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An outbreak of fear, rumours and stigma: psychosocial support for the Ebola Virus Disease outbreak in West Africa

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This field report summarises the experience and lessons learnt by the author, who was deployed as an International Federation of Red Cross and Red Crescent Societies psychosocial delegate to Liberia for the Ebola Virus Disease outbreak in July and August 2014. Psychosocial issues encountered in the field, including fear in local communities and among aid workers, the spreading of rumours, heath measures interfering with traditional rituals and stigmatisation are discussed in detail. Also included are suggestions for dealing with these issues and actions taken during the mission. The importance of psychosocial support as a lifesaving matter in this outbreak is also highlighted. Finally, the author calls for initiation of sustainable mental health care and service development in affected countries, in order to maintain the momentum for change.

Keywords: Ebola, psychological first aid, psychosocial support, psychosocial training, social mobilisation, wellbeing, West Africa

Introduction

While this current West Africa Ebola Virus Disease (EVD) outbreak has already become the deadliest recorded in history, two important questions remain unanswered: how bad will it eventually become, and how can we, as the frontline workers against this outbreak, mitigate and eventually cease its spread? Based on recent experiences in Liberia as a psychosocial delegate in the Emergency Response Unit for the International Federation of Red Cross and Red Crescent Societies (IFRC) July to August 2014, there are several psychosocial issues that direly need to be addressed in order to control the spread of the disease. This field report will summarise some of these psychosocial issues: fear in local communities and among aid workers, the spreading of rumours, heath measures interfering with traditional rituals, and stigmatisation. It will also offer some suggestions for dealing with these issues.

Fear in local communities

In mid-July, when the second wave of the Ebola outbreak started to seize Liberia, both local communities and aid workers were caught up in the fear of the unknown. Initially, this fear had positive effects in terms of quickly alerting people to make changes. While I had had much difficulty finding places to wash my hands when I had first arrived, hand washing buckets with chlorine water sprouted overnight everywhere in the city after news broke about American medical staff contracting Ebola. It was not until then that the local communities started to believe Ebola was real.

Unfortunately, fear spread even faster than the virus. News of occasional looting and confrontations within local communities arose. A government imposed curfew further incensed this fear, reminding the people of Liberia of their hardships during the nation's civil war, which only ended 11 years ago. It was also heart breaking and scary for them to see dead bodies lying on the streets on a daily basis. Apart from the sentimental and emotional impacts,

skyrocketing food and fuel prices had practical consequences on their daily lives, further increasing the level of fear. They were also frustrated and angry in response to the closure of the majority of the health care services in the country. During a health and psychoeducation on common stress reactions in this Ebola outbreak on a local radio station, the phone-in calls were, in fact, mostly cries for medical attention. Parents had no place to seek help when their children contracted malaria, or other diarrhoeal diseases, illnesses that are very common in the rainy summer season. Pregnant women were rejected by the clinics and hospitals because they bleed, for fear that the blood would carry and spread the virus. Cars transporting Red Cross staff were stopped on the street by desperate families looking for any form of care for their dying family members.

While a reasonable level of fear may help people to cope with the disaster, overwhelming fear can be paralysing. Health messages in July and August mainly focused on reinforcing the reality of the virus' existence: '*Ebola is real. Ebola kills.*' These messages were not always complemented with illustrations of concrete behaviour to prevent contraction of the virus. For most who started to believe in Ebola, and learned that it had no cure, the fear became intense, overwhelming and sometimes paralysing. They avoided going to health facilities to seek help altogether, even if symptoms developed, since they believed that with no cure, there was no reason to go. When discussing the role of denial in the Ebola outbreak, Dr. Patricia Omidian, a medical anthropologist who worked for the World Health Organization (WHO) in Liberia, stated that there few people she interviewed had actually denied the existence of the outbreak. Some of their '*denial*' behaviour simply reflected how scared they are to know about the disease and its fatal consequences (Omidian, Tehoungue, & Monger, 2014a). In order to counter this fear, we organised psychosocial trainings to frontline workers in the Liberian National Red Cross Society who were responsible for conducting contact tracing and social mobilisation. They encountered scared villagers, grieving families and frustrated or angry leaders in the community. By listening to their concerns, horror and grief, we were able to build trust within the community and deliver the health messages in a more effective way.

