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² See *Announcement* in this issue.

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Psychosocial support during the Ebola outbreak in Kailahun, Sierra Leone

Ferdinand Garoff

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.

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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

case management centre. There were a few checkpoints along the road, but less and less traffic the closer we got to Kailahun. Road construction efforts had also been halted by the onset of the epidemic, so travel slowed to a crawl as we approached the district. Some of the villages we passed along the way looked empty and in others, people did not approach the vehicle.

Ebola in a former war zone

Kailahun had also been the hardest hit by the civil war and many of its inhabitants had previously been displaced. When Ebola started spreading throughout the district, a state of emergency was declared in July 2014. Schools and banks were closed and non religious public gatherings were forbidden, bringing back memories of the civil war.

Further memories of the war lingered in the town of Kailahun, not only in the evidence of the houses still abandoned, but also in the stories still told. Such as the so-called '*slaughter house*', just outside the compound where we were staying, where numerous people had been slaughtered like animals by the rebels during the civil war. The house remains unoccupied and dilapidated.

Kailahun is also a stronghold for the current political opposition, and mistrust of the central government is common. There were even rumours that the disease had been spread in order to decrease the number of opposition supporters before the upcoming census. However, after what seemed like initial hesitancy, government officials made sure to visit the area and show that they supported efforts to combat the disease.

Kailahun district is divided into five chiefdoms, with a local hierarchy linked to traditional practices, practices that I understood are taboo to speak about with outsiders. This means that many things are opaque to an outsider and I believe this has led to misunderstandings and unnecessary

conflicts in some situations. The Sierra Leone Red Cross Society (SLRCS) staff and volunteers were invaluable in this regard.

Existing psychosocial services

My arrival in Kailahun was welcomed and the need for psychosocial support was acknowledged. Yet, it was unclear at that time what kind of psychosocial support (PSS) interventions would be best suited to the Red Cross response. The general terms of reference mentioned providing PSS to volunteers, individuals and communities affected by the fear and stigma of an Ebola outbreak, but did not specify how this was to be implemented. PSS has received increasing recognition as an essential part of humanitarian interventions, but the field is quite heterogeneous and many quite different interventions are covered by this umbrella term.

The Sierra Leone Red Cross Society (SLRCS) has a Children's Advocacy and Rehabilitation (CAR) centre in Kailahun, set up with the support of the British Red Cross. The CAR centre had been part of the efforts to support children affected by the armed conflict and worked with them to provide life skills training, promoting community reintegration and offering counselling. Now the scope of the project had been widened to include other vulnerable children and youths. The normal activities at the CAR centre had been stopped, as schools had been closed, so the centre had been refocused as a hub for social mobilisation and training sessions. The director and counsellors at the CAR centre, together with the SLRCS programme administrator became natural counterparts to the psychosocial delegation. With the SLRCS, therefore, we focused on social mobilisation and capacity building for a community based psychosocial intervention.

MSF had their own psychologist working at the Ebola case management centre. Her responsibilities were focused on supporting

the case management centre patients, their families and staff. There were also several other organisations working in the psychosocial field in Kailahun: various community based organisations (CBOs), UN agencies and international nongovernmental organisations (INGOs).

As most previously ongoing activities of these organisations had been halted due to the epidemic, these were replaced by social mobilisation efforts, such as radio messaging and Ebola awareness sessions, the latter limited by logistical constraints. To further strengthen collaboration, we started a weekly psychosocial coordination meeting with a few other agencies to clarify issues relating specifically to PSS and child protection. Once trained, the SLRCS community based psychosocial volunteers would liaise with the MSF Ebola case management centre in regard to discharged patients and others affected by the Ebola epidemic in the villages, supporting them through home visits and community reintegration efforts, as well as distributing discharge packages prepared by Save the Children and the SLRCS. The SLRCS volunteers would also support the epidemic response on a community level through Ebola awareness sessions and working with the contact tracers and burial teams.

The initial trainings for SLRCS community based volunteers in Kailahun were constrained by finances and logistics to one day sessions covering: Ebola awareness, the epidemic response and psychosocial support, including participatory exercises. The sessions concluded with the volunteers drawing up plans of action for their chiefdom teams. Follow-up trainings and supervision was provided by SLRCS Kailahun branch and CAR centre staff. I also facilitated a number of sessions on PSS in the trainings for the Ministry of Health and Social Welfare contact tracers. In order to be able to provide PSS, staff and volunteers have to be well trained in Ebola awareness in order to be able to protect themselves, and share

relevant information that can provide a sense of safety to others.

