

HEART

HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Ebola - Traditional healers, witch doctors, burial attendants

Date: 5 March 2015

Query:

The questions are:

- **Is there a difference between witch doctor, herbalist, traditional healer in terms of when people see them and the kind of treatment they provide (in particular thinking of the amount of physical contact they and others will have with the sick person) or are they different words for the same thing?**
- **Are some of these the same people that would officiate at burials - thinking particularly of preparing the body (if so which ones)?**
- **Are they the same people as secret society leaders? Or what is the overlap?**
- **Is giving them information enough or do they also need money (healing is obviously a livelihood and I understand that money also therefore plays a ritual role too)? If they need payment how would that best be done? As a retainer? For each referral of a person that meets case definition? Other?**
- **Where might other leverage points lie to get them to change their behaviour?**

Content

1. **Overview**
2. **Differences between witch doctors, herbalists and traditional healers**
3. **Burial attendants**
4. **Secret society leaders**
5. **Payment of traditional healers, witch doctors, burial attendants**
6. **Changing their behaviour**
7. **Other resources identified**
8. **Additional information**

1. Overview

This helpdesk focuses on the impact of traditional healers, witch doctors and burial attendants on ebola in West Africa. It seeks to establish if there is a difference between witch doctors, herbalists and traditional healers in terms of when people see them and the kind of treatment they provide. It goes on to explore the roles of these actors in preparing bodies for burial and at funerals. It provides information on secret societies. The report goes on to explore behaviour change. It provides information on payment of traditional healers as a leverage point.

Differences between witch doctors, herbalists and traditional healers

Many Western-based health programmes have only succeeded if traditional African beliefs and customs are taken into account. The influence of the macro-cosmos (the ancestors), the meso-cosmos (witches and sorcerers) and the micro-cosmos (everyday life) must be taken into account (Van Dyk 2001). In Sierra Leone, the ancestors, the living, and those not yet born constitute a great chain of being (MacCormack 1986).

During the 2000-01 outbreak of ebola in Uganda, indigenous epidemic control measures were often implemented. Some of these practices were found to be consistent with those being promoted by healthcare workers. Other practices, such as cultural burial practices, were found to amplify the outbreak. In Uganda traditional healers are often called witch doctors. Both terms suggest their practices have not changed since ancient times, when in fact practices are changing all the time. For example, healers now use a sponge to extract poisons or yat, rather than their mouths, after a healer contracted and died from HIV/AIDS. Witch doctor as a term is also misleading as few healers know how to treat witchcraft. The term Indigenous healer may be a more appropriate term (Hewlett & Amola 2003).

In Sierra Leone, witches and traditional healers are different from each other. Witches are believed to be evil, spreading fear and mistrust. Most Sierra Leoneans live communal lives. Witches hold opposing values based on isolation and malice. Witches derive their power from cannibalism and ritual killing. They can pass to an invisible world called “witch city” that is dominated by material items (Bolten 2014). In Sierra Leone, where patrimonial relations of agrarian production are strong, and in settings where market forces are now well established, witchcraft is less common. By contrast, witchcraft manifestations are higher in communities experiencing the competing pull of patrimonial and market norms. Witchcraft is described as a product of normative ambiguity (van de Grijpsaarde et al 2013).

For Sierra Leoneans sickness is a social occasion. To not visit someone who is sick is almost tantamount to denying that person's existence. The healthy must visit the sick to avoid suspicions of witchcraft (Coulter 2005). There are clear parallels between perceptions of witchcraft and ebola – both threaten communal life and menace those who try to control it. Ebola education campaigns create linkages to witchcraft with messages of no hugging, no handshakes, no caring for the ill, and no handling of the dead. Ebola is a disease that destroys people's ability to be human (Bolten 2014).

Dying in Sierra Leone is a period of categorical ambiguity in which a person is still living, but talks of the past, and is in the process of becoming one with the ancestors. As the ancestors are the source of both blessings and misfortune, the dying are treated with great consideration. Post-mortem examinations of internal organs are routinely done to examine the character of the deceased and look for a witch. This is carried out by officials of Poro, the men's secret society (MacCormack 1986).

