

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

Summary findings  
from the anthropological study Liberia



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

December 2015



# 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  
Hilary Kagume Njenge, Emergency Health Delegate & Co-investigator  
Dr Dewindra Widiamurti, Emergency Health Coordinator & Planner  
Linette Tariro Jonhera, PMER Delegate & Planner

## **Liberian Red Cross National Society**

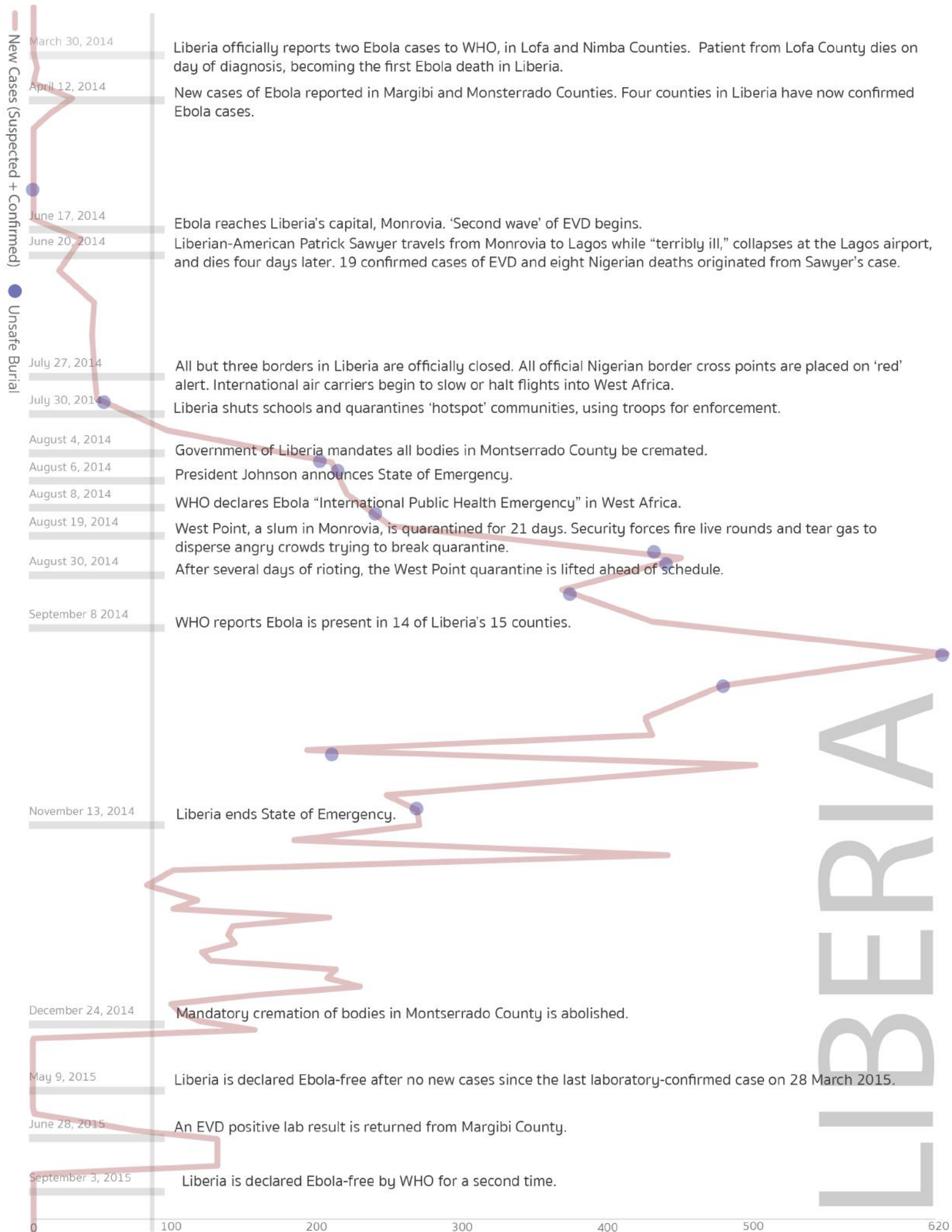
Elken Gondea, Health Officer, Field Guide, Planner & Facilitator  
Angeline Togba Roberts, Health Officer, Field Guide, Planner & Facilitator  
Roselyn Nugba-Ballah, SDB Coordinator, Field Guide, Planner & Facilitator  
Jackson S. Wankah, Montserrado Chapter Field Officer, Field Guide & Planner  
Neima Candy, Health and Care Coordinator & Planner  
Cytirus Kerbay, Recovery Programme Focal Point & Planner  
Amara Kenney, PMER Coordinator & Planner

Sincere thanks are extended to Anthrologica research assistants Deimah Kpar-Kyne and Anthony Kimba, and to Anthrologica intern Sylvia Lim who contributed to the initial literature review.

