



Cultural awareness in times of Ebola

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“What on earth am I doing here?” Hanna Schneider took a sip from her bottle of soda while trying to fight off the mosquitoes and enjoy the cool evening breeze that blew across the veranda of the guesthouse.

As she relaxed after yet another hot, humid and exhausting day, she found it difficult to absorb all the things that had happened to her during the first week of her stay in Sierra Leone. Her mind was filled with many questions that she hoped to discuss with her colleague, Charles Koroma. While waiting for Charles, Hanna took a deep breath and tried to structure her thoughts and impressions from her first week. The first thing that came to mind was a situation from that morning.

Hanna Schneider

As a German obstetrician-gynaecologist in her mid-thirties, Hannah had already spent some time working in Africa, initially during her clinical internship in the Bugando Medical Centre in Tanzania. Subsequently, she increased her experience of working for international organisations through several short-term assignments in rural hospitals in Bukavu in the Democratic Republic of Congo (DRC), Gaoua in Burkina Faso and Kailahun in Sierra Leone.

For a Master’s degree in International Health within the TropEd network, she had spent five years following courses at several European institutions. Her studies had focused on clinical tropical medicine and reproductive health – her main areas of interest. She had not taken any courses in medical anthropology.

In the summer of 2014 Hanna was sent to Kailahun, where she had worked previously. Her assignment was to support the hospital's health services during the turmoil of the Ebola outbreak, which by then had reached its peak. This was her first long-term contract.

Charles Koroma

Dr Charles was one of the few trained clinical officers at the small hospital, which he ran together with a team of dedicated nurses. Raised in Sierra Leone during the years of the civil war (1991-2002), he often referred to himself as “lucky” because he was one of very few in his generation with a good education. He had studied at the COMAHS (College of Medicine and Allied Health Sciences) in the country's capital, Freetown. After his graduation, he received a scholarship and travelled to the UK to specialise in internal medicine. Hanna had great respect for his decision to then head straight back to Sierra Leone. He had even chosen to work in this remote rural town to help the local people, rather than accept a job at a large international hospital in Freetown.



A district hospital in Sierra Leone, similar to the one Hanna and Charles were working in. Photo: E-M. Schwienhorst

Sierra Leone

Located in West Africa with its coastline facing the Atlantic Ocean, Sierra Leone shares borders with Guinea and Liberia. These three countries are also known as the Mano River Region. Sierra Leone's capital and political centre, Freetown, is located on a peninsula in the Western Area, while the second largest and economically more important city is Bo, in the Southern Province. Kailahun is situated in the Eastern Province, close to the border with Guinea (Exhibits 1 & 2).

A brief history of Sierra Leone

West Africa was integrated into the Euro-American trade networks from the 15th century. Initially, mainly iron was exported to Europe, but later slaves became the major commodity. During the American Revolution in the late 18th century, a British Colony was established for liberated slaves, named Sierra Leone. Further south, the colony of Liberia was founded to relocate African Americans to Africa from the 1820s. The decades that followed were characterised by violent conflicts between warlords and colonists, as well as migration and flight across the porous border with Liberia.

During the colonial era, political power in Sierra Leone lay in the hands of the British Empire and its appointed leaders. These were chosen by the British Crown for their obedience, and most Sierra Leoneans were barred from participation in politics. All raw materials (agricultural products and minerals) were extracted and exported with the profit going to Britain. No investments were made to improve the livelihoods of the local population, while education was only available to a few.

Independence on 27th April 1961 brought little improvement in the economic situation of the country, and political power continued to be concentrated in a few hands. During the so-called lost years of development in the 1980s, the country was characterised by poor education and failing health systems, a weak economy, high levels of corruption, an untrustworthy political regime (which allowed only a few to benefit from the wealth of the country's resources) and several military coups. All this culminated in a civil war that lasted from 1991 to 2002 – claiming 50,000 lives. It also resulted in 4,000-10,000 amputees, 70,000 former combatants, many child soldiers and an entire nation traumatised (Christodoulou, 2004, p.9, par. 48; Fairhead, 2014, chap.2; Menzel, 2015, p.40).

The United Nations High Commissioner for Refugees (UNHCR) repatriation programme for civil war refugees was completed in 2004 and the United Nations Mission in Sierra Leone (UNAMSIL) forces were withdrawn one year later. Instead, the United Nations Integrated Office for Sierra Leone (UNIOSIL) was established to support the 2007 elections. In 2008, UNOSIL was converted into the United Nations Integrated Peacebuilding Office in Sierra Leone (UNIPSIL). According to Secretary General Ban Ki-Moon, “Sierra Leone represents one of the world’s most successful cases of post-conflict recovery, peacekeeping and peacebuilding” (United Nations News Centre, 2010).

