Evaluating the impact of Safe and Dignified Burials for stopping Ebola transmission in West Africa

Summary findings from the anthropological study in Sierra Leone

Ginger Johnson & Juliet Bedford
Amanda McClelland, Amanda Tiffany, Ben Dalziel

December 2015

International Federation of Red Cross and Red Crescent Societies

Anthrologica

SIERRA LEONE RED CROSS SOCIETY

Acknowledgements

Particular gratitude is extended to the families and communities impacted by Ebola who participated in this research.

We would also like to thank the following individuals and institutions for their support and inputs:

International Federation of the Red Cross and Red Crescent Societies

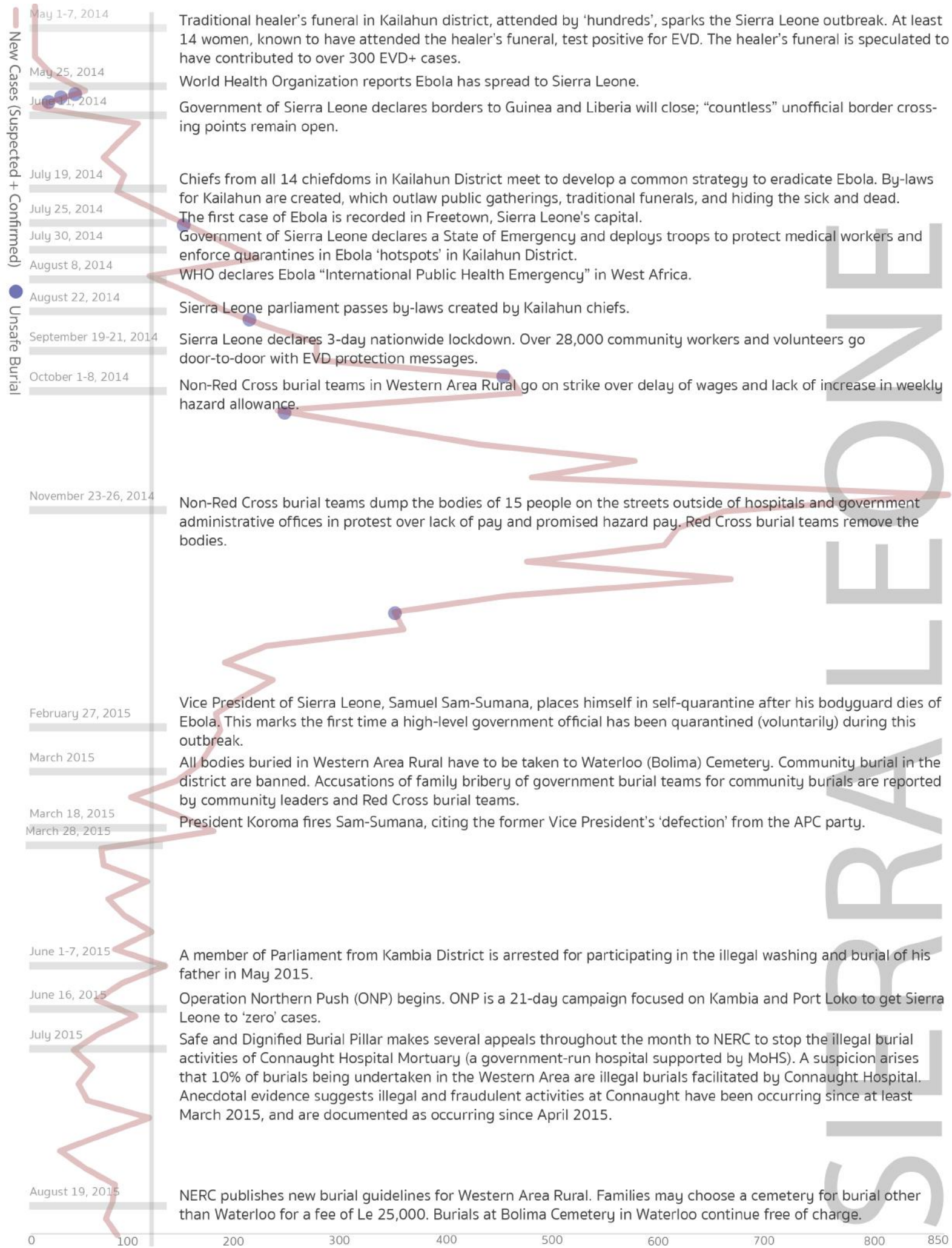
Amanda McClelland, Senior Officer, Emergency Health
John Fleming, Emergency Health Coordinator
Virgil Atchia, WatSan & SDB Delegate

Sierra Leone Red Cross National Society

Daniel F.K. James, National SDB Supervisor
Abdul K. Conteh, SDB Officer (Western Rural)
Augusta Kallone, Operations Manager (Western Rural)
Gassimu Mbayeilla, PSS Officer (Western Rural)
Christiana Kapindi, Field Health Officer (Kambia)
Saidu M. Kamara, Social Mobilisation Officer (Kambia)
Nancy Bockarie, Operations Supervisor (Kailahun)

Sincere thanks are extended to Anthrologica research assistants Aiah Yendeh, Alhaji S.Y. Turay and Kallon Mohamed, and to Anthrologica intern Sylvia Lim who contributed to the initial literature review.