# Content

Timeline.....	4
Introduction .....	5
Research objectives and reporting.....	5
Methodology.....	6
Challenges and barriers to SDB.....	7
Ebola myths, denial and violence toward responders .....	7
SDB team organisation, community approach and operations.....	8
Cremation, violence, community death and secret burials.....	9
EVD ‘swab’ results and contact tracers .....	10
Delayed burials.....	11
‘Responsible for the dead, not living’ .....	12
Stigma .....	12
Quarantine conditions.....	13
Success and drivers to SDB .....	14
SDB training and the end of cremation.....	14
End of cremation .....	14
Strategies and messages of social mobilisers .....	14
Reduced financial burden .....	15
Conclusion & recommendations .....	16
Bibliography .....	17





LIBERIA

# 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. To date, 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).<sup>1</sup>

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.

On 23 July 2014, the IFRC and Liberian Red Cross (LRC) signed a memorandum of understanding with the Liberian Ministry of Health to coordinate all burial activities in Montserrado County, particularly in the greater Monrovia area where 75% of EVD-related infections had occurred (Allen et al 2015; IFRC 2014a, 2015c). Global Communities (NGO) was designated the burial team lead for all other counties in Liberia. During the height of the epidemic IFRC/LRC had 12 burial teams in operation in Montserrado County. In November 2014, Global Communities also began working in Montserrado County alongside LRC teams, and had six burial teams in operation. Due to the lack of suitable sites in which to bury the large number of bodies, and initial concerns over the high water table, the government deemed cremation a necessary measure in Montserrado County during the early phase of the outbreak. This policy was suspended in December 2014

## 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'

---

<sup>1</sup> Not all bodies collected meet the Ebola case definition. All community deaths are managed as potential Ebola-related deaths until proven otherwise accounting for significantly more bodies being 'managed' than recorded Ebola deaths.

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 Montserrado County in Liberia. Specific field sites were agreed in collaboration with the IFRC and National Society. Data collection and in-country work was conducted over 15 days in 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: from IFRC and Liberia National Society; Red Cross SDB team members; Red Cross social mobilisers; community leaders (town chiefs, clan chiefs, religious leaders, youth leaders, etc.); other community stakeholder groups (funeral home directors, cemetery directors, etc.); and community members who had witnessed and /or participated in burial events. 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 fourteen focus group discussions with 61 participants. In total, the study included 81 participants.

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. Eight key themes emerged: 1) Ebola myths, denial and violence toward responders; 2) SDB team organisation, community approach and methodology; 3) cremation, violence, community death and secret burials; 4) EVD 'swab' results; 5) delayed burials; 6) 'responsible for the dead, not living'; 7) stigma; and 8) quarantine conditions. 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 myths, denial and violence toward responders (1)**

According to residents in urban Montserrado, the first messages about Ebola that they remember hearing was that a 'new' disease had emerged in Lofa County (bordering Sierra Leone and Guinea); that they needed to stop 'strangers' coming into their communities; stop eating bats and monkeys; and stop touching each other. These strange and seemingly disconnected messages were interpreted in a variety of locally specific ways, yet all had a detrimental impact as local interpretations often ran counter to burial operations.

Denial that Ebola was a real disease and that it could be avoided through bodily contact was reported throughout the outbreak in West Africa. The origin stories, myths and rumours that circulated in Liberia, 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.<sup>2</sup>

In order to better understand the tenure and tone of resistance in Montserrado County, and the impact this had upon SDB operations in particular, it is important to highlight the two primary Ebola myths in circulation: that Ebola was a man-made disease created by the government and/or the international community for financial gain; and Ebola was not a real disease, only the combined signs and symptoms of other common illnesses in Liberia (e.g. malaria, headache, fever) or a curse 'sent' to an individual by a witch.