Fear and stigma: self-protective reactions that may cause harm

Fear and stigma are natural and rational responses during an Ebola epidemic. It makes sense to want to protect oneself and our loved ones from the source of harm. However, during the Ebola epidemic the level of risk is often difficult to assess. The only place where this is clearly demarcated is at the treatment centres with their separate wards for suspected, probable and confirmed cases. Elsewhere, one has to rely on other cues and sources of information.

Public health messages can serve to increase fear and avoidance, as was initially the case in Sierra Leone. Rumours were also spreading, fed by a need for people to understand the disease or deny its existence. Various rumours were frequently mentioned in jest, or in earnest, at sensitisation sessions. Fortunately, the SLRCS staff and volunteers had previous experience in working with a cholera epidemic and were skilled in countering rumours and explaining complex phenomena, such as telling people that the body has '*body soldiers*' inside to fight the virus (referring to the immune system).

When the sources of harm are difficult to identify or understand, as in the Ebola epidemic, fear can easily become generalised. Everyone associated with the disease, such as health care workers, SLRCS staff and volunteers, or any person who falls ill or who has anything to do with anyone who has fallen ill, becomes suspect. Their presence becomes a threat to one's life and wellbeing, and people may use extreme measures to counter this perceived threat. This is evident in cases when ambulances are attacked, epidemic responders threatened, health care supplies burned or when people run away at the sight of epidemic response vehicles. In order to change these

behaviours, a sense of safety and empowerment needs to be promoted.

Ebola is disempowering

It is a killer disease,
Above HIV and AIDS.
It has no way to be cured.
Only God knows the way for our survival.
But it is all about death.
For we are confused, confused by fear and worried.
Death and suffering always.
Let it go away.
Just like dropped leaves in the wind.
From: EBOLA POEM by Jeremiah M. B. K. Mbonda (AKA J.Boy)

The Ebola poem above was composed by a young man in Kailahun and describes how the virus can be very disempowering. It has a sudden onset, dramatic symptoms and no cure. As Paglia (2013), points out in her article on psychosocial support in an Ebola outbreak, self-protection drives people to a sort of individuality, whereas usually people in West Africa live through relationships and alliances. The disease shatters families and communities, appearing to punish those that act selflessly by caring for the sick and putting their own lives at risk. Caring for the sick and respecting the dead becomes a dangerous business best left to trained professionals or volunteers. So, you are better off keeping your distance. Don't touch.

Sadly, epidemic response efforts can easily increase this tendency. Information campaigns had emphasised that Ebola is a deadly disease, giving little incentive to seek help. As a result, many people hid themselves and relatives that were sick, fearing that they would be taken away by ambulances, never to return. Others were abandoned and left to die alone, sometimes from another, curable disease. In a society where the local health system is weak and collapses

and there is no one else to fall back on, people are left with a stark choice: do you care for your sick family member, risking your life in the process, or do you leave them to die or let them be taken away by strange people in plastic suits, perhaps never to return?

Addressing fear through social mobilisation sessions: bringing messages that empower and give hope

Social mobilisation sessions on Ebola are done to raise awareness of the risks involved, the sources of contagion, routes of infection and means of self-protection. Talking about risks means increasing fear, anxiety and arousal levels. Some of these fears can be alleviated by sharing information and often anxiety provoking rumours can also be addressed. Is it true you can get Ebola by eating fish? Is Ebola spread by a snake that bites people as revenge for them knowing of it's existence? Sometimes the questions are trickier to answer: how long can the virus survive inside a hut? Or, how can I safely take my child to the hospital, if she gets sick? In part, these uncertainties can be resolved by solid scientific evidence, other questions by very practical information, yet others remain ethical conundrums.

By the time I arrived, the social mobilisation efforts had already been started by IFRC health delegates. In the social mobilisation sessions I presented a short talk on fear and stigma, talking about fear as a normal reaction and a protective factor that may lead to harmful outcomes, and addressed any issues that arose. I was joined in this by the director and staff of the CAR Centre, and later they took charge of the sessions. The participants were quite diverse, representatives of various community based organisations, religious leaders and other community stakeholders.

There was an interesting moment when we introduced the topic of hope into the social mobilisation sessions. The inter religious council had invited the local imams and

priests to attend a session and anxiety was spreading throughout the group as the epidemic was discussed. However, by introducing hope as a theme in the discussion, a much more constructive atmosphere resulted and several of those present decided to organise information sessions in their churches and mosques, the only venues where public gatherings were still allowed. Later, we met them as they led processions through town chanting Ebola messages.