The economy

During the early 2010s, Sierra Leone was one of the fastest growing economies in Africa, its main sectors being agriculture and mining, especially of iron ore and bauxite. Nevertheless, Sierra Leone remained one of the poorest countries in the world as it continued to deal with the aftermath of civil war and high rates of corruption. The 2013 Human Development Index ranked Sierra Leone 184th out of 187 countries in the world. Power and wealth continue to lay in the hands of the country's elite and foreign companies (Central Intelligence Agency (CIA), 2014; Menzel, 2014) (Exhibit 3).

The health system

In a report published in 2011, Amnesty International states that “Sierra Leone’s health system is characterised by a poor infrastructure, a lack of appropriately qualified health care workers, and

insufficient supplies of drugs and equipment. Even the best government hospitals in Sierra Leone often lack running water, electricity, and other basic necessities. These problems are exacerbated by poor co-ordination, management and oversight of the health system” (Amnesty International, 2011, p 11).

Ethnic groups

About 18 ethnic groups refer to Sierra Leone as home, although all of them have their own language and customs. African tribes account for the majority of the population. These include the Temne, Mende, Limba, Fula, Kono, Mandinga, Kuranko, Loko, Susu, Yalunka, Kissi, Vai, Kru, and Sherbro. The Temne and Mende are the two largest groups representing 35% and 30% of the population respectively, while the descendants of freed Jamaican slaves (the Krio/Kriole) account for 10%. A small number of Lebanese, Indians and Europeans also live in the country (United Nations (UNIPSIL), n.d.); Central Intelligence Agency (CIA), 2014).

The Ebola outbreak

The 2014 Ebola outbreak in West Africa was the 25th known event since 1976 and by far the largest and longest. According to the World Health Organisation (WHO), it represented a “public health emergency of international concern” (Piot et al., 2014, p.1034); (WHO, 2014d).

Ebola Virus Disease (EVD) is a severe illness caused by a Filovirus called Ebola. An infectious, rapidly fatal disease with a death rate between 50% and 90% and no causative treatment thus far, it is spread through direct contact with bodily fluids (blood, saliva, urine, sperm, etc.) of an infected person, as well as through contact with contaminated surfaces or equipment, including linen soiled by the bodily fluids of an infected person. The time interval between exposure to bodily fluids and development of symptoms is 2 to 21 days with an average incubation time of 8 to 10 days. It is important to note that an infected person is only contagious when he or she has already developed symptoms. The person suffering from EVD is most infectious during the last stage of infection, and immediately after death (Richards and Fairhead, 2014, n.4; CDC, 2014a; CDC, 2014b; CDC, 2014c; WHO, 2014a).

The outbreak began in Guinea in December 2013, although the WHO was not officially notified before 23rd of March 2014. During the epidemic, the EVD mainly spread across Guinea, Sierra Leone and Liberia with a few isolated cases reported in Mali, Nigeria, Senegal, Spain, the UK and the US. However, in these latter countries an epidemic was preventable through infection control measures. During 2014 the number of cases rose to 20,206 with 7,905 deaths reported by 31st December 2014.

The WHO assumed a significant level of under-reporting and the number of cases was believed to be higher. It was anticipated that the number of people who contracted the virus would continue to rise in 2015 and by 10th May 2015 26,759 cumulative cases and 11,080 cumulative deaths had been reported. Thereafter, there was a rapid decline in the number of registered cases (WHO Ebola Response Team, 2014, p.1482; WHO, n.d.; WHO, 2015a).

On 9th May 2015, after a period of 42 days since the last case had been reported, the outbreak was officially declared over in Liberia, while new cases still occurred in Guinea and Sierra Leone. In July 2015, however, new cases were again registered in Liberia (WHO, 2015b).

The Kailahun district was one of the first affected parts of Sierra Leone. Due to the high infection rate, different measures were implemented to avoid transmission. One of these measures was a ban on the consumption of bushmeat (Exhibit 4).

In addition, both the national authorities and international organisations experienced a growing resistance to their aid efforts by the community, culminating in the refusal of access to certain areas. This was attributed to the low level of education and a strong adherence to traditions (WHO, 2014c) (Exhibit 7).