Content


New Cases (Suspected + Confirmed)
Unsafe Burial
May 1-7, 2014
Traditional healer's funeral in Kailahun district, attended by 'hundreds', sparks the Sierra Leone outbreak. At least 14 women, known to have attended the healer's funeral, test positive for EVD. The healer's funeral is speculated to have contributed to over 300 EVD+ cases.
May 25, 2014
World Health Organization reports Ebola has spread to Sierra Leone.
June 11, 2014
Government of Sierra Leone declares borders to Guinea and Liberia will close; "countless" unofficial border crossing points remain open.
July 19, 2014
Chiefs from all 14 chiefdoms in Kailahun District meet to develop a common strategy to eradicate Ebola. By-laws for Kailahun are created, which outlaw public gatherings, traditional funerals, and hiding the sick and dead.
July 25, 2014
The first case of Ebola is recorded in Freetown, Sierra Leone's capital.
July 30, 2014
Government of Sierra Leone declares a State of Emergency and deploys troops to protect medical workers and enforce quarantines in Ebola 'hotspots' in Kailahun District.
August 8, 2014
WHO declares Ebola "International Public Health Emergency" in West Africa.
August 22, 2014
Sierra Leone parliament passes by-laws created by Kailahun chiefs.
September 19-21, 2014
Sierra Leone declares 3-day nationwide lockdown. Over 28,000 community workers and volunteers go door-to-door with EVD protection messages.
October 1-8, 2014
Non-Red Cross burial teams in Western Area Rural go on strike over delay of wages and lack of increase in weekly hazard allowance.
November 23-26, 2014
Non-Red Cross burial teams dump the bodies of 15 people on the streets outside of hospitals and government administrative offices in protest over lack of pay and promised hazard pay. Red Cross burial teams remove the bodies.
February 27, 2015
Vice President of Sierra Leone, Samuel Sam-Sumana, places himself in self-quarantine after his bodyguard dies of Ebola. This marks the first time a high-level government official has been quarantined (voluntarily) during this outbreak.
March 2015
All bodies buried in Western Area Rural have to be taken to Waterloo (Bolima) Cemetery. Community burial in the district are banned. Accusations of family bribery of government burial teams for community burials are reported by community leaders and Red Cross burial teams.
March 18, 2015
President Koroma fires Sam-Sumana, citing the former Vice President's 'defection' from the APC party.
March 28, 2015
June 1-7, 2015
A member of Parliament from Kambia District is arrested for participating in the illegal washing and burial of his father in May 2015.
June 16, 2015
Operation Northern Push (ONP) begins. ONP is a 21-day campaign focused on Kambia and Port Loko to get Sierra Leone to 'zero' cases.
July 2015
Safe and Dignified Burial Pillar makes several appeals throughout the month to NERC to stop the illegal burial activities of Connaught Hospital Mortuary (a government-run hospital supported by MoHS). A suspicion arises that 10% of burials being undertaken in the Western Area are illegal burials facilitated by Connaught Hospital. Anecdotal evidence suggests illegal and fraudulent activities at Connaught have been occurring since at least March 2015, and are documented as occurring since April 2015.
August 19, 2015
NERC publishes new burial guidelines for Western Area Rural. Families may choose a cemetery for burial other than Waterloo for a fee of Le 25,000. Burials at Bolima Cemetery in Waterloo continue free of charge.
0
100
200
300
400
500
600
700
800
850
SIERRA LEONE

Introduction

In the West African Ebola Response, the International Federation of the Red Cross and Red Crescent Societies (IFRC) was designated the lead agency for safe and dignified burials (SDB). Across the three most affected countries, the IFRC and the Red Cross National Societies (NS) were able to mobilise their extensive network of volunteers and infrastructures to facilitate and coordinate SDB (IFRC 2015a). The IFRC collaborated with other agencies and local partners to establish common protocols, map responses, share good practices, provide technical guidance and identify service gaps. At the time of writing (November 2015) the National Societies of Sierra Leone, Liberia and Guinea have managed more than 27,000 bodies in West Africa and continue to learn and incorporate dead body management protocols into effective public health programming (IFRC 2014a, 2015b).

The importance of SDB as an integral part of reducing the transmission of Ebola and stopping the outbreak is significant, but not well understood. The key question of the research was therefore 'What impact did safe and dignified burials have on the epidemic?' Understanding this was key to contributing to 'good practice' programme design as emergency responders strived to 'Get to Zero' in the current crisis, and also to provide evidence for the planning, implementation and prioritisation of activities for future epidemics.

The IFRC/NS was the only organisation conducting SDB across all 14 districts of Sierra Leone and, at the height of the emergency response, had 54 burial teams in operation. The coverage of the NS burial teams differed at the district level according to the roles and responsibilities of other agencies (and the government) that also provide burial services.

Research objectives and reporting

The importance of SDB as an integral part of reducing the transmission of Ebola Virus Disease (EVD) and stopping the outbreak was significant, but not well understood. The IFRC and collaborative partners therefore conducted research to determine what impact safe and dignified burials had on the epidemic.

This report summarises the anthropological component of the research. Focusing on the work of the National Societies of Sierra Leone, Liberia and Guinea, the study used anthropological methods to assess the impact of safe and dignified burials in the West African Ebola epidemic as understood by frontline responders (e.g. burial teams and social mobilisers) and Ebola affected communities themselves (particularly 'hotspot' communities). Understanding and documenting these perceptions and experiences is key in contributing to 'good practice' programme design and provides evidence for the planning, implementation and prioritisation of activities for future epidemics.

The report is structured to be of operational use to the IFRC and its partners at local, national and international levels. It provides an overview of the methodology used and presents key findings that detail a) the challenges and barriers to SDB, and b) the successes and drivers to SDB.

Prior to the report's completion, IFRC and key National Society stakeholders in Sierra Leone were given the opportunity to provide written and verbal feedback that was incorporated as appropriate. Related outputs from the larger research project include substantive country

reports and a detailed literature review of burial practices across the three countries. A research paper synthesises the qualitative narratives with the epidemiological data used to estimate the reproductive number of unsafe burials to produce a new quantitative modelling of the impact of the SDB programme.

Methodology

The research focused on three districts in Sierra Leone: Western Area Rural, Kambia and Kailahun. Specific field sites were agreed in collaboration with the IFRC and National Society. Data collection and in-country work was conducted over 25 days in June-July 2015. Data collection sites were purposively selected according to the evolution of the epidemic and presentation of significant caseloads, and included both urban and rural areas.