Another set of very important social mobilisation sessions were organised by the Ministry of Health and Social Welfare for stakeholders in the various chiefdoms in Kailahun. These included, among others, the paramount chiefs and mammy queens, youth leaders, religious leaders, elected counsellors and representatives of the drivers, traders and bikers. The sessions covered Ebola awareness, aspects of the epidemic response and a session on psychosocial support. It ended with the stakeholders drawing up plans of action for their chiefdoms.

The Ebola awareness sessions and messages of hope, as well as working collaboratively, played an important role in empowering the various community leaders to re-assume their usual role and to promote social mobilisation. These messages may also help to defuse undue anxiety and foster a collaborative atmosphere within the community as a whole. Additionally, they hold a particularly important role for local leaders, as people look to them for support as without their support and a collaborative atmosphere, stopping the epidemic becomes very difficult.

Obstacles that challenge epidemic response: logistics and communication

It is quite difficult to access some parts of Kailahun district, making community based interventions more difficult to develop. In practical terms, trainings and social mobilisation sessions required people to travel for many hours, which also constituted

a considerable expense. Mobile phone reception was unreliable due to several overlapping mobile phone networks, with some areas having no reception at all. All of this contributed to making planning and coordination more difficult. Banks had also been closed, as it was suspected that money might spread the contagion, this meant that funds had to be taken by road from elsewhere, making financial transactions more difficult. Radio programmes were, therefore, a very useful means of sharing public health messages, and a radio drama performed by the SLRCS volunteers was well received. It was also quite useful that people could call in and ask questions, as this allowed for some interactivity in a medium that otherwise was very much of a one direction information pathway. It also proved to be useful to give some training in psychological first aid to social mobilisation volunteers, as they initially were quite focused on providing information, but less inclined to listen to peoples' concerns. Active listening improves rapport and provides an avenue for addressing rumours and misconceptions. This can be quite useful in situations where people are fearful and contradictory messages have created distrust.

Stress and staff wellbeing

An atmosphere of diffuse anxiety and fear was tangible in Kailahun, understandably, this also affected the staff and volunteers of aid organisations. Evaluating risks was quite difficult at times and this created some tensions among the responders. Perceptions were divided as to what was safe and what was risky. As perceptions diverged, it had the potential of creating situations where some people were seen as risk takers and should be avoided.

Illness among staff was another source of stress. The symptoms of Ebola are not easily recognisable at the early stages, making diagnosis difficult. So, in addition to the discomfort of the symptoms, any illness among staff had to be evaluated against

any potential exposure to Ebola that may have happened. This subjected anyone who fell ill to close scrutiny by self and others. Self-scrutiny for any minor signs of ill health comes quite naturally and was something everyone did. Awareness of these phenomena and addressing them promptly can help to defuse unnecessary stress and unhealthy group dynamics.

In order to address these issues among SLRCS volunteers, we set up a system whereby the trained counsellors of the CAR centre staff would provide phone supervision for the community based volunteers on a weekly basis. In addition, the volunteers were invited to monthly training and peer support sessions facilitated by the counsellors.

Working during an emergency is always stressful, but in an Ebola epidemic where mistakes can be fatal and may put others at risk, it is particularly important to minimise stress that can affect performance. During the Ebola epidemic many of the local staff and volunteers may experience additional pressures from their community, and may risk being ostracised by their families. Therefore, putting support and supervision systems in place is of paramount importance. Personally, I found it very helpful to interact with colleagues with previous experience of Ebola epidemics; their calm demeanour and practical approach served as a mental compass when trying to navigate an environment that provides contradictory signals about risks. Calm and reasoned management of this crisis is essential.

Conclusions

It is difficult to evaluate outcomes, as the situation in Sierra Leone has continued to evolve. Also, as the epidemic spread to other parts of the country, the SLRCS was asked to take on major responsibilities in safe and dignified burials. The Red Cross movement also opened their first Ebola treatment centre, and attention has shifted to these efforts. There was also a discontinuity in terms of follow-up, as there was great difficulty in identifying trained psychosocial delegates within the Red Cross movement for deployment to Sierra Leone.

However, PSS is an essential part of the Ebola epidemic response as it addresses fear and stigma that may otherwise lead to harmful outcomes. Psychosocial support may also be a way of increasing community empowerment and collaboration between responders and community members. Many of these aspects can be incorporated into general social mobilisation efforts, but more specifically, PSS interventions are needed with those affected and it is likely that these needs will continue long after the epidemic is contained.

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