The countries that were the most affected (Guinea, Sierra Leone and Liberia) were confronted with enormous problems in trying to stop the epidemic. Throughout the early months of the epidemic national governments denied the outbreak, while the response was too slow and inefficient. As the first international organisation on the ground, Médecins sans Frontières (MSF) established the first Ebola treatment units in Guinea and in Kailahun, Sierra Leone. When the governments and WHO finally acknowledged the magnitude of the outbreak and multi-national and multi-sectoral efforts were mobilised to implement control measures and provide clinical care for people with EVD, it took considerable time and effort to bring the epidemic under control (MSF, 2014).

Earlier that day

That morning, Hanna had heard agitated voices. Looking towards the direction of the noise, she had seen three nurses she knew, standing in a huddle, all three speaking at once in excited voices. Curious, she had decided to go and see what was happening. As she had approached she had heard Maria, one of the nurses saying: “Disrespectful! Unbelievable, can you imagine it?”

“Hey Maria, is everything all right? What happened? Can I help?” Hanna had asked. “No, you can't. You wouldn't understand”, Maria had replied. “What wouldn't I understand? Please, tell me,” Hanna had insisted. Maria had looked uncertain but one of her colleagues had urged “Tell her, I think she should know what's going on here.”

Maria's story

Maria had sighed before she started to tell her story: “Three days ago a pregnant woman died in my home village of Folima, which is about 30 km away near Buedu. She had a fever and the health workers suspected she died from Ebola, so some international health workers came into our village wearing their masks, and they wanted to bury her immediately without respecting our traditions. The villagers tried to explain that it was impossible to bury her because she was pregnant. Our chief told them that first, they had to remove the baby from her womb. The health workers replied that this wasn't possible; that it was too dangerous. They didn't understand,” Maria had continued, “that it is not possible for us to bury her that way. We are Kissi!”

“I can understand that you want to bury her according to your customs,” Hanna had replied. “But during an Ebola outbreak it is far too dangerous to carry out such an operation. Contact with a dead body likely to be infected with the Ebola virus has to be kept to a minimum. An operation would be hazardous both for the doctor and the nurses” (Exhibit 5).

Maria had interrupted her: “If they will not extract the fetus before they bury her, we are all in danger. This mistake will affect us all...”

Kissi 'tradition'

The Kailahun district was mainly populated by Kissi and Mende. The Kissi believed that a well-functioning, healthy and orderly world was a world in which people, crops, domestic animals and wild animals reproduce as they should. Therefore, it was essential that reproduction took place in several cycles and was not intermingled. For example, the reproduction of people took place in the village, the reproduction of crops in the field and the reproduction of wild animals took place in the bush. The same was true for different generations. Every child had its own cycle as did every crop and one was kept separate from the other.

This also applied to death. Death, they believed, should occur in the village and not in the bush. A death of one generation should not be confused with another, so a mother was never buried with her child even if she died while pregnant. In this case, the baby had to be removed from the

deceased mother's womb. Women who were pregnant or in the reproductive age were not allowed to care for terminally ill people. After death it was important to respect the last wishes of the deceased, clear their debts and make the correct sacrifices over the tomb (which included the payment of incomplete bride wealth).

Failure to obey these rules would be punished either through illness among the people or of the whole social agro-ecosystem. In addition, the spirit of the deceased might not reach the village of the dead and instead torment the descendant (Fairhead, 2014, chap. Culture perspectives and Ebola; Government of Sierra Leone, 2006, p.6) (Exhibit 6).



Photo: CDC Global Health 2015 <https://creativecommons.org/licenses/by-nd/2.0/>

Back on the veranda

Hanna was still lost in thoughts, remembering what Maria had said when Charles approached the veranda.

“May I?” he asked. “Sure, have a seat”, Hanna replied. “I'd be happy to have some company.” “How are you doing so far?” asked Charles. “Quite honestly,” said Hanna, “I really wonder what I'm doing here. I've worked in Africa before but never had an experience like this. Our hospital is just not prepared for Ebola patients. We lack basic equipment, there are too few of us and I can feel the fear of the staff and the patients. I also get the impression that the local people are starting to mistrust us. Half the hospital beds are empty and people do not seek healthcare when they need it. What can I do to help? Even though international aid is increasing, the situation is getting worse, not better. We're not only lacking basic things like materials and ambulances, but also proper coordination. It seems like there are many forces pulling in different directions.”

Sighing, Hanna took another sip of her soda and continued, “And what about today's events? Maria told me about that pregnant woman who died in her village.” “Ah, yes”, said Charles. “Everyone is talking about it. As far as I know, the family has still not allowed the health team to bury her.”