The anthropology team investigated issues related to the unsafe burials identified by the epidemiological study team (reported separately), but sought to root their analysis in a broader socio-cultural and political context. A purposive sample of key informants was therefore selected for informal interview, in-depth interview and/or focus group discussion including: representatives from IFRC and Sierra Leone National Society; Red Cross SDB team members; Red Cross social mobilisers; community leaders (Paramount Chiefs, Village Chiefs, Religious Leaders, Women's Leaders, Youth Leaders, etc.); other community stakeholder groups (Funeral Home Directors, Bike Rider's Association, etc.); community members who had witnessed and /or participated in burial events; and representatives from the Ministry of Health and Sanitation, the National and District Ebola Response Centres, and District Health Management Teams. Selection of research participants was based on an individual's knowledge of community burial events and/or involvement in the SDB response. Fifteen interviews were conducted with 20 participants, and 32 focus group discussions with 188 participants. In total, the anthropological study included 208 participants (Western Area Rural, n=70; Kambia, n=42; Kailahun, n=96).

Permission to conduct the study was granted by the Ministry of Health, and all interlocutors provided their informed consent prior to their participation.

Summarised findings

Challenges and barriers to SDB

The qualitative analysis focused on a) the challenges and barriers of SDB implementation as reported by responders who participated in the study; and b) the (non-)acceptance of SDB as reported by affected communities and families. Eleven key themes emerged: 1) Ebola denial and violence toward responders; 2) notifying the SDB team and operational issues; 3) stigma; 4) physical and mental health concerns; 5) delayed burials; 6) death of a 'title holder'; 7) burial location; 8) corpse manipulation; 9) non-Red Cross burial teams: early impressions and on-going fraud; 10) quarantine homes and aid distributions; and 11) complacency. This section presents the key findings for each theme, highlighting the different perceptions of the main stakeholder groups: the responders (e.g. burial teams and social mobilisers), and the Ebola affected communities (e.g. community leaders and Ebola survivors).

Ebola denial and violence toward responders (1)

Ebola denial in EVD 'hotspot' communities

Denial that Ebola was a real disease and that it could be avoided through bodily contact was reported throughout the outbreak in West Africa. As a bike rider from Daru (Kailahun) concluded, "*Ebola is a disease that loves deniers*". The origin stories, myths and rumours that circulated in Sierra Leone, including the notion that Ebola was manufactured by foreigners to kill Africans, or that it was 'sent' through witchcraft, differed according to place, timing of the epidemic, and local practices and politics. This has been well documented elsewhere, and contributes to our understanding of how Ebola denial sparked violence towards SDB teams and social mobilisers.[1] Communities attributed their initial denial about the existence of Ebola to four key explanations: the inability to understand a 'new' disease; the early communication messages that Ebola had no cure; confusion over who survives, who dies and why; and misunderstandings about how Ebola was transmitted.

Violence towards burial teams and social mobilisers

Communities expressed confusion and anger over the presentation of Ebola, and in some cases, Ebola-denial fuelled violent confrontations between EVD responders and communities. In Sierra Leone, resistance to burial teams and social mobilisers 'intervening' in traditional care practices for the dead first began in hotspot communities in Kailahun District. Here, lingering community resentment over a 'new' disease, with no cure, was readily apparent in their narratives. If Ebola was not thought to be real, then responders were perceived as 'community outsiders' interfering in local affairs for their own gain (for example, to 'eat Ebola money', or to collect and sell African blood or organs). Against this backdrop, there were many reported occasions when burial teams and social mobilisers were prevented from accessing communities or specific households. A social mobiliser in Kailahun recalled, "*We had to lock*

[1] See Wigmore 2015, Kargbo et al 2015, Wilkinson and Leach 2014, Mark 2014, Anderson 2014, Global Development 2014, Social Mobilisation Subgroup 2014, and Fairhead 2014 for additional references on popular Ebola myths and rumours circulating in Sierra Leone.

ourselves in a room in the community for almost a day because of our safety, at that time nobody wanted to listen to us, especially when we were wearing our 'Stop Ebola' T-shirts". A burial team member in the same district explained, "*The community people would throw stones at us, and try to destroy our vehicle*". Although the EVD responders who participated in this study could easily recall specific instances of physical or verbal abuse in the initial days and months of the outbreak, they also emphasised how, in the course of performing their duties, they frequently faced more passive (and on-going) forms of community resistance, including failure to alert authorities of a death. This, and resistance to by-laws and burial protocols, is discussed further below.

Notifying the SDB team and operational issues (2)

Notifying the SDB team

Families directly affected by Ebola and in need of intervention, were largely beholden to the 'consent' or agreement of their surrounding community prior to the arrival of the response teams. Community acceptance was built on several inter-linking conditions: that Ebola was real; that suspected Ebola cases/corpses should be identified and isolated; that identified cases/corpses should be reported to the authorities [2]; that authorities should notify ambulances/burial teams of all sick/dead alerts; and that ambulances/burial teams should be allowed entrance into the community. If any of these conditions were not enacted, then Ebola affected families had little (or no) agency to accept (or conversely to deny) burial teams access to their deceased. For many affected families, it was their community leader, rather than the family themselves who made the death alert. Family members or concerned neighbours usually notified their leaders who, after investigating the sickness or death, would make the call. If community members did call 117, they often did so anonymously. Community residents who were found to have 'informed' on families by calling 117 were often the target of community shaming (particularly during the early months of the outbreak) for bringing the community unwanted attention from government and Ebola responders. Several study participants who contacted 117 to make an actual death alert described having to call the centre several times in order to convince the operator of the veracity of their alert. If the caller did not know (or was not able) to telephone the call centre multiple times, burial teams may not have been notified that a corpse needed to be collected. In particular, community leaders in Western Area Rural concluded that call centres frequently failed to notify burial teams of a legitimate death alert. As a result, community leaders who accepted SDB interventions often called their nearest Red Cross Branch Office to directly request a burial team, and preferred to use their personal contacts rather than be 'screened' by the call centre.