At the same time, we also stressed the importance of protecting ourselves when conducting activities in the community. Since patients with Ebola are not infectious if they present with no symptoms, it is always a good practice to ask the participants in trainings, and people we encountered in the community, whether anyone did not feel well before starting activities.

Fear among aid workers

In August, when President Ellen Sirleaf of Liberia declared a state of emergency in the country (Sirleaf, 2014) and the WHO declared the current outbreak as a public health emergency of international concern (WHO, August 2014), a lot of humanitarian aid workers had questions about how these measures would affect their daily operations and their stay in the country. Subsequently, the suspension of the commercial flights, closing of land borders and uncertainties about the arrangements of medical evacuation in case of emergency posed additional and significant stress among aid workers in the community.

While frontline workers have been spreading clear messages to affected communities that they should report to health facilities on developing any symptoms of Ebola, it was not unusual to see aid workers not taking their own advice and continuing to perform their duties, even when they had fever or other symptoms. Some workers also told me the moments when they struggled about whether or not to report their conditions when developing some symptoms and suspecting they might have contracted the

virus. So, it appeared that when it came to translating knowledge to self-practice, there was a gap.

As a result, apart from providing psychosocial support to patients, families and communities, part of my duties were to also support frontline local and overseas workers. Psychosocial wellbeing workshops for staff were conducted, and individual consultations were arranged for those who were in particular distress. Apart from psycho education on stress reactions and coping for this outbreak, I tried to incorporate some simple mindfulness exercises, for example a body scan exercise, whenever I conducted trainings and support sessions with frontline workers. Mindfulness techniques have been widely documented as an effective way to cope with stress (Grossman, Niemann, Schmidt, & Walach, 2004), therefore, I have also been using this as one of the strategies to cope with the stress during this mission. Some participants told me that they felt they were losing a sense of inner peace during this fight against Ebola and had been facing both high level personal and work related stress every single day. They felt they were reconnecting to a sense of peacefulness in their minds and bodies when they did the mindfulness practice and were encouraged to continue practising the exercise as one of the ways to cope with the unprecedented stress.

The spreading of rumours

Although health messages relating to the Ebola virus can be found anywhere in Monrovia, the capital of Liberia, community members had reported rumour mongering that counteracted these efforts. During the community based, psychosocial training of trainers (ToT) programme, we allocated some time for the participants to collect all the rumours in the community about the current outbreak. In some of the more distant rural communities, at the beginning of the outbreak, people believed that Ebola was brought by health workers, particularly by foreign aid workers, who seemed to be dressed in '*space suits*', spraying an unknown substance everywhere. Most of the time, patients who were taken away by ambulances never returned, leading to the spread of falsified rumours about patients' organs being stolen and cannibalised. In response, some communities chased away and sometimes attacked aid workers and their vehicles. Some people also believed that the entire outbreak is a hoax enabling the government to collect donations from international communities.

When I was preparing a training one morning, my attention was captured by a newspaper headline: '*Queen Sheba did not come to Liberia: President Sirleaf Clarifies*'. Some people attributed the outbreak to Queen Sheba, a mythical figure who was linked with evil forces. The fatalities were stemmed from the fact that she wants the blood of Liberians. Such an unfounded rumour was so widespread and subsequently treated as fact that the president needed to make a statement to deny its credibility. Participants of the community based psychosocial ToT programme agreed that we must first understand how the community perceive the current outbreak before providing any health information or support. Some of the health information was criticised as being too scientific and had too wide a gap with local perceptions of the disease. When local people were told not to eat bush meat because of it being the origin of the Ebola virus, there were those who did not believe and disagreed with this notion. As their ancestors had been eating bush meat for over one thousand years, they found it difficult to accept that suddenly this behaviour had become so dangerous. Lack of information and fear breed more rumours. This was the reason behind us including a short session to sensitise the frontline workers, including those who are responsible for contact tracing, health education and potential psychosocial support through telephone hotlines, about local perceptions and rumours related to the current outbreak.

