outbreak”*. As an emergency that has been heavily influenced and shaped by faith leaders and FBOs, the response offers some important lessons for the future of humanitarian response in West Africa and beyond.

The value of adopting a holistic approach to emergencies

One of the most important lessons from the Ebola response is the importance of going beyond traditional response types for non-traditional crises. Ebola could not be addressed by the secular humanitarian system and neither could it be brought under control as a consequence of the actions of faith communities alone – it is both of these plus traditional leaders, working together, that offered the potential to improve the situation significantly. In responding to the Ebola outbreak in West Africa, there has been equality within the response between people of all faiths and none in sharing and shaping the humanitarian agenda, which provides an encouraging example for the future.

The essential role played by faith leaders in social mobilisation and behaviour change

The confidence that initially existed in adopting a purely biomedical approach to the EVD outbreak was misplaced; health facilities, treatment units and case management were important but they missed an essential element which was the need to mobilise communities to change behaviour and in many cases neither health staff nor the government were ideally positioned to achieve this. Instead, the local community itself was best placed to effect change, and faith leaders as trusted and respected members of communities played an important role as agents of social change. It is important to note that in and of itself community leadership was insufficient to prompt the changes that occurred (and in comparison to faith leaders, the KAP surveys suggest, local chiefs had far less influence despite having greater power). It was the spiritual dimension to the messages that played a decisive role in communities that were deeply religious in changing their behaviour.

The effectiveness of an inter-faith approach

In approaching the task of working together in Sierra Leone, Christian and Muslim faith leaders established an important ground rule: to discuss issues that united them and to ignore issues that divided them. This permitted a conversation that was focused on how to address the Ebola outbreak and allowed them to find similarities in their religious texts in how to address issues of behaviour change (see Figures 6, 10 and 13 earlier in the report). The coherence in the messaging between the two major religions and the unity that was demonstrated in how the messages were delivered provided an important platform for change to happen. With Islam and Christianity accounting for the majority of the populations of Liberia and Sierra Leone and with the significant trust and respect that was afforded to leaders of both religions, the potential audience included all but a small minority. There were also some important lessons for leaders of both faiths about how they collaborated which included an agreement to put aside religious differences to focus on a problem that was common to both faiths. The practice of pastor exchanges and pulpit swaps was considered to be particularly powerful in challenging behaviour as well as role-modelling the unity that existed between the faiths.

The need for faith leaders to preserve their integrity

Perceptions of the integrity of faith leaders were among the most important factors in convincing communities to adhere to their behaviour change messages and it is essential that this is not compromised. While faith leaders made an important contribution to promoting change and providing assistance to those affected by Ebola, the limited access that they had to funding and resources was frequently raised as a concern, particularly in Sierra Leone. A number of faith leaders spoke of the resources that the government provided to the Paramount Chiefs for the Ebola response and spoke of their frustration at not having access to greater resources from the government. However, others spoke of the importance of maintaining their independence from government: such reasons were outlined by a faith leader who was a member of the Inter-Religious Council in Kenema town and who considered that *“there is a risk that fundraising will corrupt and compromise our integrity. We should not ask the government for anything, but we need to ensure that we can adequately represent ourselves at senior levels as well as at village level.”*

The value of engaging with faith leaders as part of two-way communication with communities

The international humanitarian system has traditionally been weak in engaging local communities in the provision of assistance. The engagement of faith leaders in the Ebola response was typified by two-way discussion and allowed the contextualisation of behaviour change messages. By engaging in this way, the response offers a rare example of power being shifted from the international to the local level and serves as an important example for humanitarian response elsewhere.

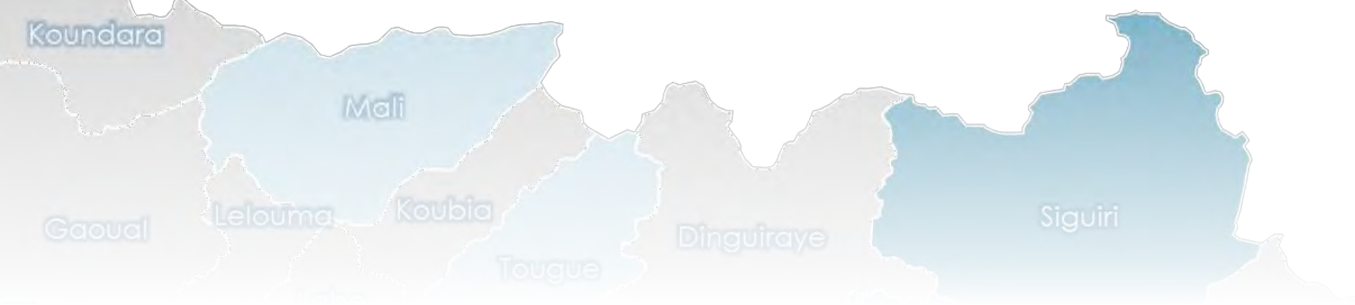
The missing link between the organised faith response and traditional beliefs

The intersection and overlap between the organised religions and traditional beliefs is not explored in detail in the study. Yet, given the link that exists between the two and the comparatively tardy efforts to incorporate the latter into the broader efforts to stop the transmission of the virus, the failure to engage with the traditional religions, healers and secret societies more quickly after the outbreak was one of the most significant missing links in the response. So too was the absence of levers (such as the religious texts) in the early stages of the outbreak to promote behaviour change and to stop negative practices that perpetuated the spread of Ebola.