Operational issues

There were two key elements of the SDB protocol that were discussed by all stakeholders as major challenges for community acceptance of burial teams: the use of body bags and chlorine spray. Burial teams described the use of body bags as the most frequent cause of confrontation with families, leading to aggressive behaviour from the community, and/or attempts to bribe the burial team not to use the bag. Concerns about the use of body bags centred around six reoccurring themes. Their use was: 1) something new to Sierra Leone and frightening because it was unknown; 2) something inappropriate or forbidden ('haram') by religious law; 3) something which interfered with the natural process of decomposition; 4) something which prevented the deceased from entering heaven (Christian), paradise (Muslim) or the village of the dead (animist/traditional); 5) something which prevented proper identification and viewing of the corpse prior to saying a final goodbye; and 6) something demeaning and associated with garbage – the plastic was seen to be similar to that of a garbage bag and, when linked with the ways bodies were handled early in the outbreak, caused relatives to think their loved ones were being "*thrown away like rubbish*".

The use of chlorine solution, used to disinfect the body and contaminated areas, also caused tensions between burial teams and communities. Participants thought that chlorine was used

[2] Depending on location, 'authorities' were described as the 117 hotline, community leaders (who would contact 117), or the Red Cross.

excessively, disliked its strong chemical smell, and feared it as a cause of death or illness in itself. Burial team members also discussed the harshness of chlorine. Some were concerned that the chemical was too strong and may cause them future illness.

Stigma (3)

Different forms of stigma were reported by burial team members and social mobilisers, and by EVD affected communities and families. These issues were consistent across the three districts included in the study.

Stigmatising events experienced by burial teams and social mobilisers

- Abandonment by family (e.g. mother, father, partner, children)
- Eviction from family home/rented rooms
- Physical, verbal and spiritual abuse
- Criticised for 'eating' Ebola money and continuing the outbreak
- Refused services (e.g. transportation, food and merchandise vendors, healthcare providers)
- Prevented from entering cemetery for burials in the course of their work [women only][3]

Stigmatising events experienced by 'hotspot' communities and Ebola affected families

- Physical, verbal and spiritual abuse
- Shamed for being the cause of death(s) in their community or district[4]
- Criticised for 'eating' survivor money to the detriment of other communities/families in need
- Loss of food and livelihood as communities/individuals refused to do business
- Loss of home and community[5]
- Loss of secret society status (e.g. Poro, Sande)

Physical and mental health concerns (4)

Both physical and mental health issues were reported by the study participants. The trauma and impact on psychosocial wellbeing caused by Ebola has been well documented (IMC 2014; Cooper 2015; Omidian et al 2014), and is reinforced by the study's findings.

Burial teams

Of the burial team members who participated in this study, the average age was 29 years and the teams were made up of 95% male members. This composition was reflected across the three districts included in the study, and indeed across all burial teams in the country. In Sierra Leone, the term 'youth' is used to categorise persons up to 35 years of age. Although it was pragmatic that they be involved in burials (it was heavy, challenging work) this marked a shift away from the use of 'culturally appropriate' people usually involved in preparing the dead (elder community members, religious leaders, and society members who keep the 'secrets' of the dead) and caused tensions particularly during the earlier phases of the response. Burial team members were cognisant that they were not society's chosen handlers of the dead. They

[3] This was reported by female burial team members in reference to a cultural taboo against women entering cemeteries.
[4] 82% of the unsafe burials traced for the anthropological study were the first case of Ebola in their villages.
[5] It has been reported that some survivors moved to other areas of the county in an attempt to start anew. Having been affected by Ebola, it was too difficult for some to reintegrate into their natal villages. The research team acknowledges that some survivors were warmly welcomed by their communities (as 'heroes'), but this was not a significant finding in the study's data. As referenced in the previous footnote, 82% of unsafe burials investigated for the anthropological component of the research were the first cases of Ebola in their respective communities. In many cases, this was a highly stigmatising event, particularly if it resulted in elevated levels of morbidity and morality, unwanted attention from responders, and blame associated with negative behaviours (for example, if community members felt they had been deliberately misled by a family who produced a false Ebola negative death certificate).

described Ebola as something that had made them 'know' secrets of the dead that according to social norms they 'were not to know.' As a consequence, nightmares and spiritual sickness were concerns frequently discussed by burial team members who described 'spiritual attacks' from both the dead they had buried and living witches who disapproved of their role and/or were jealous of the perceived financial benefits they obtained during the outbreak.[6]

Community members

A 'properly' conducted funeral – however socially defined according to the age, gender, religion and social status of the deceased – is supposed to be an opportunity to provide the 'last honour' to the dead and help facilitate their acceptance to God and amongst relatives in the afterlife. Properly conducted funeral rites in Sierra Leone are as much about mediating the concerns and fears of the living, as they are about protecting the living from the recently deceased. Several families who participated in the study described feelings of shame as they perceived their relatives had been buried 'improperly' during the outbreak. Many explained anguished nightmares in which spirits of their deceased would visit the unconscious minds of their relatives, angry about the manner in which their bodies had been buried. When burial teams were delayed in responding to a death, the trauma families experienced was exacerbated, particularly when bodies started to decompose. As described further in the following section, the delayed arrival of burial teams also led to community burials, particularly among Muslim families who wanted the burial to be performed on the day death occurred.