Health measures in conflict with traditional rituals

One of the most devastating experiences for family members of those who had died from the virus was that they could not claim the body of their loved one to perform traditional rituals. So this became another topic discussed in detail during the ToT programme, traditional ways of dealing with the grieving process and funerals without retrieving the bodies. Valuable discussions took place where insightful ideas were generated regarding the ways people had commemorated their deceased families in previous times of war, which had also meant they had been unable to retrieve the actual bodies. Such practices were included and discussed in the provisional *Psychological First Aid (PFA) guide* (adapted for the Ebola context) that has published by the WHO and partner organisations (WHO, Christoffel-Blindenmission[1] (CBM), World Vision International, & United Nations Children's Fund (UNICEF), 2014) (see *Announcement*, this issue).

Stigmatisation of family members and aid workers

For the people of West Africa, Ebola is a new disease with high fatality rate. It is also a cruel disease, as it tends to kill people in the family one by one, as they become infected from taking care of family members who are sick. Shame or disgrace was imposed on people related to the disease, regardless of whether they are sick, healthy or have recovered. Unattended orphans, due to Ebola, have been reported around the country. Recovered, healthy individuals were denied access to health care and materials, and also rejected by their community, as they were seen as a threat.

The fear of such disease leads to stigma attached to those who are affected, regardless of whether in a direct or indirect context. The dead body management team at the Liberian National Red Cross Society was one of the teams that I worked closely with during the deployment. While I was undergoing the safe burial training together with the teams, I incorporated one session into the training to talk about the stress reactions that they might experience, ways to cope with these stressors and also the peer support that might help them during their unprecedented challenges. Not only were they facing high risk of contamination, heavy workload, anger and violence from the community and grief from witnessing tragic deaths on a daily basis, some team members also reported being stigmatised by families and friends. Some of them were asked by their families to quit the job and some chose not to disclose their work nature to family at all. One team member told me that he was sleeping outside of his house for fear of transmitting any potential disease to his family. Working under such tremendous stress can pose significant risk to these workers, especially when the smallest mistake can become fatal. Psychosocial support to these frontline workers is not a luxury – it is indeed a matter of life and death.

Stigma and fearful reactions were not solely confined to West Africa. As a delegate going back to Hong Kong from working in areas affected by this deadly disease, the general public had much concern over the possibilities of my bringing back the virus. My arrival at the airport was broadcast live on all local major television and social media channels. The reactions of the public, both positive and negative, are understandable as Hong Kong had once withstood the ravage of SARS in 2003, when its people experienced first-hand the perils of an outbreak of a new infectious disease. Beyond Hong Kong, different countries currently have imposed varying degrees of precautionary measures for returning aid workers. While some have been instating a more relaxed surveillance mechanism based on exposure and risk, some chose to isolate all delegates for days and weeks on their return. Unlike other previous large scale disasters, the international humanitarian community has

been experiencing a difficult time in recruiting delegates to work in the current EVD operation. Such restrictive measures at home have further hampered the deployment of delegates to cope with this humanitarian crisis. Although it is absolutely crucial to install proper measures to battle against the spread of the disease, it is also equally important for the international community to understand the importance of providing a supportive environment for current and aspiring delegates to work and curb the outbreak at its origin. These actions, in combination, would represent the most effective means to prevent further spread of the disease.

From chaos to coordination

According to the IFRC, psychosocial support is one of the five essential pillars for the entire Ebola operation (IFRC, Sept 2014). Among all of the hectic duties during the mission, an important task in the overall mental health and psychosocial support (MHPSS) activities in this current EVD outbreak was communication and coordination among MHPSS partners, both within and outside of the country. It was a valuable experience to participate in the MHPSS Who is Where, When, doing What (4Ws) mapping exercises (WHO & UNHCR, 2012) with the Ministry of Health and Social Welfare. Through this exercise we were able to inform our stakeholders of the progress of actions and facilitate better utilisation of resources. The Inter-Agency Standing Committee MHPSS Reference Group meeting was also able to bring together all actors in the region to support the collaboration and exchange of lessons learnt. Being a delegate deployed from Hong Kong Red Cross, not only did I receive seamless support from the team in the back office, the IFRC Psychosocial Reference Centre had also prepared me by linking up the delegates who worked in the region and shared the resources developed. This not only tremendously facilitated my work, I knew that I could always return for additional support whenever needed.