In the wider region including Sierra Leone, Guinea and Liberia, informal health workers is a term that covers a variety of different providers drawing on different health understandings to offer biomedical, herbal and spiritual treatments. Informal providers include:

- Unlicensed pharmacies or pharmacies operating outside of official regulations.
- Unlicensed street (biomedical) drug peddlers.
- Bone setters.
- Herbalists.
- Pepe doctors selling either or both biomedical and herbal treatments.
- Spiritual healers (including those of Christian or Muslim faith).
- Traditional birth attendants.
- Female chiefs.
- Senior members of secret societies.
- Other traditional healers who have received knowledge either from their families or from secret societies.

Informal health providers should not be categorised on the basis of being either traditional or biomedical. Most informal health workers gain legitimacy by demonstrating skill and compassion to the community (Wilkinson et al 2014). The term witch doctor mistakenly suggests a specialist role only of detecting witches, when most do much more. Healing is regarded as far more than the curing of disease or illness. In Nigeria, traditional healers remain the very embodiment of conscience and hope in society. In many places they are the major or only source of health care (Offiong 1999). In Guinea, in addition to herbalists who enjoy great prestige as the “real” practitioners of traditional medicine, divine healers and witch doctors also employ medicinal plants that are supposed to have either special spiritual or exorcising powers. In remote communities that lack hospitals and doctors, traditional herbalists operate closer to the people, taking advantage of the biodiversity of plant species in such areas to cure various diseases and ailments (Magassouba et al 2007).

Medical anthropologists are rarely involved in efforts to control high mortality diseases (Hewlett et al 2005). Anthropologists and the insights of anthropologists could be used to mount more effective public health campaigns (Hewlett & Hewlett 2007). For example, during the 2000–01 ebola outbreak in Uganda, misunderstandings from the health authorities led to a ban on all traditional healing, with those who continued to practice being stigmatised, reducing their ability to help (Hewlett & Amola 2003). Some cultural practices of local people are helpful and should be incorporated into control procedures. Many responses to epidemics are rooted both in culture and in human nature (Hewlett & Hewlett 2007).

Burial attendants

Ebola-infected bodies are at their most contagious at the point of death. They must be contained and buried quickly to avoid further contagion. There is a responsibility for burial teams to maintain respect for the deceased, and their families (EducAid 2014). Sanitary funeral practices, case isolation and contact-tracing with quarantine must be implemented with utmost urgency in order to reverse the growth of the outbreak. Practices including washing, touching, and kissing the body exacerbate ebola (Pandey et al 2014). Considering previous outbreaks of ebola, it is clear that traditional burial ceremonies have a varying impact depending on regional practices. Burial ceremonies played a more important role in DRC and less so in Uganda where community transmission may have been a more significant source of infection (Legrand et al 2007).

Safe and dignified burials of those who have died from ebola have been a top priority of the international and government agencies of the past months. Government burial teams have been accused of being insensitive, lacking clarity as to grave locations, and ignoring cultural formalities. However, traditional burial rites have long been attributed as a cause for the virulent spreading of ebola, with ceremonial body washing recognised as the main vehicle of transmission. Sierra Leone must be unified by the counter-ebola programmes, not divided by them. More thought needs to be given to the importance of religious ceremonies, as well as the social and spiritual implications of forgoing them. To make progress the authorities must

pacify and win over an increasingly angered and alienated population. An appropriate balance must be struck between swift and decisive burials, as well as accountability and sensitivity (EducAid 2014).

The burial of a well known and respected traditional healer who worked in both Sierra Leone and Guinea was attended by hundreds of people. Participation in that funeral has been linked to as many as 365 ebola deaths. The healer's funeral as a seminal event at the outbreak's explosive start. It is now accepted that to control the spread of the disease will also require stronger district surveillance and epidemiology, contact tracing and burial teams. (WHO 2015). In Guinea, 60% of all cases had been linked to traditional burial practices (WHO 2015).

There have been accusations, particularly from religious leaders that traditional healers and witch doctors in West Africa are contributing to the spread of ebola. Traditional practices, such as touching and kissing the corpse during the funeral, is also contributing to the spread of the disease, as dead bodies are able to host the virus and transfer it to the living. Bodily fluids that leak out of a corpse upon the failure of the immune system, remain highly contagious for at least three days after a victim has died. Families significantly increase their risk of contracting the disease by entertaining traditional funeral rites (Lodge 2014).