The most violent resistance EVD responders faced in 'hotspot' communities in Montserrado County related to the first myth. Here, the timing of the 'second wave' of the epidemic in Montserrado County was key. Before Ebola reached the urban regions of Western Liberia it circulated with low reproductive numbers in Lofa County from March-May 2014. This was typically referred to as Liberia's 'first wave' of EVD. The 'second wave' struck Montserrado County in June 2014. When Ebola was seen to 'jump' from Lofa to Montserrado, it confirmed

---

<sup>2</sup> 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.

the suspicions of many who accepted that Ebola was a reality, but perceived it to be a 'new' disease that was man-made. What else would explain the 'coincidence' of a virus jumping from one location to another, hundreds of kilometres away, just when the flow of international dollars into the county was starting to decline? People regarded Ebola as a government ploy to ensure the flow of money, and populous Monrovia was the obvious next target. The power of this myth was reinforced by the lack of communication urban residents received about the ongoing outbreak in Lofa during the spring of 2014, so when the virus travelled to Monrovia, the government were blamed for introducing the virus into a heavily populated urban location for monetary gain.

Linked to this myth was the belief that any 'stranger' to a community, such as an ambulance or burial team, were deliberately bringing the virus into their community under the cover of providing services. Similarly, healthcare workers were seen to expose communities to the virus by setting up Ebola treatment centres, which were likely to bring infectious 'strangers' into their area. If Ebola was perceived as a government-sent sickness, then responders were not regarded as people helping their community, but strangers purposefully bringing the virus in order to continue the outbreak (and therefore continue the influx of international money). Rather than following the recommended protection measures (which were also treated with suspicion), communities tried to avoid Ebola by avoiding those who were telling them about the virus. In this way, the violent clashes that occurred can be interpreted as frightened communities trying desperately to protect themselves from infection.

Individuals and communities who believed in the second myth (that Ebola was not a real disease, only the combined signs and symptoms of other common illnesses in Liberia, or a curse 'sent' by a witch) were likely to engage in more passive forms of resistance, hiding the sick and performing secret burials for example. People did not believe that their relative had died from Ebola, and wanted to avoid the indignity of a medical burial or cremation.

Distinguishing between how Ebola messages were received, interpreted and understood is important and provides the context for why different communities rejected EVD responders, including burial teams and social mobilisers, in different ways and at different times. It should also be noted that belief in one myth did not necessarily preclude belief in another. Individuals who had participated in unsafe burials and had lost many family members because of the virus, would often describe how they had believed that Ebola was a real (albeit man-made) disease, but would deny that their friends or relatives had contracted Ebola. This complexity resulted in the manifestation of active forms of resistance (against EVD responders coming into the community unnecessarily and bringing elevated risk) and passive forms of resistance (hiding the signs and symptoms of the virus). It was telling, that even at the time of this research, when Liberia had been declared Ebola free, the first myth (that Ebola was a man-made disease created by the government and/or the international community for financial gain) was persistent, and was clearly articulated by several participating families who had been directly affected by EVD.

## **SDB team organisation, community approach and operations (2)**

### **Burial team approach to communities**

Due to intense community resistance to burial team activities in Montserrado during the height of the epidemic and the pressure burial teams felt to collect as many corpses as possible per day, team members described a strategy of only dealing with the deceased's immediate family. They felt that engaging with angry community members not only delayed their work thereby putting community members at greater risk of exposure to the virus, but the risk of violence against the team also increased the longer they remained in the area.

Challenges associated with adequately covering a county as large as Montserrado were also discussed by burial team members. At least at the start of the response, teams were not assigned to any specific location and were often unfamiliar with the areas and communities in which they were required to work. Team members felt that this made it easier for families and communities to mislead them, hiding how many deaths had occurred in the same household and potentially sheltering other symptomatic individuals.



In discussions with community leaders, many concluded that if they had been advised in advance that a burial team was coming to their area, they would have been better able to facilitate their smooth arrival and community cooperation. Instead, the lack of knowledge about burial team's activities and limited communication, again at the start of the response, were acknowledged as major barriers to building effective trust. Leaders also highlighted that because many different burial teams with revolving team members would come to their area over time, the community was prevented from getting to know a particular team.

### **Operational issues**

In addition to issues of cremation, discussed below, there were two key elements of the SDB operations that were raised as major challenges for community acceptance of burial teams: mass graves or multiple bodies per grave; and the use of chlorine solution. Community participants emphasised how disturbing and disrespectful it was to see more than one person laid in a grave, particularly because there is a strong cultural taboo against opposite sex, non-married relatives touching after death. Before the period of cremation began in August 2014, the use of single graves for multiple bodies was a concession to having many bodies to bury, in limited space and under severe time pressures. Communal graves were used by a limited number of non-Red Cross burial teams during the early phase of the outbreak.