Delayed burials (5)

Study participants attributed delays in performing burials to two main issues: logistical delays and socio-cultural delays. Logistical delays resulted from poor travel conditions (e.g. bad roads or excessive rain), and distant or hard-to-reach locations requiring burial teams to hire a motorbike or boat, or walk on foot carrying their equipment. Socio-cultural delays mainly related to issues of religion and financial concerns (e.g. debt settlement). Burial teams also experienced logistical delays if they had to wait for Ministry of Health and Sanitation swab teams to arrive at a burial location. Swab team delays may have been related to the same logistical and transportation issues burial teams faced, or (more commonly) were due to the workers striking against the government employers over lack of pay. In this way, employment issues faced by government workers also had ramifications for the operations of the Red Cross burial teams.

EVD responders and affected families expressed different opinions about what constituted a 'delayed' burial. For example, Muslim doctrine dictates that burials be performed the same day as death, so a person who dies in the morning should be buried by 2pm that afternoon. In non-Ebola times, Christian communities generally preferred to wait several days (or even weeks) after death to enable the family to collect donations to purchase funeral supplies (e.g. a coffin), and to allow relatives time to come and view the body. SDB protocol required all burials be performed within 24 hours of death. This caused pressure for the burial teams to perform SDB in a timely manner, and pressure for the family to accelerate normal funeral processes in order to meet the timescale of SDB during the outbreak.

[6] IFRC and the SLRC took the mental and physical impact of SDB work very seriously from the start of the operation. SDB teams were provided with on-going psychosocial support and access to debriefing services. A recent study, designed to identify those staff and volunteers at risk of post traumatic stress syndrome indicated that SDB teams were managing the stress of their task reasonably well and were at lower risk than some of the other cadres such as drivers and psychosocial support staff (IFRC 2015c). On-going support and reintegration back in to 'post Ebola' life will continue to ensure the impact of their experiences is limited.

Death of a 'title holder' (6)

'Title holder' is a generic term used to reference any influential person in village life such as a chief, traditional healer or secret society leader (and may occasionally be used for a higher placed political official such as a member of parliament). Across the three districts, community participants repeatedly highlighted the death of a title holder as the locus for 'super-spreading' events that produced many Ebola positive cases and/or contributed to violent and sustained conflict between communities and burial teams. Although such narratives may have been biased by the media focusing on well-known super-spreading events, local accounts broadly confirmed epidemiologically documented chains of transmission resulting from the funerals of title holders (e.g. traditional healers). Even communities who were otherwise accepting of burial teams (particularly during the latter months of the outbreak), still reported that they found it difficult to allow 'community outsiders' to handle the bodies of their leaders. Narratives from burial team members consistently highlighted challenging (and sometimes failed) negotiations with communities to perform an SDB for a title holder. They discussed communities hiding bodies and performing night burials, attempting to bribe team members, and being violent or aggressive in order to force the team to leave a community before an SDB could be performed.

Burial location (7)

Before Ebola, in most areas of Sierra Leone (particularly rural areas), bodies were routinely buried in community cemeteries or next to individual homes within easy viewing or walking distance to the village. Not knowing where a grave was located remained a point of contention between communities and Ebola response workers that may have led to resistance, both passive and aggressive. Responders continued to be frustrated by 'secret' burials in the community. From the community perspective, the way bodies were handled at the start of the outbreak continued to cause tension and a high level of suspicion about burial team operations (issues raised included the lack of information given to families on what happened to the ill/dead bodies taken by ambulances; 'lost' bodies at Ebola Treatment Units; mass graves; and concern that bodies were buried in far off locations, sometimes in other districts). Many 'hotspot' communities had intense and frequent contact with burial teams early in the response (before the introduction of SDB protocols) and experienced little or no follow-up on the status of people removed by ambulance and/or a burial teams. At the time of the study, many communities remained concerned that if they called for a burial team it would result in them not knowing where their loved one had been buried, despite the fact that SDB operations had started to perform burials within the community setting (with the exception of in Western Area Rural). During fieldwork, SDB resistance resulting from not knowing or having access to the location of deceased loved ones, and (potentially) not having experienced important changes in SDB protocols as the outbreak continued, was an issue most apparent in Kambia where the Red Cross was not the lead agency for SDB.

Corpse manipulation (8)

While external signs of bleeding were not common in the majority of Ebola cases, the virus weakens blood vessels, prevents coagulation, and the internal haemorrhaging that results can lead to multiple-organ failure and shock. Patients experience vomiting, diarrhoea and extreme weakness during the advanced stages of illness, and most are unable to move from their sick beds. This has significance for the instruction 'not to touch the dead body', a fundamental component of the SDB protocol. In Sierra Leone, the process of washing the dead is present in every ethnic and religious description of a 'proper' funeral. Being told not to wash the body of a loved one who died was hugely problematic, particularly if they died in a sick bed 'polluted' with the evidence of their illness. That some community members washed and dressed the body prior to the arrival of a burial team was universally discussed as a barrier to SDB protocol across the three districts studied, and across all social, ethnic and religious groups. Members of the burial teams were able to recall with clarity many instances (over the length of the outbreak) in which they found that a corpse had been manipulated prior to their arrival. Despite

government intervention, it was reported that even if communities resisted washing most bodies, they persisted in washing the bodies of title holders (see above).

In some (although not all) cases, the obvious washing and dressing of a corpse prior to the arrival of a burial team would be reported to the local command centre who punished families with fines, jail time and/or quarantine until negative swab results for the offenders were processed. In the case of communities known to routinely manipulate corpses prior to the arrival of a burial team, the police or military would intervene, often violently, to discourage other communities from similarly rebelling against the by-laws. While washing the body prior to the arrival of the burial team was common across all study sites, there were additional district-level influences regarding the on-going manipulation of corpses. In Kailahun, teams noted that as the number of days the district went without a positive case increased, so the practice of manipulating corpses rose. In Kambia, border communities would use the relaxed (or unenforced) laws of Guinea as a method of avoiding punishment for washing corpses or performing secret burials in the district. Ebola response workers in Kambia frequently recounted that families either argued with officials for imposing fines or jail time claiming that they were residents of Guinea, and/or would flee to Guinea (Forécariah Prefecture) to evade the by-laws of Sierra Leone (Kambia District) should they be reported to the authorities.