Lessons learnt and looking ahead

To summarise my mission experience, there are a few points for better preparation of delegates and facilitation of their work. Firstly, there is a great need for increasing awareness about the facts and prevention of EVD. This is true for those who work in the community, as well as those in the Ebola treatment centres. This is crucial not only for our own protection, but also for ensuring the ability of delegates to handle all sorts of questions related to the disease outbreak from anyone they encounter within the community. In the PFA guide adapted to the Ebola context,[2] health information related to the disease was presented first due to the uptake of this knowledge as an important prerequisite to providing proper psychological support. Health information will be best supplemented with concrete behaviour for those affected to follow so as to enhance the sense of self-efficacy in coping with this deadly disease outbreak.

Furthermore, it is also useful to remind ourselves that our own behaviour should not cause further panic within the community. We understand that maintaining good hand hygiene, avoiding body contact and staying away from people who exhibit symptoms are good measures to keep us and others safe. Unnecessary and often inappropriate use of protective equipment may sometimes create more fear, misunderstanding and stigma.

Understanding the cultural background of the community is crucial in order to implement appropriate support to address local psychosocial issues and concerns. It is important, not only for psychosocial workers, but also those are responsible for conducting contact tracing and health education in the community, to be well informed. Related themes have been discussed in detail in another report prepared by Omidian and colleagues

(Omidian, Tehoungue, & Monger, 2014b) and the briefing note prepared by the IFRC Psychosocial Centre (November, 2014). Successful effort in social mobilisation, contact tracing and all other forms of community work require incorporation of related psychosocial components, local beliefs and local practices.

Emergencies, though tragic in nature, also inadvertently provide us with opportunities to further develop mental health systems for all people in need. The WHO also echoes this need to build capacity of health systems in addressing mental health issues post disaster, as clearly delineated in the *Building Back Better* document (2013). In this regard, the current Ebola outbreak also comes with a chance to scale up mental health care sorely needed within the affected countries. I was, in fact, quite surprised to so often about the importance of mental health being mentioned by high officials during government coordination meetings for the EVD operation. The heightened awareness of mental wellbeing among the government and political leaders and committed local mental health professionals, better and more trainings among health workers, and assistance from international experts and agencies, all provided the best breeding ground for development of longer term, community based mental health and psychosocial support systems. With that in mind, there comes a time when relevant actors and policy stakeholders need to advance from discussions and contemplations to realistically consider the incorporation of sustainable MHPSS development in affected countries at this stage of the emergency, so as not to miss the golden opportunity to reach and benefit all people in need of mental health and psychosocial support beyond the outbreak and in times of peace.

I felt so grateful that psychosocial and mental wellbeing was regarded so highly by Liberians, and that my work has been strongly supported by my local colleagues. I speculated that it was partly due to the history of civil war that people were well informed and understood the importance of mental wellbeing as an indispensable part of health. All of my colleagues had been so determined to take all necessary actions to curb the spread of the outbreak and were confident that they would eventually *Kick Ebola out of West Africa.* During the last evening of my mission, our team had a nice gathering by the beach enjoying a beautiful sunset. That moment sadly marked the last sunset before the dawn of the curfew implemented in the country. With the continuing, concerted and tireless efforts of all frontline staff, including the psychosocial workers employed in various local communities, I am confident that one day soon the people of West Africa can recover from the shadows of this terrible outbreak and embrace the beauty of its land again.

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[1] CBM is committed to improving the quality of life of persons with disabilities in the poorest countries of the world.

[2] See *Announcement* in this issue.

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Psychosocial support during the Ebola outbreak in Kailahun, Sierra Leone

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This field report describes the author's deployment as a psychosocial delegate to the International Federation of Red Cross Ebola epidemic response in Sierra Leone during June and July 2014. He highlights the ongoing impact of an epidemic in a post conflict zone, how addressing fear and stigma is essential in social mobilisation and capacity building efforts, as well as providing empowering messages that give hope and foster collaboration between epidemic responders and community members. Additionally, stress management and adequate supervision are essential for staff and volunteer wellbeing and safety during an Ebola epidemic.

Keywords: Ebola, psychosocial support, Sierra Leone, social mobilisation

Psychosocial support during a state of emergency

I had the opportunity to work in Sierra Leone in June and July 2014 as a psychosocial delegate in the International Federation of Red Cross (IFRC) Ebola epidemic response. Response efforts were focused in Kailahun, the district hit first and hardest by the epidemic. By the time I arrived, Médecins Sans Frontières (MSF) had just set up their