Hanna replied, “But don't they understand that it is too dangerous to extract the dead fetus and that they must bury her quickly? Trying to remove the fetus would result in a high likelihood of the health workers themselves being infected with Ebola! Why can't they understand? Why does the family want to run the risk of someone else getting infected, whether it's health workers or themselves?”

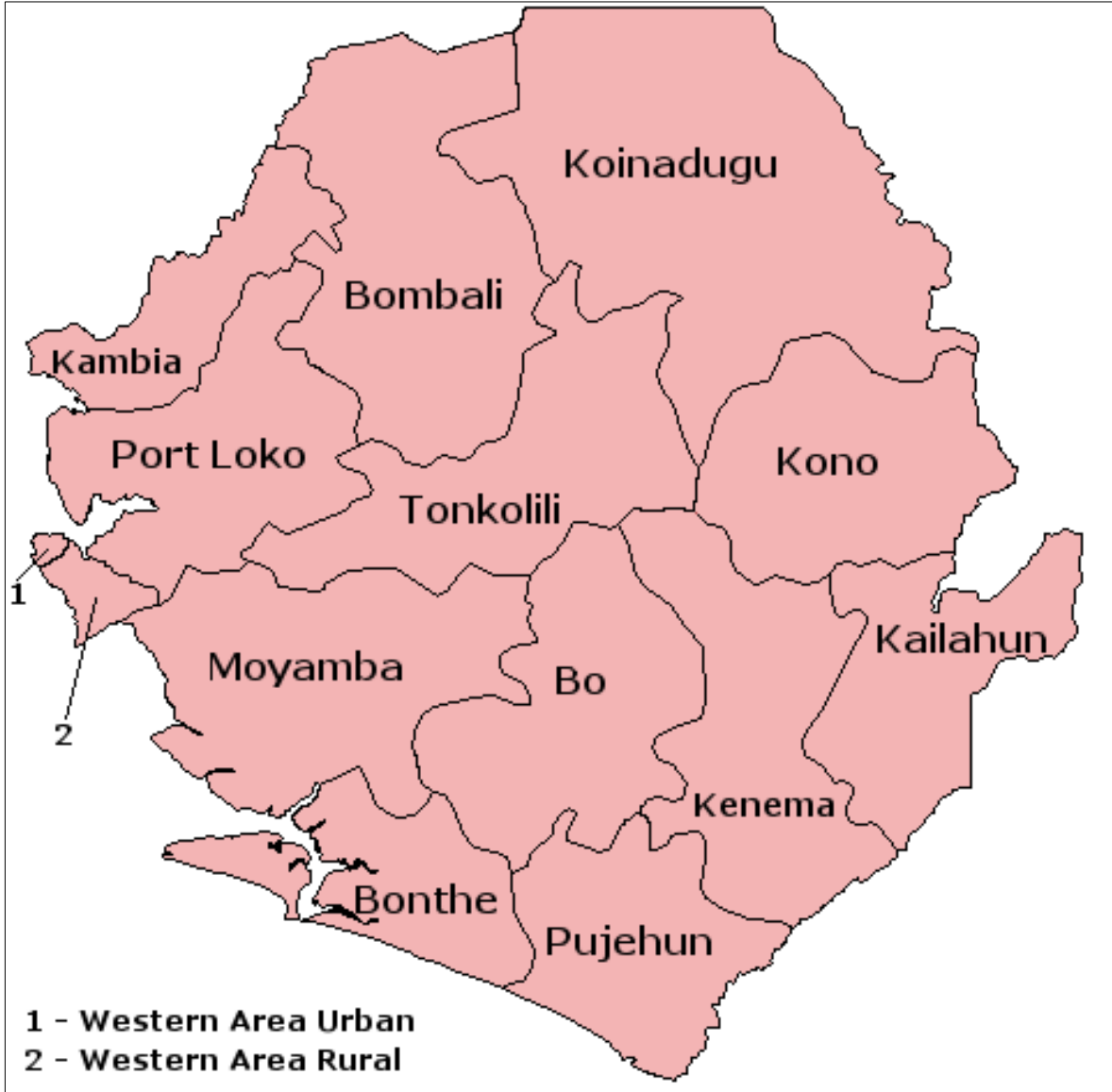
Charles nodded. “Hanna, I can understand that all this seems strange to you. But they don't react like this out of ignorance. Their mistrust is a form of protection. In this country we have a lot of experience with disappointment – the government has so often lied to us. And international teams come and go, still most of the time, the situation remains more or less unchanged. People here have a different view of things. They have different rites and traditions. Should they change their behaviour just because strangers, be it from the government or international aid workers, demand it? They will not accept these new rules, because it is against everything they believe in” (Exhibit 7). “How can this situation ever be resolved then?” asked Hanna. “What kind of measures would allow us to accept local traditions while at the same time prevent the transmission of the disease so that the epidemic can be stopped? How can we work to prevent people from hiding their sick and dead family members?”