Non-Red Cross burial teams: early impressions and on-going fraud (9)

Early impressions

Community impressions of burial team activities were heavily influenced by how bodies were handled in the early months of the outbreak before the SDB programme was established. When discussing experiences from early in the response, communities frequently reported the activities of non-Red Cross burial teams in negative terms. Such poor impressions continued to shape community perceptions and resulted in challenges (often violent) that Red Cross burial teams had to overcome. Communities in Western Area Rural were more likely to make the distinction between non-Red Cross and Red Cross burial teams on the basis that it was thought possible to bribe a non-Red Cross team to ensure that community graves would be used instead of the designated cemetery at Bolima.

Although SDB teams in Western Area Rural and Kailahun were confident that they had successfully overcome such negative early impressions, this did not appear to be the case in Kambia. Due to the lower profile of Red Cross burial operations in Kambia, communities did not readily distinguish between Red Cross and other burial teams that used unmarked vehicles. In addition, Red Cross teams in Kambia most frequently served hard-to-access areas that presented logistical challenges for timely SDB operations and this may have made it more likely that communities would have negative opinions of the teams due to burial delays (see above). Access issues also meant that these communities were less likely to have benefited from on-going engagement with social mobilisers regarding SDB protocols. As a result, the widespread rumours that circulated at the outset of the epidemic about burial teams (e.g. disrespectful etiquette, blood and organ harvesting) left a lasting and detrimental impression that continued to influence community perceptions of burial teams in Kambia.

On-going fraud

The illegal behaviour of burial teams, swabbers and mortuary staff operating from the government mortuary at Connaught Hospital (Freetown) was a poorly kept secret. The Connaught Mortuary was known to (illegally) charge families for collecting and keeping corpses, and for providing (false) negative swab results to enable families to bury their deceased in the community or employ the services of a chosen funeral home (i.e. for a non-medical burial). During the course of the study, all stakeholder groups in Western Area Rural (burial teams, community leaders and affected families) raised the events at Connaught Hospital mortuary. From the perspective of the burial teams, the hospital's illegal activities contributed to community resistance to SDB (a burial team member explained, "*It happened even yesterday there was an alert and we went to collect the corpse. But when the team went there, the family refused to give the body to the burial team, they said that they want the corpse to be taken to Connaught and we were not permitted to take the body*"). Community leaders

and affected families provided it as an example of how the government was hypocritically forcing burial regulations on 'poor people' that they did not follow themselves. This stemmed from the popular belief that bodies accepted into the mortuary at Connaught were those of influential people (or their relatives) with either enough money or influence to avoid the by-laws.

Quarantine homes and aid distributions (10)

If an Ebola positive case was found in a home or village, families and communities feared the repercussions of quarantine, partly because of the stigma and shame associated with quarantine, but also because of economic and livelihood concerns (e.g. the inability to tend farms while under quarantine due to restricted movement). Such issues provided an incentive for people to hide their sick and secretly bury their deceased as a way of avoiding quarantine. Loss of crops has a long-term impact upon the food security of a household as each year's yield is used to seed the next year's crops. Without a good harvest, families do not have surplus food to sell, resulting in less household income, but the need to buy additional food and seeds, requiring greater expenditure. Although food was provided to quarantined households, distribution had a detrimental effect on the response. Government, non-government and international agencies who were engaged in distributing supplies to quarantined homes and Ebola survivors, particularly in hotspot areas, reported tensions with communities who questioned the 'outsiders' over: who was (or was not) eligible to receive assistance; how much (or little) assistance was provided; what types of assistance or supplies would (or would not) be given; and how those supplies were (or were not) distributed.

Complacency (11)

The issue of complacency was raised repeatedly during the study, particularly by social mobilisers who were concerned that even at the time of data collection (four months before the WHO announced that the country was Ebola free) many Sierra Leoneans were becoming relaxed in their adherence to Ebola protection measures. Although they acknowledged that complacency was a component of community fatigue with the outbreak and response, many social mobilisers felt that communities prematurely celebrated an end to Ebola (particularly in districts with no recent cases), and this caused renewed resistance towards the mandatory burial policy. Similarly, mobilisers believed that security at checkpoints decreased as officials became complacent, and that communities neglected to follow key behaviours and preventative practices such as routine hand-washing with soap or chlorine.

Summarised findings

Success and drivers to SDB

In analysing the drivers to successful SDB and the acceptance of SDB by affected communities, five key themes emerged: 1) Ebola acceptance and community allies; 2) appreciation of safe and dignified burials; 3) tstrategies and messages of social mobilisers; 4) reputation of non-violence; and 5) reduced financial burden.

Ebola acceptance and community allies (1)

Just as denial that Ebola was real helped to fuel community confusion, fear, and on occasion, violence towards burial teams and social mobilisers, acceptance that Ebola was present in Sierra Leone, that it could be transmitted through human-to-human contact, and that it caused people to die, were major factors in convincing communities to allow SDB. The most frequent explanations given by community members and survivors about why they started to believe that Ebola was real were linked to the deaths of healthcare workers early in the response, to multiple family/community deaths that may have experienced both directly and indirectly, and the return of survivors. In accepting that Ebola was real, community reticence towards burial teams and SDB may have lessened in some areas. Also, the passing of by-laws, whilst not referenced as a reason for accepting Ebola, was often discussed as a motivating factor for communities to accept burial teams, given that most people were not prepared to be jailed or fined (500,000 SLL or USD100, equivalent to an average three month's salary) for defying the burial protocols.

