Special Section: Ebola

Introduction to the *Special Section* on Ebola: reflections from the field

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In 2013, journalists began to write about the first Ebola patients in West Africa. Now, in 2015, we are at almost twenty thousand cases of people who are suspected of, or actually are, infected and many thousands of deaths further, mainly in Sierra Leone, Liberia and Guinea. These countries, as well as the international community, not only face the loss of all those people, but also the tremendous impact on family members, communities, aid workers and the societies as a whole. We read and hear heart breaking stories of dying patients in hospitals or just along the road, about people who could not hold their dying loved ones in their arms or comfort their children who were in pain, because they would touch the death. Many health workers risk their lives to help, and many have died.

When the world finally started to acknowledge that a humanitarian disaster was going on in West Africa, the fear travelled much faster and further than the virus, mainly induced by a '*fear riddled media*' in western societies (Shultz, Baingana, & Neria, 2014). The result has been that those brave health workers have not only put their own lives at risk, but now also face stigmatisation and exclusion within their own communities, including those returning to the west.

That mental health and psychosocial support (MHPSS) should be an essential part of the aid is, fortunately, the conviction of most players in the field, including governments. Although we know how to address MHPSS in disasters, we are inexperienced in addressing MHPSS within the specific context of the Ebola Virus Disease (EVD).

It is for this reason that the editorial team of *Intervention* felt it was essential to give attention to this subject.

In this *Special Section* of *Intervention,* the six invited mental health and psychosocial workers: *Eliza Cheung, Janice Cooper, Peter Hughes, Ferdinand Garoff, Teresa Gonzalez, Peter Hughes and Elín Jónasdóttir,* describe their experiences and work in Liberia and Sierra Leone.

It is important to note that these valuable and rich contributions are mainly from the perspective of international staff working in West Africa. Although Janice Cooper is Liberian, she is at the same time international staff. Hopefully, in the future, we will be able to focus on reflections from West African workers.

Before I specifically discuss the six contributions in this section, I would like to highlight the tensions between local cultural concepts and worldviews, and western concepts and medical knowledge (e.g. Paglia, 2013). MHPSS programmes for people in all affected regions need to acknowledge the differences and frictions between these perspectives when planning interventions. The anthropological studies of Abramowitz et al. (2014) and Omidian, Tehoungue, & Monger (2014) offer us valuable insights into local concepts and worldviews. Both studies were conducted mid 2014, within Ebola affected areas. Abramowitz et al. describes how communities are trying to be self-reliant now health, infrastructural and material support are unsatisfactory, or absent. They show that, although cultural practices are very important, communities and families

are willing to follow 'uncultural' practices in an attempt to survive (Ibid. 2014, p. 3). Their moral experiences change through the interactions with social experiences and cultural representations (Kleinman, 2006). However, Abramowitz et al. also notices that the messages health experts convey; such as hygiene practices, food practices and death rituals do not address what really is at stake for the people they interviewed. They state that we need a better understanding of how strong and dense are the emotional ties in families and communities, in order to understand the *'culture of caregiving'*.

Community leaders are all looking for the best strategies to end the Ebola outbreak, and at the same time, keep community spirit more or less intact (Abramowitz et al., 2014; Omidian, Tehoungue, & Monger, 2014). Training in prevention, response to treatment and aftermath elements are considered essential. However, in each of these three fields there are serious problems. Looking at prevention, many communities have developed a surveillance system, to watch over each other and to keep strangers outside the community. This is mainly being done by young men, but in a post conflict society this practice easily can slip into a *'militarisation of social organisation'* (Abramowitz et al., 2014, p. 10).

In the field of treatment there are also gendered aspects of the Ebola outbreak (Omidian et al., 2014). If a child felt ill, the mother will comfort it. She cannot isolate her child. Most women interviewed said that they consider it impossible to leave an ill family member to fend for him or herself. In other words, the women would continue to take care of their ill relatives and thereby put their own lives at serious risk. During the first period of the outbreak, due to the lack of response by governments, of course they had no other choice. Women and children also face other, additional problems and risks. Now that schools are closed, the children are at home and bored. They want to play outdoors and with other children. Although mothers constantly convey the *'no touch'* message, often the children are too young to fully understand or simply forget in the heat of play.

Another aspect that hits women and children particularly hard is the lack of treatment possibilities. There are many unnecessary deaths among people who had preventable and treatable diseases and injuries, but were afraid to go near the hospitals or were unable to get treatment. Pregnant women are very vulnerable and are dying because hospitals are closed or health workers are afraid to touch them.