Some traditional practices, such as ceremonial body-washing, may have been adopted from Islam. In Sierra Leone, divinatory interrogation of the corpse is a standard part of burial practices (Shaw 1997). Many of the other burial practices that hold significant spiritual meanings to communities are unable to be enacted due to ebola. The interruption of these ceremonies is troubling the communities involved. Aside from the trauma of an ebola death, the family and community must also deal with being unable to bury their dead with the accepted rites. It has also led to instances of stigmatisation and dishonour to families (EducAid 2014).

On safety grounds, it has been suggested that traditional burials are restricted. Cadavers should be disinfected before inclosure in a body bag that is further disinfected (Pandey et al 2014). A prompt burial or cremation of the deceased, with minimal handling is recommended. No embalming should be done and surgery or post-mortem examination should only be done after consultation with experts (Borio et al 2002). Human behaviour, and likely adherence to recommendations must also be considered. Funeral attendance and traditional burial practices may decline with increased awareness of the disease, facilitating the enforcement of sanitary burial practices. In contrast, other behaviour changes may hinder intervention efforts (Pandey et al 2014).

Secret society leaders

Secret societies in West Africa have largely been considered from the point of view of their social function, rather than a structural function. The Sande society initiation ceremony has three dominant dimensions: people, space and supernatural spirits. Each is shown to be dichotomised as women and men, forest and village, invisible spirits and visible maskers in a configuration encompassing and specifying the representations involved (Jędrej 1976).

It is argued that ebola transmission in West Africa was enabled by the influential Zoes (traditional healers, ritual specialists) of the secret societies. They deny ebola is real and continue to hold public village gatherings and secret Poro activities within their Sacred Groves. The traditional secret society rituals have an adverse influence on modern infection control efforts (Carey 2015).

However, in opposition to this argument and drawing on research by MacCormack in the late 1970s, it has been recommended that lineage and secret society chiefs must participate in the planning and implementing of primary health care initiatives, including visiting sick people

in hospital. If this is not permitted, patients will be kept away from hospitals and those who are already in hospital may flee. Secret societies and their leaders have a genuine interest in the health and wellbeing of the communities that they represent. Secret societies are also likely to perform traditional rites at funerals (Fairhead 2014).

In Liberia, the Ministry of Internal Affairs through its Bureau of Customs and Culture and the National Council of Chiefs and Elders suspended all Poro and Sande activities throughout Liberia from September 17, 2014. The aim was to reduce the risk of ebola infection. However, there have been reports that the activity of many societies continues (AllAfrica 2014).

In Sierra Leone, all activities of secret societies in Makeni and the entire Bombali district have been temporarily banned as a result of the ebola outbreak. The Bondo, Poro, Gbangbani, Ojeh and Hunting societies have been asked to help raise awareness by sensitising their various communities about ebola. The By-Laws instituted are within the general consensus of the Ministry of Local Government, Council of Paramount Chiefs and the Sierra Leone Parliament. Public gathering, trade fair (Lumors), sale of bush meat, hunting bush animals, and burial ceremonies all temporarily banned till further notice. Those found to be breaking the law are liable to both punishment and fines. Harboring suspected or positive cases of ebola, spreading false rumour and disseminating misleading information, failure to report deaths and burials, drug peddling and treatment of patients at home are also punishable by law. Herbalists and Spiritual Healers are requested to avoid treating patients at home or in their shrines (Kamara 2014).

Payment of traditional healers

Evidence of the best way to pay or engage with traditional healers was limited, although it is argued that the ebola epidemic may have had less impact if they had been properly included in the outbreak response. At the start of the outbreak the guérisseurs (medicine men) in Sierra Leone didn't know how to deal with ebola victims. Now with training from the UN, they can help stop the virus spreading. If a guérisseur has been trained on ebola and is then caught treating a suspected case, they are fined 50,000 GNF (\$7), stripped of their membership and reported to the police. Now healers are seen as part of the solution, rather than part of the problem, it is argued that their efforts should be recognised. It is suggested that the authorities should cover costs of transport, food and their time and effort. The counter argument to this is that addressing and treating ebola may be turned into an industry or a business (Hussain 2015).