Exhibit 1: Map of Sierra Leone



(‘File:UNSierraleone.PNG – Wikimedia Commons’, n.d.)

Exhibit 2: Districts of Sierra Leone



(File: Sierra Leone Districts.png - Wikimedia Commons', n.d.)

Exhibit 3: Facts and figures Sierra Leone

Human Development Index (HDI)	Rank 183 (2013) out of 187 countries (UNDP, 2014)
Population	5,743,725 (July 2014 est.)
Urbanization	Urban population: 39.2% of total population (2011)
	Rate of urbanization: 3.04% annual rate of change (2010-15 est.)
Median age	Total 19 years
	Male 18.5 years
	Female 19.6 years (2014 est.)
Religion	60% Muslim
	10% Christian
	30% indigenous beliefs
Birth rate	37.4 births/1,000 population (2014 est.)
Death rate	11.03 deaths/1,000 population (2014 est.)
Mother's mean age at first birth	19 years
Total fertility rate	4.83 children born/woman (2014 est.)
Maternal mortality rate	890 deaths/100,000 live births (2010)
Infant mortality rate	73.29 deaths/1,000 live births
Life expectancy at birth	total population: 57.39 years
	male: 54.85 years
	Female: 60 years (2014 est.)
Health expenditure	18,8% of GDP (2011); 15.1% (2012) (WHO, n.d.)

	Per capita: 205 (Intl. \$, 2012) (WHO, n.d.)	
Physicians' density	0.02 physicians/1,000 population (2010)	
Hospital bed density	0.4 beds/1,000 population (2006)	
Sanitation facility access	improved	unimproved
	urban: 22.5% of population	urban: 77.5% of population
	rural: 6.8% of population	rural: 93.2% of population
	total: 13% of population	total: 87% of population (2012 est.)
HIV adult prevalence rate	1.5% (2012 est.)	
Major infectious diseases	Degree of risk	very high
	Food or waterborne diseases	bacterial and protozoal diarrhoea, hepatitis A, and typhoid fever
	Vector borne diseases	malaria, dengue fever, and yellow fever
	Water contact disease	schistosomiasis
	Animal contact disease	rabies
	Aerosolized dust or soil contact disease	Lassa fever (2013)
Children under the age of 5 years underweight	18.6% (2010)	
Education expenditures	2.9% of GDP (2012)	
Literacy	Definition: age 15 and over can read and write English, Mende, Temne or Arabic	
	Total: 43.3%	

	Male: 54.7%
	Female: 32.6% (2011 est.)
School life expectancy (primary to tertiary education)	Total: 7 years
	Male: 8 years
	Female: 6 years
Child labour – children ages 5-14	Total number: 573,287
	Percentage: 48% (2005 est.)

(Central Intelligence Agency (CIA), 2014)

Exhibit 4: Early strategies to contain the outbreak

The Ebola outbreak in West Africa can be traced back to a single case of a two year-old, who came into contact with a fruitbat. Fruitbats have been known to be the reservoir for the EVD, as these animals are regularly caught and eaten by the local population. The Ebola outbreak was directly linked with eating exotic animals, which contain the Ebola virus. The main public message from the health authorities was therefore that people should stop eating 'bushmeat'. This statement is highly problematic. First, the fruitbat was deemed to be the reservoir for EVD, nevertheless, people have been in contact with those animals for decades. Second, with this statement, people are forced to cut 'bushmeat' out of their diet. This results in a loss of the most important and often the only source of protein and other nutrients for an already poor and often undernourished population. Third, this statement skews the reality, as apart from the first case(s), transmission was apparently exclusively human-to-human throughout the epidemic.

Those messages given initially by the health authorities were extremely counter-productive as the affected population was deprived of a vital source of food. Moreover, they were blamed and looked at with disgust for eating 'bushmeat', even though it is the equivalent to 'game' in European and American contexts. Many people not used to 'bushmeat' tend to find it disgusting and look down on those eating it. This in turn could lead to the assumption that consuming 'bushmeat' is the main reason why the Ebola outbreak started and could spread so rapidly. Most importantly, however, this message in no way significantly contributes to breaking the chain of transmission. Thus, poverty stricken areas of the population are stigmatised for consuming "ugly" meat and in turn for spreading the disease. All of which adds nothing of value to an effective disease prevention (McGovern, 2014; Richards et al., 2014, chap. Beyond zoonosis).