Communities perceived spraying individuals (particularly children) with chlorine solution to be highly disturbing. The scenario in which people leaving an Ebola suspected house were sprayed by the burial team was repeatedly described by participants. They associated chlorine with the decontamination of the deceased, and feared that it was the chlorine solution itself that may spread the virus and/or cause death.

## **Cremation, violence, community death and secret burials (3)**

Cremation was known collectively as 'burning bodies' or the 'Indian way' – phrasings which implicitly reject the practice as being un-Liberian and unacceptable. On the order of the Office of the President, cremation was mandatory for all corpses in Montserrado between August and December 2014. In discussions, however, community participants most often associated the Liberian Red Cross and Global Communities as being responsible for cremation. When community members commented that '*they* were burning the bodies', they most often referred to these organisations (rather than the government).

### **Cultural abhorrence to the practice of 'burning bodies' was discussed on multi-levels:**

Cremation remained one aspect of Ebola time that Liberians found it incredibly difficult to discuss. When it was, the cultural abhorrence to the practice of 'burning bodies' was manifested in several ways.

- Recognition that prior to Ebola cremation had never been a cultural tradition of Liberia
- Confusion over how a burned body could enter the afterlife
- Sadness and anger that families would have no grave to visit for Decoration Day<sup>3</sup>
- Horror over reports about how bodies were treated disrespectfully at the crematorium
- Rumours that cremation was a tactic for government/NGO financial gain
- Rumours that bodies taken for cremation were part of an induction ceremony for a secret 'medical' society, and/or that organs would be removed and sold or used for medical experiments.

### **Increase in community violence**

The impact of cremation upon burial teams and social mobilisers was intense. In the latter months of 2014, resistance to cremation often led to violent and aggressive behaviour directed

---

<sup>3</sup> A Liberian national holiday occurring the second Wednesday in March where friends and relatives can clean and decorate the graves of loved ones.

towards EVD responders when they would enter a community to run sensitisation activities or retrieve a corpse. Burial teams were respectful of, and grateful to, the important role their beneficiary communicator ('ben com') colleagues performed during corpse retrieval, but suggested that regardless of the skill and competency of the social mobilisers, negotiating with families and community leaders during the early phase of the response was an impossible task because of cremation. Team members commented that having to answer or evade probing questions from family members about what would happen to the body of their loved ones was challenging and traumatic, and some felt they had to conceal the truth to avoid being attacked. Community participants reported that they gained information about cremation procedures from rumour and observation, rather than directly from burial teams.

Cremation also resulted in additional logistical challenges and time delays for the burial teams as they often had to wait for a police escort to accompany them for community corpse retrieval. In addition, the crematorium was located outside Monrovia and the travel time was long, particularly during heavy traffic (despite the police escort). Because there was only one crematorium in Liberia, there was often a delay of several hours (or even days) for the bodies to be offloaded, and from August to October 2014, there was a backlog of bodies that had to be dealt with using limited resources.

### **Increase in community death**

In addition to the collapse of Liberia's healthcare system and the refusal by some healthcare workers to treat potential EVD patients, the period of cremation frustrated the efforts of social mobilisers to convince communities to seek medical care for those experiencing signs and symptoms of Ebola. The arrival of EVD responders to any community (regardless of whether they were ambulance/medical staff or burial teams) was a signal that someone was going to be 'taken'. In the early phase of the response, there were limited communication loops with communities, and many individuals who were 'taken' never returned with families remaining uncertain as to where their relative had gone. This lack of information greatly fuelled the fear communities experienced and made them more reluctant to report sick and death alerts. In taken communities on where and how their deceased were being taken, fuelled this fear.

### **Increase in secret burials**

For the majority of research participants in Montserrado, the issue of cremation led to discussions of 'secret' or 'illegal' burials. EVD affected communities and responders both reported that once it became common knowledge that bodies in Montserrado were being cremated, the number of secret burials increased as families of the deceased were prepared to engage in highly risky behaviour to avoid having their relatives burnt. Burial team members could easily recount details of numerous secret burials that had to be investigated during the period of cremation. In addition, it was reported that some families would move the body of the relative to neighbouring counties where cremation was not being practiced.