Behaviour change

In Sierra Leone and other countries in West Africa, traditional healers are sought-after, with people turning to them for treatment before considering hospitals or clinics. In parts of Sierra Leone, upon receiving information about how ebola spreads, many traditional healers have postponed their activity, to protect the members of their communities. Many traditional healers have expressed a wish to learn more about ebola and how to stop it. Many traditional healers believe they were born into the role and therefore are not motivated by material rewards. Healers are well respected and can spread positive messages in communities. They can bring about behavioural change in their communities if they are provided with the correct information (Mueller 2014).

Health increasingly relies on behaviour. To successfully change behaviour, direct, open, understandable and timely information from a single authoritative source is required. Intermediaries can assist with reinforcing the message. To achieve change in behaviour, information must be provided in a language and format that is understood. If large proportions of the society are illiterate, this must be taken into account (Ratzan 2014).

To successfully change behaviour, all healthcare workers should be aware of and expect a sorcery explanation for ebola, especially at the beginning of an outbreak. Respect and understanding for the social economic-spiritual context can develop rapport and build trust. It is reported that people may be open to biomedical treatment even though they believe sorcery is the cause. Being able to use local criteria to distinguish sorcery from epidemic illness is useful (Grant 2014).

The networks that traditional healers control have potential to be used to address the outbreak, if the healers are mobilised/trained/sensitised/linked in to the response. They might be useful in referral, surveillance and prevention communication. Health workers could be invaluable for supporting, staffing and lending legitimacy to the response. The unintended consequences should also be considered. If the response does not go to plan, it may destroy the few trusted care networks that exist. It is inevitable that some healers can be trusted and some should not be. Some will have established networks and reputations, others will not. Some will want to help, some will not. Before behavioural change can take place, research is needed to establish the situation and any tensions that may exist (Grant 2014).

The first ebola outbreak in 1976 in Zaire (now known as Democratic Republic of Congo) was brought under control quickly. The current outbreak has spiraled out of control. Behavior changes among the affected communities may be the reason for the difference. The decline of the outbreak in Zaire most likely resulted from changes in the community's behaviors, such as altering traditional burial practices so that people could avoid catching the virus from dead. Informing the community and getting people to change their behavior is critical to bringing the current outbreak under control. Denial, ignorance and a weak healthcare system and logistics have made the current outbreak in Sierra Leone worse. There has been little change in behaviour in remote border regions (Gholipour 2014). Whether traditional healers could play a role in this required behaviour change is not established.

It is known that faith leaders are trusted and respected members of their community, and are often the first port of call when people are panicked or afraid. They can assist in the response effort by disseminating key messages and mobilising their communities to do the same (Stephanie et al 2015). Whether traditional healers can perform a similar role to faith leaders is not elaborated on.

Communication and social mobilisation to raise awareness about ebola and its risk factors are central to the response. Risky behaviour related to traditional practices must be addressed. Strategies that do not engage in the material, social, or spiritual implications of changing social practices will not succeed. Burial practices often incorporate procedures to distribute inheritance and ensure the deceased an afterlife. Failure to do so may cast family members as negligent, or foster suspicion of malicious causes of death - concerns that may override health considerations. A flexible approach must be taken and these concerns not disregarded (Chandler et al 2014).

Local leaders are vital in the ebola response, as they can provide information about what is needed at ground level in terms of funding and equipment, as well as what sort of strategies might improve community trust. Much of the focus on local belief systems has framed it as something ignorant/nefarious that must be overcome. There are deep, historical reasons why local belief systems exist, and it makes no sense to try and overturn them. Instead the response and its actors must work with them. Some people believe that speaking the name of the disease may summon it. Appropriate language must be developed and used that fits in with local beliefs (Haagaard 2014).

2. Differences between witch doctors, herbalists and traditional healers

Articulating the Invisible: Ebola Beyond Witchcraft in Sierra Leone.