In Sierra Leone, some of the people most opposed to the response in the early phase were community and religious leaders and youth, but over time, these stakeholders became the strongest allies of the response. For example, the 'youth' of Koindu, were often acknowledged by research participants in Kailahun District as perpetrating the most violent opposition to burial team activities. Yet, as the epidemic peaked and communities began to self-mobilise for protection and prevention, the same youth that were 'throwing the stones' became the ones to help build MSF treatment centres, assist contact tracers in finding Ebola suspected patients, and volunteer to join burial teams and social mobilisation groups.

Appreciation of safe and dignified burials (2)

Red Cross burial teams in Western Area Rural and Kailahun were successful in overcoming the negative impressions left by the 'first' burial teams operating early in the response. Recognising the need for the burial teams and acknowledging their good practice were drivers that led to community acceptance of SDB. Before providing a candid critique of burial team activities, many community leaders who participated in the study, would emphasise their gratitude to the Red Cross in terms of their service to the community and nationally. Appreciation of the SDB protocol changes implemented by the Red Cross focused primarily on three key areas: allowing a member of the family to dress in PPE in order to observe the team

and/or participate in dressing a corpse; using 'kasanky' (white cloth Muslims use for wrapping the dead) or dressing the corpse 'in their nice clothes' (e.g. a suit or dress as preferred by Christians); and giving the family time and space to grieve and/or pray over the body. During the study, knowledge of the new protocols implemented by Red Cross burials teams was most apparent during interviews with surviving family member(s) who had been involved in performing an unsafe burial, and were later exposed to the acceptable actions of the Red Cross burial teams.

Strategies and messages of social mobilisers (3)

As discussed above, some of the people who most opposed responders early in the outbreak, later became some of its strongest allies. The dedication and perseverance of social mobilisers in spreading Ebola awareness messages and negotiating on behalf of the burial teams, played a large role in this transition, particularly in more resistant communities. The messaging to counter misconceptions and strategies successfully employed by Red Cross social mobilisers clearly illustrate their ability to 'put on the shoes' of the communities in which they worked (see Table 1). Social mobilisers reported that some of the most successful communication strategies employed included: the utilisation of community leaders to gain safe entrance to communities (e.g. Paramount chiefs, village chiefs); direct and personal communication (e.g. house-to-house visits, focus group discussions); sensitisation messages first delivered by social mobilisers to their 'peers' in the community to cascade to others (e.g. religious leaders, TBAs, secret society members); the utilisation of elder community members with personal experiences of Ebola; reaching adults through children; and using music, drama and dance to clarify and reinforce the printed communication materials (posters, flyers etc.). These messages and strategies should not be viewed in isolation, but instead as a series of cumulative events that helped communities understand the reality of Ebola, and facilitated the activities of SDB team members.

Table 1 – Messaging to counter misconceptions

Misconception	Counter Message
Ebola is not real. The government is lying.	Listen to the medical professionals. If you want to know about building tables, listen to a carpenter. If you want to know about Ebola, listen to medical professionals. "Would you ask a doctor to build you a table?"
Ebola is not real. First they told us don't eat monkey, and then they said don't touch other people.	The message is the same: don't touch things that might be dangerous. You don't know where the monkey you eat comes from, and you don't know where the people you touch have come from.
Ebola is not real. White people manufactured Ebola to kill us.	White people make the medicine we buy in the pharmacy to help us.[7] If they wanted to kill us they could just poison the drugs.
It is an act of love to care for the sick. It is impossible for me not to touch.	Is it not also an act of love to prevent others from death?
It is safer to treat Ebola at home with local remedies.	We know that if you boil guava leaves in water it is a solution to diarrhoea, but now you can see that it is not working. It is not stopping Ebola because this is a different disease and all these medicines you have been using before can't stop Ebola.
Chlorine kills.	Look at the burial teams. Nobody is sick and they deal with chlorine and Ebola dead everyday. It is the chorine that is protecting them.

[7] Pills and tablets are commonly referred to as 'Queen's medicine' in Sierra Leone in reference to their colonial ties to the UK.

Reputation of non-violence (4)

Red Cross operations in Sierra Leone have a long history and the organisation is well known for the assistance it provided during the country's civil war (the 'rebel war'). As a community leader from Kailahun confirmed, "*During the rebel war they were training people to give first aid treatment and also transport the war wounded*". Ebola was frequently referred to by both response workers and affected communities as 'yet another war' that Sierra Leone had been forced to fight. Red Cross methods of engaging communities (often in contrast to non-Red Cross burial teams) were universally recognised by Red Cross burial teams, social mobilisers and community leaders as fighting the Ebola war through non-violent means. This finding was most apparent in Western Area Rural, where numerous violent clashes had resulted from the interventions of non-Red Cross burial teams, the military and the police. It was telling that although Red Cross burial teams were required to notify their command centre of illegal activities such as corpse washing or community resistance (thus alerting police or military), community leaders would rarely blame the Red Cross for the resulting actions, concluding instead that they were 'only doing their jobs'.

Reduced financial burden (5)

Although not as prominent in community narratives as the other drivers of SDB acceptance, the reduced financial burden of performing funerals during the outbreak was noted by both burial teams (who had been thanked by families for helping to alleviate their financial commitments) and community leaders. Reduced financial responsibilities were most commonly related to the 'sacrifice' ceremonies that would normally occur after death in Muslim communities. This ceremony involves the careful preparation of food (often the slaughter or 'sacrifice' of a chicken, goat or cow depending on the family's financial status) to be distributed amongst the deceased's community and network of friends and family. Because they were considered a public gathering, such ceremonies were forbidden by the country's by-laws, and in accepting SDB, families did not have to bear the major financial expenditure that funerals usually cost.

Conclusion & recommendations

Safe and Dignified Burials was a fundamental EVD control measure and an integral part of reducing EVD transmission in West Africa. The anthropological study reported here considered 'impact' as a process (rather than a product) of engagement (Baim-Lance and Vindrola-Padros 2015). This approach recognises SDB as a comprehensive public health measure, which maximises impact when it addresses cultural practices, with an emphasis on community education and engagement.