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Meeting of faith leaders in Sierra Leone.



Conclusion and recommendations

This section draws conclusions from the study and builds on the lessons identified above to make recommendations about the role of faith leaders in supporting the Ebola response and recovery in Sierra Leone and Liberia.

10.1 Conclusion

Faith plays an important role in people’s lives in Liberia and Sierra Leone where the majority of the people are practising believers and faith leaders enjoy significant trust and respect. In the initial weeks after the Ebola outbreak, there was a lack of information about the disease and as a consequence, the response of faith leaders was mixed, particularly as the important potential role of faith leaders in addressing the EVD outbreak was not initially recognised. As the outbreak spread, draconian measures were taken which went against cultural values and religious practices and which resulted in denial of the disease and hostility towards those who were seeking to contain it. As the panic grew, efforts were taken to engage faith leaders in the response and Christian and Muslim leaders collaborated in unprecedented ways to challenge the myths and misinformation surrounding the virus and offer life-saving advice to their local communities on Ebola protection and prevention methods. They played an important role in addressing stigmatisation of those who survived the virus and provided psychosocial support and counselling.

The role of faith leaders in addressing the Ebola outbreak offers a compelling example of the important role that faith can play in humanitarian response. Through the use of religious texts and with the leadership of the faith community, biomedical messages which seemed harsh at first and which brought fear were given religious context and delivered with compassion in a way that provided hope and encouragement and led to changes in knowledge, attitudes and behaviour. Moreover, the embeddedness of faith leaders in the community allowed them to harness relationships that have their roots in the trust and respect that people have for them. As such, the response to the Ebola outbreak offers a powerful example of humanitarian response in the post-secular age – where humanitarian agencies were able to partner successfully with the faith community to effect urgent and lasting change to address the Ebola outbreak.

The response offers some important lessons, not least of all the added value that came from seeking to respond to crises in a holistic manner. But faith leaders should not be considered merely as behaviour change agents to be used in times of crisis; with the number of people affected by conflict and disaster escalating at an alarming rate and with the World Humanitarian Summit less than a year away, there is growing consensus on the importance of local engagement in response and resilience. Many of the skills and capacities that faith leaders have demonstrated in the response to the Ebola outbreak have important value in placing people at the forefront of rising to meet these important challenges. This presents an exciting opportunity for the future.



Public health messages are important in informing the public about appropriate responses to Ebola.

Recommendations on the engagement of faith leaders in response and recovery efforts

For international organisations, government and donors

- **Include faith leaders in planning for recovery and in health emergencies:** While faith leaders were considered to be instrumental in promoting positive change during the Ebola response there was a significant delay in engaging them at the start of the outbreak. Given their embeddedness in communities and their unparalleled knowledge of local-level needs, it is essential they are proactively engaged in planning processes for recovery.
- **Engage faith leaders in restoring health systems:** Faith leaders are well placed to draw on their respect within communities and a shared agenda in strengthening the health and well-being of their communities.
- **Strengthen faith literacy among humanitarian staff and undertake research:** Many relief and development staff have a narrow view of faith and the role of faith leaders and communities, particularly at field level. All humanitarian agencies should take advantage of the growth of literature on how to engage with FBOs and train their staff accordingly. The capacities of faith leaders are largely unmapped and their overall impacts uncharted. Further research should be undertaken to address this.
- **Avoid instrumentalisation of faith leaders:** There is a risk that the success of faith leaders in promoting behaviour change may lead to them being seen as a means to an end and used as passive actors to address social ills. Yet the changes they promoted came out of dialogue and a shared agenda, which should serve as a blueprint for their future engagement.

For faith-based organisations (FBOs)

- **Provide technical support:** FBOs should continue to build capacity and provide technical support to faith leaders as they respond to the Ebola crisis and recovery, including in psychosocial support, addressing stigma and behaviour change. FBOs should support faith leaders to be empowered to respond to future EVD outbreaks and other disasters.
- **Strengthen inter-faith dialogue:** FBOs should work across denominations and faiths to catalyse and strengthen inter-faith dialogue and ensure consistency and accuracy of messages delivered by faith leaders. This could also incorporate pooling resources, undertaking cross-learning visits, coordinating activities and monitoring progress.
- **Facilitate national-level engagement:** Faith leaders should be supported to continue their engagement with national-level processes such as recovery plans and the rebuilding of health systems. If FBOs are unable to connect them directly to these processes they should engage with agencies who may be better placed to do this, such as humanitarian international NGOs.