Exhibit 5: Safe burials

During Ebola outbreaks it is essential to conduct burials which follow rigorous bio-safety rules. Without proper care, transmission is highly probable. The following important steps for safe burials should be strictly followed (these steps are extracted from two protocols, which have been developed by WHO and Sáez and Borchert):

- The handling of human remains should be kept to a minimum
- **Only trained personnel should handle remains during the outbreak:** burial teams should consist at least of four members, plus one sprayer and one technical supervisor
- **Equipment to prevent infection:** disinfectant solutions for hand hygiene and for disinfection of subject and surfaces, and Personal Protective Equipment (PPE) which consists of gloves (disposable and heavy duty gloves), disposable coverall suit, impermeable plastic apron, goggles and mask, rubber boots
- **Body bag** for the deceased must be available and used
- **Waste management materials:** disinfectants, leak-proof and puncture resistant sharps container, leak-proof water containers
- The staff should not be wearing PPE upon arrival
- The Burial team leader should ensure that the family witness and other family members have understood these procedures. **Obtain the formal agreement of the family's representative before proceeding**
- Verify that the grave is dug. If this is not the case, send selected people to dig the grave at the cemetery or to the area identified by the family.
- Evaluate the set-up of the environment:
 - Locate the room where the body of the deceased patient is, open the windows and doors for optimal light and ventilation
 - Evaluate the size and weight of the deceased in order to choose the right size of the body bag. This bag needs to be opaque.
 - If a coffin is to be used, place the coffin outside the house
 - Identify with the family, the rooms and annexes (bathroom, toilet) that were used by the deceased patient, as they need to be cleaned and disinfected
- Put on all Personal Protective Equipment (PPE) by burial management team in the presence of the family according to the recommended steps
- Placement of the body in the body bag:
 - Entry into the house with at least two persons of the burial team.
 - Manipulation of the body should be minimal.
 - Remains should not be sprayed, washed or embalmed.

- Placement of the body in a coffin where culturally appropriate
 - **Transport the body bag to the coffin**, which should be placed outside the house, by two or four persons wearing PPE (depending on the weight of the body and the number of persons in PPE)
 - At the end of this step the coffin is decontaminated and is ready to be transported
 - In case no coffin is available, the body bag should be gently placed on the rear of the pickup vehicle by placing the head towards the front. This should be performed by two staff wearing PPE.
- Collection of soiled objects, disinfection if needed, or burning, cleaning and disinfection of the environment (rooms, house) wearing PPE
- After this operation and before proceeding to remove the PPE think through: Did the burial team disinfect or place in a disinfected bag all belongings of the deceased patient? Did the burial team burn the mattresses?
- At the end of this step all places in the home are disinfected
- Remove PPE, manage waste and perform hand hygiene
- Transport the coffin or the body bag to the cemetery
 - For the transport of the coffin, which has not been soiled, protection with household gloves is sufficient
 - No family member should sit in the car cabin
 - Only the burial management team, without PPE, has the right to sit in the car cabin
 - The other participants of the funeral will follow on foot, behind the car at walking pace, with the alarm lights on and possibly dressed with funeral signs (bundles of palm trees on the bumper)
- Burial at the cemetery:
 - Place coffin or body bag into the grave
 - Family to communally wash hands with disinfectant after the burial (using chlorine solution 0.05% or make an alcohol-based hand-rub solution available for hand hygiene performance) for all members involved in the funeral process.
- Return to the Hospital or Team headquarters:
 - Organise the incineration of the single-use (disposable) equipment at the hospital or in another designated place for burning this type of equipment
 - The reusable equipment is again disinfected and dried
 - The post-mortem samples are sent to the laboratory team
 - The car used for the funerals needs to be cleaned and disinfected (especially the rear)

- At the end of the working day, before going back home, each team member should take off rubber boots and disinfect them with 0.5% chlorine solution. Rubber boots should be kept at the team headquarter hospital.

Source: (WHO, 2014b, pp.1–17; Sáez and Borchert, 2014, pp.1–3)

Exhibit 6: Kissi – Death and burial

The following are extracts from “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 by J. Fairhead, 2014). It should be noted here that the Kissi is a small ethnic group and that their traditions, rites and customs may differ from other ethnic groups in the region that are also cited here. More information is provided by J. Fairhead in the above-mentioned paper.