## **EVD 'swab' results and contact tracers (4)**

Prior to preparing a corpse for removal, it was mandatory for the burial team to take an oral 'swab' so the body could be tested for EVD. While communities knew the purpose of the oral swab and usually accepted that it was necessary, there were misunderstandings about the timing of when the swab was taken (complicated by community knowledge and experience of different protocols used earlier by the Ministry of Health) and the lack of communication about the test result. Families wanted an immediate 'on-the-spot' confirmation of EVD status, the implication being that if the test result was negative they should be allowed to perform the burial themselves. Community leaders were also frustrated by the lack of follow-up after a potentially infectious corpse had left the village as they were left not knowing the status of their community member(s). In Montserrado, because it was the Red Cross burial teams that took the swab, they were implicated as the organisation that failed to provide families and communities with the result, and were accused of taking bodies without first providing proof of Ebola.

Communities also expressed confusion about the role of Red Cross volunteers who were working locally as contact tracers. When a death alert originated in an area where a volunteer was known to be based (a common occurrence in urban hotspot locations), the contact tracer would often be the first to arrive at the house to make sure the death alert was legitimate and (if possible) to lock the door of the room/house where the body lay until the burial teams could arrive for SDB.<sup>4</sup> During the height of the outbreak when burial teams were overstretched and the communication mechanism of reporting a death alert and dispatching a burial team did not always function rapidly, it sometimes took three or more days for a burial team to respond. In these circumstances, the role of the national volunteer in preventing access to the body likely saved many lives. Their prompt arrival on-site, however, also triggered confusion as family members often thought they were there to 'test' the body and communicate the results to the burial teams so that if positive, the Red Cross team would perform the burial, and if negative, the family would be allowed to. Several burial team members recounted how, upon arrival in a community, residents would ask if they were the 'testing team'.

When and how test results would be communicated to families was a real concern not only for communities but also for burial team members. As the outbreak progressed and families were still not rapidly informed of swab results, the lack of information was a source of renewed anger and frustration directed towards the LRC. According to several stakeholders, non-communication of negative EVD test results was a deliberate strategy during the period of cremation in order to reduce the risk of violence against burial teams.

## Delayed burials (5)

EVD affected families and community leaders who participated in the study reported that, during the height of the epidemic, it took burial teams an average of three to four days to retrieve a body (and in some cases, up to two weeks). As described above, many of these time delays were attributed to the crisis Montserrado faced from August to October 2014 when there were too many bodies for the teams to respond to rapidly. Several participants confirmed that they had buried their relatives themselves after waiting multiple days for the burial team to arrive. In addition to the volume of bodies during the height of the outbreak, participants discussed additional internal and external factors that contributed to the delay of SDB operations.

### Internal delays

Red Cross volunteers highlighted that internal delays were caused by insufficient supplies. Particularly during the early phase of the outbreak (June-September 2014), there was a lack of PPE for team members, they were dependent on rented vehicles, and lacked adequate funding for fuel. There were also human resource challenges associated with recruiting emergency staff, particularly technical staff, to provide surge capacity. This was a problem for many agencies, however, not only the Red Cross.

### External delays

Community members and EVD responders also highlighted a range of external factors contributing to burial delays including: challenging travel conditions (e.g. bad roads, excessive rain) and distant and hard-to-reach locations requiring walking through swamplands or hiring a canoe; political pressure to ensure the collection of the bodies of influential or government connected officials were prioritised above daily burial procedures; and socio-cultural delays related to religious beliefs and the influence of funeral homes.

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

---

<sup>4</sup> 'Fake' death alerts to the Ebola hotline ('4455') were common during the height of the urban outbreak.

performed within 24 hours of death. As a predominantly Christian country, Red Cross staff and burial teams reported that families would delay making a death alert (sometimes by several days) whilst trying to gather the financial resources required for a proper funeral ceremony. If they had the resources, families would attempt to preserve the corpse during this period by calling funeral homes or known 'embalmers' to preserve the body. If they could not afford an embalmer, some would attempt to preserve the body themselves by pouring liquor or beer down the throat of the deceased.

## 'Responsible for the dead, not living' (6)

The healthcare system in Liberia was unable to adequately respond to the outbreak, and issues such as the weak ambulatory system, healthworkers refusing to treat patients, lack of equipment and training etc. resulted in widespread community anger that the government and international agencies appeared 'to care more about the dead than the living', a finding that has been well documented elsewhere (Abramowitz 2014; Peters 2014; Omidian et al 2014) and was broadly corroborated by this study. This sentiment also highlighted community perceptions about the response time of SDB teams in the latter months of 2014 and throughout 2015, and the additional psychological demands the prolonged response had upon burial teams.