Participants of this study made recommendations about SDB in Sierra Leone, suggesting how future public health initiatives may have a greater, more positive impact on local communities. Nine key recommendations were shared and validated with members of the IFRC and National Societies during the feedback workshop held at the conclusion of in-country data collection.

- Increase support for social mobilisers as trusted 'insiders' in their communities able to deliver health promotion products and information. In addition to supporting social mobilisers during an outbreak, support for increased preparedness and for post-outbreak activities is also required, reaffirming the importance of hygiene for preventing future disease outbreaks.

- Increase collaboration between international aid agencies, NGOs and the Government of Sierra Leone so that all key actors have a defined role and follow agreed procedures to reduce fraud and other illegal activities that occurred during the outbreak (e.g. illicit burial teams and mortuaries).

- Provide EVD protection training (and protection materials) to religious leaders and respected community elders who normally perform the role of corpse washing, body preparation etc.

- Improve communication to EVD-affected communities about what happened to their relatives who were taken out of the community, either by ambulance or by burial teams.

- Provide on-going capacity building and skills training for SDB volunteers (social mobilisers, burial team members, etc.) to develop and maintain a strong cadre of emergency support staff who can be rapidly deployed to respond to future outbreaks.

- Engage key stakeholders in emergency planning and response efforts so that they may engage communities, calm community fears, pave the way for burial teams, increase community acceptance of infection control efforts, etc. Key stakeholders should include religious leaders, traditional healers and a diverse grouping of political representatives (i.e. political leaders who represent both the central government and opposition party) who could also be mobilised as part of community-based surveillance.

- Provide psycho-social support and resources to EVD-affected families and survivors (particularly orphans) to help them manage the on-going ramifications of Ebola, reduce community stigmatisation, and serve as a reservoir of knowledge for their communities.

- Enable communities to perform reparation rituals for the dead (post-Ebola) so that communities can ask their relatives to forgive the way their bodies were buried during the outbreak and ensure their entrance into paradise/placement with ancestors. Facilitating such rituals may involve financial support.

- Focus on 'overall' community health needs to create stronger and more resilient communities, even in times of emergency response (e.g. interventions should also address issues of water, hygiene and sanitation, and contribute to the sustainable health system strengthening).

Bibliography

Anderson, Mark (2014). Ebola Myths: Sierra Leonean DJ Tackles Rumours and Lies Over the Airways. The Guardian (October 9, 2014) http://www.theguardian.com/global-development/2014/oct/09/ebola-myths-sierra-leone-dj-tackles-rumours (accessed 11 December 2015)

Baim-Lance, A. and C. Vindrola-Padros (2015). Reconceptualising "Impact" through Anthropology's Ethnographic Practices. *Anthropology In Action*, 22: 5–13. doi:10.3167/aia.2015.220202.

Cooper, Janice L. (2015). Mental Health and Psychosocial Support in the Face of Ebola in Liberia: The Personal and Professional Intersect, A Personal Account. Intervention 13(1): 49-57.

Fairhead, James (2014). The Significance of Death, Funerals and the After-Life in Ebola-Hit Sierra Leone, Guinea and Liberia: Anthropological Insights into Infection and Social Resistance (Draft). Ebola Response Anthropology Platform.

Global Development (2014) Ebola in Sierra Leone: Myths and Misconceptions. The Guardian (August 9, 2014) http://www.theguardian.com/global-development/2014/aug/09/ebola-sierra-leone-myths-misconceptions (accessed 11 December 2015)

IFRC (2015a). IFRC Ebola Operations Update. International Federation of Red Cross and Red Crescent Societies.

IFRC (2015b). International Red Cross and Red Crescent Movement: Ebola Strategic Framework. International Federation of Red Cross and Red Crescent Societies.

IFRC (2015c). Helping Ebola Responders in Sierra Leone Cope with the Emotional Impact of Their Jobs. http://www.ifrc.org/en/news-and-media/news-stories/africa/sierra-leone/helping-first-responders-in-sierra-leone-cope-in-continued-ebola-emergency--68774/ (accessed 11 December 2015)

International Medical Corps (IMC) (2014). Assessment of Mental Health and Psychosocial Support (MHPSS) Needs and Resources in the Context of Ebola: Lunsar, Port Loko District, Sierra Leone (December 2014).

Kargbo, Alpha Umar, Christiana Sam, Jack Frith-Powell, and Simone Carter (2015). Summary of Research Findings to Date: A Quick Write up for Port Loko Teams. Unpublished document.

Mark, Monica (2014). Thankless, Dangerous – The Task of the Ebola Burial Boys in Sierra Leone. The Guardian (September 4, 2014) http://www.theguardian.com/society/2014/sep/04/ebola-kailahun-sierra-leone-burial-boys-west-africa (accessed 11 December 2015)

Omidian, Patricia, Kodjo Tehoungue, and Josephine Monger (2014). Medical Anthropology Study of the Ebola Virus Disease (EVD) Outbreak in Liberia/West Africa. World Health Organization.

Social Mobilisation Subgroup (2014). Current Rumours, Incorrect Information, Knowledge Gaps, and Challenging Attitudes within the Target Population. Ebola Outbreak Sierra Leone: Social Mobilisation Subgroup (June 17, 2014). Unpublished document.

Wigmore, Rosie (2015). Ebola and Rumours in Sierra Leone: Contextualising Ebola Rumours from a Historical, Political and Social Perspective. MA thesis, Department of Social Development, University of Sussex.

Wilkinson, Annie and Melissa Leach (2014). Briefing: Ebola – Myths, Realities, and Structural Violence. African Affairs: 1-13.

International Federation
of Red Cross and Red Crescent Societies

Anthrologica

SIERRA LEONE RED CROSS SOCIETY