“As soon as death is certain, women relatives and neighbours undo their hair, throw themselves to the ground and may roll in the dust and mud singing lamentations. [...] This expression of violent grief is necessary: “If I did not cry much, people would suspect that I'm a witch/sorcerer; that it was I who killed him.” This is the power of collective consciousness.”

“A funeral can be conducted very quickly for less significant people (for uninitiated children, the socially marginal), or might be surrounded by very complicated ceremonies for those who are socially particularly important. [...] After their death, however, all people can be suspected to have been a sorcerer, and one can attribute to them misfortunes that may recently have occurred. In some instances the dead body will be used to divine whether suspicions were correct. There are many techniques. [...] Whether such interrogation of corpses remains a common practice, and whether symbolic substitutes are used instead of corpses is an open question, but it has been noted in the Ebola crisis as one reason why the body is touched, to discover the cause of death: whether the person died a natural death or died of sorcery.”

“There are other important reasons for touching a body. The body's eyes need to be closed, and for a dead man this will be done by their ‘brother’ (their nearest classificatory brother). In the privacy of their hut, the corpse must also be washed, oiled (with palm oil), and then dressed in their best clothes before being rolled into a mat. Men will wash and prepare men, and women, women.”

“The funeral is usually held the same evening of the death, at sunset, or at the latest the next day to allow maternal kin and friends from neighboring villages to attend. [...] Those from a village should be buried inside their village if they are to rejoin their already-dead family and friends. [...] Graves can be marked by an oval of stones surrounding the tomb, on which a hoe handle or a fragment of wooden bowl used when digging the grave is abandoned. A stake can be placed in the location of the head, on which is hung a cap for a man or calabash or fishing net for a woman.”

“As mentioned above, the death of a pregnant woman or those unsuccessful during childbirth, always gives rise to a complicated ritual controlled by the women’s society; guardians of fertility. The community must address the calamity that such a fault will bring on. These rituals will be highly infectious events for Ebola. Only sterile or menopausal women (or those whose children have all died) may approach a pregnant corpse. They invade the village with shrieking yells and all other inhabitants bar themselves in their homes. The women roam the empty village, warning everyone not to look. They sprinkle a secret leaf decoction around the house that they then enter en masse. At the sight of the body, they raise a new roar and sprinkle the body and the entire house with the decoction, seize the corpse and carry it to the women’s society secret forest – fixing an amulet to the house door as they leave to prohibit entry. At the waterside (all women’s sacred forests are by streams), the senior guardian of the sacred place (sulukuno), opens the dead woman’s belly with a knife, tears out the fetus; and the corpse of the woman is then washed, and stuffed with strips of sewn cloth. Some say that the fetus is buried on the right bank of the water and the mother on the left. Others say that the little body is buried naked in the bed of the same stream, and the body of the mother is taken back to the village for burial following the usual rites. We are not to know. The husband himself is kept in the dark.”

“After burial there are three important events, all of which finally install the dead among the ranks of the ancestor. The first is the ‘sacrifice of expulsion’; the sacrifice of an animal (from cock to bull depending on status) at the tomb in the presence of assembled lineage. This marks the admission of the dead among the ancestors. After this sacrifice, no further sacrifice will be paid at the grave, but at the common altar of the lineage. The deceased has received all the food and all the attention to which they were entitled. They should henceforth not trouble the living. With this event, the living have paid their dead for the right of entry among the ancestors. The second event is the laying of a stone on the ancestral altar. A stone from the tomb over which earlier sacrifices have been made is solemnly placed on the ancestral altar (mandu) and bears the name of the deceased. When the sacrificial blood associated with this event flows on the stone, the heir says to the deceased: “Until now you were alone, now you join our ancestors, you came to Mandu.” Importantly, when death occurs away from home and the body could not be brought back, the stone is taken from the actual tomb and brought to the native village so the deceased can be integrated with his ancestors.”

“Kissi women usually have a meeting place where famous women worship the cult of Mama Folanda, the "grand mothers of yore" and two or three days after the funeral of an old woman, a stone is taken there from the grave. A sacrifice is not so obligatory. However, if a woman is rich and if, above all, if she wants to honour the dead (her mother maybe), she might kill a sheep or a goat whose meat is given to older women. For younger women, there is no public sacrifice. A party without religious rites will mark the end of mourning, and will depend on the economic resources of the husband and his taste for ostentation. Villagers often agree to organise are

party for two or three dead at the same time, with food, music and dance that echoes events celebrating excision. The third event – the settlement in inheritance – should normally take place at the time of the expulsion of the dead but is usually three or four months after the death. It is the end of mourning.”