As discussed above, multiple-day delays in burials as a contributing factor to community resistance and local justifications for unsafe burials, was undisputed by all stakeholders. As the crises period in dead body management waned and the backlog of corpses became more manageable, however, burial teams were increasingly able to respond to death alerts within the recommended 24-hour period. This shift was acknowledged by both burial teams and community leaders who reported that there was a noticeable decrease in the time it took for burial teams to respond to a death from the end of 2014 onwards.

In terms of infection control, a rapid burial was positive. Without a reciprocal increase in response time from government ambulance services, however, the faster response times of burial teams then contributed, in many cases, to renewed community frustration that the Red Cross appeared to care more about the dead, than the living. It is important to note that whilst communities could often recall who the burial teams that operated in their community were affiliated with (e.g. Red Cross or Global Communities), they did not distinguish burial team operations from wider response efforts (e.g. ambulance services for transporting the sick). Therefore, if one organisation or entity was perceived as failing in their responsibilities, all were implicated. The inability of ambulance services or hospitals to care for the ill was also a source of trauma to EVD responders who felt conflicted over 'leaving sick patients behind' and only collecting dead bodies.<sup>5</sup>

## Stigma (7)

Different forms of stigma were reported by burial team members and social mobilisers, and by EVD affected communities and families in Montserrado County. To some burial team members, the challenges faced in the course of their work actually motivated their service to overcome Ebola, '*My response to those who taunt us is that only us Liberians can fight this disease*'. However the stigma that individuals and Ebola affected communities faced led people to hide sickness, hide bodies and perform secret burials in order to avoid the associated stigma of Ebola, and frequently frustrated SDB efforts.

---

<sup>5</sup> IFRC and the LRC 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 indicate 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. On-going support and reintegration back in to 'post Ebola' life will continue to ensure the impact of their experiences is limited.



### **Stigmatising events experienced by burial teams and social mobilisers**

- Abandonment by family (e.g. mother, father, partner)
- Eviction from family home/rented rooms
- Physical, verbal and spiritual abuse
- Criticised for 'eating' Ebola money and continuing the outbreak
- Refused services (e.g. food and merchandise vendors)
- Inability to return to pre-Ebola employment/social activities once completing SDB service
- Misconceptions of personal habits.

### **Stigmatising events experienced by 'hotspot' communities and EVD affected families**

- Verbal and spiritual abuse
- Shamed for being the cause of (community, district) deaths<sup>6</sup> and the cause of quarantine
- Loss of food and livelihood as communities/individuals refuse to do business
- Denied access to community water pumps
- Shamed for calling the burial teams (particularly leaders and social mobilisers).

## **Quarantine conditions (8)**

Burial teams and community members discussed the negative impact of quarantine, particularly during the early months of the outbreak. Quarantine contributed to the impression that the government cared more about 'guarding' the sick, rather than caring for them. Many were critical of quarantine conditions, including the way food and other aid was distributed, and it was suggested that the risk of being quarantined was a motivating factor for people to hide their sick and dead from EVD responders. In this way, quarantine also acted as a barrier to SDB.

---

<sup>6</sup> The unsafe burials followed for this research were often the first case of Ebola in their villages.

# Summarised findings

## Success and drivers to SDB

In analysing the drivers to successful SDB and the acceptance of SDB by affected communities, four key themes emerged: 1) SDB training; 2) the end of cremation; 3) strategies and messages of social mobilisers; and 4) reduced financial burden.

### SDB training and the end of cremation (1)

Burial teams spoke with pride about the training they had received from the Red Cross. This was particular evident in terms of the SDB protocol that they felt provided them with the necessary tools to 'negotiate' with families. The inclusion of beneficiary communicators, case investigators and swabbers was highlighted as a major component in helping teams to successfully conduct SDB and protect communities from future transmission.

### End of cremation (2)

Community participants were clear that the end of cremation and the corresponding opening of the Disco Hill was a driving force in the acceptance of burial team interventions, and encouraged people to stop hiding bodies.