The *'no touch'* approach also feeds the fear, and people are easily considered as potentially dangerous and therefore stigmatised and isolated. To have a sense of safety and liveability, a person needs to feel connected with others and the spiritual world, it is one of the most important needs of a human being (Weil, 1952 in Jackson, 2006, p. 12). The *'no touch'* message can destroy this feeling, leaving people disconnected, or as Paglia in her article in *Intervention* stated, are driven into *'a form of individuality, whereas in Africa … people live through the relationships and the alliances to family, tribes and ancestors'* (2013, p. 196). Community leaders in severely affected areas are aware that they have to find solutions for this, especially for the orphans or other affected community members. We do not know how this will work out in the long term, but we can learn from the lessons of HIV/AIDS.

As I stated earlier, negotiating psychosocial support has to take into consideration both the local cultural concepts, as well as western concepts. Our approach should support the need to contain the spread of the EVD, but also to support the needs of the community and family members who are experiencing EVD, as well as in the relationships and linkages in the real and spiritual world. For people who live through relationships, this disaster is not just bad luck, but is personalised (e.g. angry

ancestors). This notion is important in terms of the burial rituals that can't be performed, thereby further disturbing relationships with the ancestors. All of this increases distress. Fortunately, there are also good examples where medical and local needs are respected, for example, the dead body management team of the Sierra Leone Red Cross Society performs burials attended by families, who remain safe behind a window. In this way, they can see that their dead relatives are treated with respect, and there is space for prayers (Mueller, 2014).

At the same time, we also need to focus our attention on our brave colleagues, local and international. They experience their own fear, distress and stigmatisation during the mission, but also after their mission and in their home countries. We have to address this and support them.

The invited six professionals all give us, in their field reports and personal reflections, a glimpse into their work in Ebola affected Liberia and Sierra Leone. We choose to start with personal reflections as, although this is a large epidemic, everything we learn is that it is also a very personal crisis for those involved.

Janice Cooper writes a gripping report of how personal experiences interact with collective and social events in Liberia. She gives us a breathtaking insight into her personal and professional lives in the first months of the Ebola outbreak, and the point at which they collide. *Teresa Gonzalez's* penetrating reflection describes how measures implemented to combat Ebola in Sierra Leone are creating additional fear among affected communities that runs deep and has almost been completely ignored. *Peter Hughes*, as a psychiatrist, emphasises mental health problems and risks, now and in the long term, and pleads for attention to be given to the wellbeing of the children who survive this traumatising period. He also warns us of the potential problems medicalising this distress. In her field report, *Eliza Cheung* explains the psychosocial elements she has taken note of in Liberia, such as fear within local communities and among aid workers, rumours, stigmatisation and health measures that conflict with traditional practices. She argues for the initiation of sustainable mental health care and service development in the affected countries, in order to maintain the momentum of change. *Ferdinand Garoff* further addresses these issues of fear and stigma in Sierra Leone and explains how they try to tackle them with social mobilisation and empowering messages. He also pays attention to the essential issue of staff care. Staff care, support and training are also highlighted by *Elín Jónasdóttir* in her field report on Sierra Leone. She illustrates the enormous pressure on aid workers, coming from deeply affected families and communities themselves, and having the constant risk of becoming infected. She also highlights the fact that governments (national and international) did not react to the first warnings by the Red Cross and Médicine Sans Frontierès. In some of the contributions it has become clear that Psychological First Aid (PFA) seems to be helpful for aid workers. Therefore, attention is given to the new version of PFA adapted to the Ebola crisis at the end of this section (*Announcement*), with references to the material.

I will not draw any conclusions or lessons learned from these contributions, but do want to stress a few elements. It is clear that communication is extremely important at all stages. Not only aspects as to what, where, to whom and how are important, but also that it is empowering and creates a collaborative atmosphere. To defeat Ebola and to reduce the distress, working in close collaboration with the community leaders, religious leaders and other representatives is essential. By doing this, the history and social situation (e.g. gender aspects and position of children) has to be taken into

account, reminding us that Liberia and Sierra Leone are both post war countries with specific lingering problems, such as lack of trust. Furthermore, it is important to find ways to reduce the tension between the culturally bound and imported interventions, or bring them into line, in order to strengthen MHPSS.

Finally, I hope that, as *Eliza Cheung* mentioned, we can use this disaster as a momentum for change and introduce sustainable mental health care and service development in these affected countries. I hope the readers of *Intervention* will read these multifaceted contributions with the same interest as I did, and will be able to draw various conclusions for themselves, their organisations and their programmes.

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