Bolten C. 2014. Fieldsights - Hot Spots, Cultural Anthropology

<http://www.culanth.org/fieldsights/596-articulating-the-invisible-ebola-beyond-witchcraft-in-sierra-leone>

Sierra Leoneans use the language of witchcraft to describe the evils of living antisocially, with witches the epitome of the inhuman behaviours of isolation, selfishness, and malice. Witches control an invisible world and grow fat and wealthy through the bodily consumption of people and the destruction of their sociality by spreading fear and mistrust. The special danger of ebola is that it threatens communal life in exactly the same way. It is now so dangerous that it menaces the powerful that attempt to control it.

In Sierra Leone, people live communally, caring for family and social networks through the sharing of food, work, and the fostering of children. Witches, as antisocial consumers, are the antithesis of human beings. A witch's power derives from the consumption of human flesh and human potential, implicating them in ritual killing and cannibalism. Unlike humans, witches in their human forms live alone and eat alone, and, most disturbingly, grow wealthy through unseen means. Their wealth is linked to a parallel invisible world that they inhabit at night, a "witch city" that is technologically advanced and dominated by many of the material items—such as cell phones—that are now implicated in the spread of an equally deadly, also invisible force. As ebola education campaigns intensify, their message—no hugging, no handshakes, no caring for the ill, and no handling of the dead—creates clear linkages to the malevolent world of witchcraft. Ebola is a disease that destroys people's ability to be human.

Ebola, Culture and Politics: The Anthropology of an Emerging Disease

Hewlett B & Hewlett B. 2007. Cengage Learning

http://books.google.co.uk/books/about/Ebola_Culture_and_Politics_The_Anthropol.html?id=kjRF9OSJLkC

In this case study, readers will embark on an improbable journey through the heart of Africa to discover how indigenous people cope with the rapid-killing ebola virus. This account addresses political, structural, psychological, and cultural factors, along with conventional intervention protocols as problematic to achieving medical objectives. The authors find obvious historical and cultural answers to otherwise-puzzling questions about why village people often flee, refuse to cooperate, and sometimes physically attack members of intervention teams. Perhaps surprisingly, readers will discover how some cultural practices of local people are helpful and should be incorporated into control procedures. The authors shed new light on a continuing debate about the motivation for human behaviour by showing how local responses to epidemics are rooted both in culture and in human nature. Well-supported recommendations emerge from a comparative analysis of Central African cases and pandemics worldwide to suggest how the United States and other countries might use anthropologists and the insights of anthropologists to mount more effective public health campaigns, with particular attention to avian flu and bioterrorism.

Mobilising informal health workers for the Ebola response: potential and programme considerations

Wilkinson A, Marí Sáez A, Lipton J, Martineau F & Chandler C. 2014. Ebola Response Anthropology Platform

<http://www.ebola-anthropology.net/wp-content/uploads/2014/11/Mobilising-informal-health-workers-Ebola-Response-Anthropology-Platform.pdf>

This briefing note describes how informal health workers are important care providers in the West Africa region and continue to be so during the current Ebola Virus Disease (EVD)

outbreak. Many are well respected and trusted members of the community who can mobilise large numbers of people for a particular activity and lend legitimacy to a particular programme.

Informal health workers in Sierra Leone, Guinea and Liberia consist of a wide variety of different providers drawing on different health understandings to offer biomedical, herbal and spiritual treatments. Different types of informal providers include: unlicensed pharmacies or pharmacies operating outside of official regulations, unlicensed street (biomedical) drug peddlers, bone setters, herbalists, 'pepe' doctors selling either or both biomedical and herbal treatments, spiritual healers (including those of Christian or Muslim faith), traditional birth attendants, some female chiefs and senior members of secret societies, and other traditional healers who have received knowledge either from their families or from secret societies.

Rather than categorising informal health providers as being either traditional or biomedical, categories that are far from being mutually exclusive, it is perhaps more useful to conceptualise informal providers as being more or less renowned and embedded in local social, political and economic structures, along a spectrum. Part of being embedded in localities and regional networks, will be being embedded in local institutions such as the societies, as in the case of traditional birth attendants. This could also mean village (or urban section) politics, economies, marriage and kinship ties. Their legitimacy then comes from demonstrating skill and compassion to the community, in the context of what is appropriate for these institutional ties.