For faith leaders

- **Support the Ebola response:** The continued engagement of faith leaders to maintain momentum on changing behaviour, facilitate psychosocial support to survivors and affected families, address stigma and discrimination and support vulnerable groups is critical.
- **Catalyse community engagement:** As health systems are re-established, faith leaders should play a key role in advocating for, and engaging communities in, health-related programmes. It is important that women are proactively engaged in this and suitable conditions are established to enable their involvement.
- **Build resilient communities:** Faith leaders should continue to play a critical leadership role in supporting communities' capacities to prepare for and respond to uncertainty, shocks and stresses.⁷⁷

Annex: Methodology

The study was undertaken by an international researcher working with a national research team in Sierra Leone and Liberia with the support of the commissioning agencies. Research methods included the following:

- A literature review was undertaken to examine the role of faith leaders in humanitarian response (23 documents) and their specific role in the Ebola outbreak (54 documents), in addition to background documents on the broader outbreak, the humanitarian response and recovery (44 documents) and inter-faith humanitarian response in Liberia and Sierra Leone (9 documents).
- A field trip to Sierra Leone with key informant interviews and focus group discussions in Western Area, Bo and Kenema districts and in Montserrado and Bong counties in Liberia, which included interviews and focus group discussions over a four-week period.
- Key informant interviews and focus group discussions with faith leaders (33 interviews), NGOs and UN agencies (31 interviews), government representatives (10 interviews), donor agencies (4 interviews) and community members (18 focus group discussions, 176 people).
- A formal survey and additional focus group discussions were undertaken in Western Area, Bo and Kenema districts, by a team of two research staff. This was largely targeted at village-level faith leaders (92 interviews with faith leaders).
- The research in Sierra Leone also drew extensively on the interviews and focus group discussions undertaken by Anne Street of CAFOD during an initial scoping visit to Kambia in the north of the country.

The research was conducted over a period of one month in three administrative districts of Sierra Leone including Western Area (including Freetown), Bo district in the Southern Province and Kenema district in the Eastern Province, and in Montserrado and Bong counties of Liberia. In both of the countries, the research was conducted in the capital city, at district/county level and at village level, with a priority placed on those areas that were affected by the Ebola outbreak.

Approach

A set of core questions were developed from the terms of reference which were adapted to make them relevant to different stakeholder groups including (i) faith leaders (ii) NGOs, UN agencies and government, and (iii) communities. Key informant interviews were held with the first two groups and focus group discussions were conducted with communities. A community discussion template and interview template was prepared to ensure consistency in the application of the methodology by the research teams in Sierra Leone and Liberia. In order to solicit the views of religious leaders at lower levels of the religious structures, a structured survey was administered to faith leaders at village level in Sierra Leone. The purpose of this was to validate responses from faith leaders at district and national level.

In developing the methodology there were some important design issues that were taken into account in order to ensure the veracity of the findings (see Figure 18).

Figure 18: Summary of issues for the research

Research issue	Approach
Measurement	A mix of methods was used which included both qualitative and quantitative tools (focus group discussions, key informant interviews, faith leader survey).
Replication	While replication is not a key output of the research, importance was attached to building the evidence base and for this reason, the questions were developed in such a way as to permit replication of the research in other humanitarian contexts.
Credibility	To ensure the credibility of the results, to mitigate the risk of bias and to facilitate replication of the research method by organisations with diverse stakeholder groups, the research data was triangulated across different interviewee groups and within each group.
Causality	The research sought to identify a causal link between the specific actions of faith leaders and the transmission of the EVD. Because of the multi-faceted nature of the response, it was not feasible to attribute specific changes to the actions of the faith leaders, but by triangulating the research findings across different stakeholders in the two countries and analysing secondary data, it was possible to draw some conclusions about the contribution of faith leaders to reducing the transmission and addressing the consequences of the virus.

Limitations

There were a number of limitations that affected the study in Liberia and Sierra Leone:

- The breadth of the research topic meant that while efforts were made to be as inclusive as possible, it was not possible to include all the potential stakeholders.
- The research and preparation of the report was undertaken in one month which meant that there was limited time for the research team to analyse and submit their findings. While the methodology that was used sought to compensate for this, it did mean that some of the richness of the findings may not have been fully exploited.
- The research occurred at a time of renewed efforts to contain the spread of the EVD virus in Sierra Leone through Operation Northern Surge as a consequence of which changes were made to the original itinerary.
- The research covers only Sierra Leone and Liberia. While Guinea was also affected by the outbreak and faith leaders there played an important part in the response, a detailed consideration of this is beyond the scope of the study.

Endnotes

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