### Strategies and messages of social mobilisers (3)

The dedication and perseverance of social mobilisers in spreading Ebola awareness messages and negotiating on behalf of the burial teams played a significant role in decreasing tensions with communities. Red Cross mobilisers were articulate that Ebola was a virus that did not 'pick and choose' its victim, but affected everyone. The messages and strategies that were successfully employed by Red Cross social mobilisers clearly illustrate their ability to counter the strong resistance they encountered working in many the communities (see Table 1). The mobilisers who participated in the study reported that some of the most successful communication strategies employed included: the utilisation of community leaders to gain safe entrance to communities and encourage community participation; direct and personal communication (e.g. house-to-house visits, focus group discussions); and the use of local volunteers who spoke local languages and could talk to 'their people' in a way that would be easily understood and trusted. 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 – Messages of social mobilisers to counter misconceptions

<b>MESSAGE</b>
<p><b>1. It is not a normal illness if an entire family dies in a short period of time.</b>  <i>“One way that I try to convince people to believe Ebola is real is that I ask them: have you ever seen a sickness that will kill a mother, father, brother, sister and relatives that live in that house the same week? I then try to explain to them that the virus is real and it kills faster than any other sickness that we have known in Liberia.”</i></p> <p style="text-align: right;">Social mobiliser, New Kru Town (Fundaye)</p>
<p><b>2. It is not a normal illness if the signs and symptoms come on very strong, very quickly.</b>  <i>“I would say if you have a headache before Ebola and you take pain tablet, it will subside but Ebola headache is very painful and cannot stop with just the pain killers we have in the pharmacy; it needs medical treatment to go away.”</i></p> <p style="text-align: right;">Social mobiliser, West Point</p>
<p><b>3. Even if you suspect sorcery as the cause of illness, go to the medical facility first to be sure.</b>  <i>“I always encourage people that I speak with to seek medical advice first and if the doctor says he cannot treat that illness then you can take your patient to the spiritualist or the herbalist.”</i></p> <p style="text-align: right;">Social mobiliser, New Kru Town (Central)</p>

## Reduced financial burden (4)

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. Many participants discussed the importance of performing a ‘proper’ Christian funeral for the deceased, although details about how a proper funeral was conducted was dependent on a family’s ability to pay. Burial teams members recounted several instances in which family members argued with their relatives to advocate for SDB in order to avoid the financial burden of a funeral ceremony. Once cremation had ceased and communities were aware that cemetery burials were being performed, burial teams used the free burial services they provided as a method to encourage family acceptance of SDB.

# 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. Seven 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.
- Provide EVD protection training (and protection materials) to religious leaders, respected community elders and funeral home directors 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. Retrospective information sharing was also requested post-Ebola (e.g. to inform families about the results of the swab so they would know if their relative had / had not been Ebola positive).
- 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. Participants also requested on-going research to better understand the longer-term impact of Ebola on both mental and physical health.
- 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

Allen, Denise Roth, Romel Lacson, Amos Gborie, Manisha Patel, and Michael Beach (2015). Understanding Why Ebola Deaths Occur at Home in Urban Montserrado County, Liberia: Report on the Findings from a Rapid Anthropological Assessment December 22-31, 2014. CDC. Unpublished Powerpoint.

Abramowitz, Sharon Alane (2014). How the Liberian Health Sector Became a Vector for Ebola. *Fieldsights - Hot Spots*, Cultural Anthropology Online, October 07, 2014, <http://www.culanth.org/fieldsights/598-how-the-liberian-health-sector-became-a-vector-for-ebola> (accessed 11 December 2015)

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.

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).

Government of Liberia (2008). 2008 National Population and Housing Census: Preliminary Results. Liberia Institute of Statistics and Geo-information Services (LISGIS). Monrovia: Liberia.

IFRC (2014a). Liberia: EVD Outbreak. International Federation of Red Cross and Red Crescent Societies.

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

IFRC (2015b). Red Cross Concludes Safe and Dignified Burials in Liberia. Geneva: International Federation of Red Cross and Red Crescent Societies.

IFRC (2015c). Report of the Real Time Evaluation of Ebola Control Programs in Guinea, Sierra Leone and Liberia. International Federation of Red Cross and Red Crescent Societies.

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 Organisation.  
<http://reliefweb.int/sites/reliefweb.int/files/resources/WHO-Anthro.pdf> (accessed 11 December 2015)

Peters, Melissa Minor (2014). Community Perceptions of Ebola Response Efforts in Liberia: Montserrado and Nimba Counties. Oxfam GB. Unpublished document.

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*