Exhibit 8: Resistance and ignorance

During the 2014 Ebola outbreak in West Africa, many assumptions spread about the resistance of the population to the messages of the Ebola teams and managers.

These included:

- People denied that Ebola was real
- People didn't want to understand the disease and ways of transmission
- People believed that patients in the Ebola Treatment Units (ETUs) were not treated properly and that their minimum needs were denied
- People believed that organs and blood were extracted and sold after death
- People failed to collaborate with, and even hampered the work of national and international health teams and managers
- People weren't able or willing to follow official rules and guidelines (e.g. they did not agree with the safe burials and even paid bribes to rebury people)
- People hid sick persons, fled, claimed and abducted people from ETUs

This behaviour was considered to be the result of the low level of formal education and a strict adherence to traditions. Officials and international managers tended to blame the population for their reactions and demanded an Ebola response which followed the given rules and which had to be obeyed by the population.

Anthropologists described the origin of traditions in Sierra Leone and explained that these 'traditions' were not traditions in the usual sense of the word. They are linked to Sierra Leone's history of slavery, colonialism and war, which is deeply engrained in the population's culture. It was assumed that due to the slave trade and civil wars, "a pervasive fear of cannibalistic¹ and capricious wandering spirits emerged in a world fearful of slave raiders; the all-pervasive fear of duplicitous witches in the community emerges from a social world lacking of trust within villages and confederacies that were apt to 'sell their own'" (Fairhead, 2014, Chap. 2).

The Colonial powers were seen as extractive rulers, who strengthened only a few political chiefs. The population resisted these political leaders either through bribery or through the construction of a second and secret governance structure: the 'secret initiation societies'. The

¹Fairhead mentions in his paper that ritual cannibalism was introduced in regional military tactics by the Liberian Frontier Force during the 1920s. *ibid.*

result was that the official state was nothing more than a façade, while the ‘secret societies’ constituted important political and social decision-making bodies up to the present day.

This mistrust in the state and the ‘White Colonial Powers’ led to a ‘tradition’ of believing in witchcraft and evil nature spirits. This also contributed to the belief that evil spirits often resembled white men and women.

Against this background it was hardly surprising that the population related to messages from European aid workers during the Ebola outbreak with considerable scepticism. The mistrust of government and international organisations was further exacerbated through infection control measures and instructions. These included the ‘no touch’ or the order to avoid gatherings of people and funerals, and protection procedures in isolation wards (wearing of PPE and the exclusion of the family during treatment, dying and funeral of victims), which were considered signs of witchcraft.

Another source of resistance was that the people of Sierra Leone had their own understanding of disease, dividing fevers into ‘ordinary fevers’ and ‘big fevers’. When people declared that Ebola was not real they were not saying that there was no disease as they knew well the symptoms and process of the disease. Rather, it was believed that Ebola was a ‘western disease’, which was new and already defined by ‘western’ views. Moreover, although people often preferred traditional healers they were also using ‘modern’ treatments, such as antibiotics and painkillers which were available in markets and pharmacies.

Other aspects also emphasised the association of Ebola with (‘Western’) sorcery. It was a disease which easily spread in a social world. Those who attended funerals, those who cared for sick persons, those who respected their culture were also those who became infected. People who behaved in an unsociable way were considered sorcerers or under the influence of witchcraft.

Ebola Treatment Units (ETUs) were places where people were separated from their families and communities. People were not allowed to contact victims, touch the body or care for them. Their last wish was often not communicated, and the family was not involved in the procedures of care, dying and burial. Burials often took place without rituals, without the family and not in the home village of the deceased, which was an essential part for most ethnical groups. Rumours spread that health teams extracted and then sold blood and organs from the dead people.

Health, decontamination and burial teams often approached villages in full Personal Protective Equipment (PPE). There, they took away the sick or dead persons and disinfected the house and belongings. Wearing a mask and sprinkling an unknown liquid, which resembled a well-known purifying practice of a secret society, were interpreted as sorcery. The fact that the family did

not know where their relatives were taken and whether they were alive or dead and where they were buried, added greatly to the mistrust of these health teams. The same was true for surveillance and contact tracing. Already distrusted foreigners and state officials asked very sensitive questions about family and friends and their movements.

Source: (Fairhead, 2014, chap.2; Pellecchia, 2015)

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