Social thought and commentary: reflections from the field: a girl's initiation ceremony in Northern Sierra Leone

Coulter C. 2005. *Anthropological Quarterly*; 78 (2)

<http://www.jstor.org/discover/10.2307/4150841?sid=21105514334831&uid=2&uid=3739256&uid=4>

Three years after the official declaration of peace in Sierra Leone, people have finally relaxed and now try to reconfigure their lives in a very visibly war-torn surrounding. In this setting, the girl's initiation, *dimusu biriye*, becomes not only a ceremony of the making of women, or a social event, but an important post-war event reconfiguring social relations. Also, this event challenges the anthropologist on a more personal level regarding issues of womanhood, bodily integrity, and the position as outsider.

This paper reflects how in Sierra Leone, sickness is a social occasion and not to visit someone who is sick is almost tantamount to denying that person's existence. Also, to visit those sick here has also to do with avoiding suspicions of witchcraft, of having been the one causing the sickness.

Dying as Transformation to Ancestorhood: The Sherbro Coast of Sierra Leone

MacCormack C. 1986. *Sterben und Tod Eine kulturvergleichende Analyse*

http://link.springer.com/chapter/10.1007%2F978-3-322-88770-2_14

People who live in the Sherbro coastal area of Sierra Leone have a social organisation based upon descent from named ancestors and ancestresses. Ancestors, the living, and those not yet born constitute a great chain of being. This continuum of existence is punctuated, and made discontinuous, by rites of passage (birth, puberty, death). Dying is a period of categorical ambiguity in which a person is still among the mundane living, but babbles of the past, a sign that he or she is also in the process of becoming one with the ancestral shades. Indeed, senility is positively interpreted as a sign that the person has begun to slip across into that other aspect of being, in close communication with ancestors. Since ancestors are the ultimate source of blessings (and misfortune), the dying are treated with great consideration. The ambiguity of senility and dying is resolved through rituals which 'carry' the immediate deceased through this betwixt-and-between stage, placing him or her unambiguously into the

category of ancestors. Until this is done, the period of ambiguity is perceived by the community as a period of danger.

Post-mortem examinations of internal organs are routinely done by officials of Poro, the men's secret society, to look for signs of the true character of the deceased (a possible witch). These signs have a bearing on the specific content of the death rites. The paper will consider the status of moribund males and females, in descent systems which are patrilineal, matrilineal, or cognatic (as with the Sherbro). Although the paper is based upon 15 years' intermittent field work in coastal Sierra Leone, this analysis of death in societies structured into descent groups will be relevant for most of Africa, and many other non-European societies as well.

Who believes in witches? Institutional flux in Sierra Leone

van de Grijspaarde H, Voors M, Bulte E & Richards P. 2013. African Affairs; 112 (446)
<http://afraf.oxfordjournals.org/content/112/446/22.short>

Witchcraft has been documented across the globe. The widespread occurrence of such beliefs in modern Africa affects politics, economic development, and poverty alleviation. Anthropologists have analysed the semiotics of African witchcraft, but there is less information on distributional issues. An important question is which communities are most affected, and why? Using data from a survey of 182 villages and 2,443 household heads in the Gola Forest region of eastern Sierra Leone, the authors examine three manifestations of witchcraft – concerns, conflicts, and detection. They find that where patrimonial relations of agrarian production remain strong, and in settings where market forces are now well established, witchcraft is less of a concern. By contrast, witchcraft manifestations are higher in communities experiencing the competing pull of patrimonial and market norms. It is concluded that witchcraft, is a product of normative ambiguity.

Traditional Healers in The Nigerian Health Care Delivery System and The Debate Over Integrating Traditional And Scientific Medicine

Offiong D. 1999. Anthropological Quarterly; 72 (3)
<http://www.jstor.org/discover/10.2307/3317426?sid=21105527728831&uid=4&uid=3739256&uid=2>

Relying on experience with a traditional healer, focus group discussions, and interviews with traditional healers, the author analyses the functions and importance of traditional healers in the health care delivery system of Nigeria. It is concluded that in a society where healing involves not just the curing of disease but also the protection and promotion of human physical, spiritual, and material well-being, traditional healers remain the very embodiment of conscience and hope in their respective communities. The holistic and cathartic nature of their treatment and the fact that in certain places in the country they are the major or only source of health care, make them very important. The author also examines the debate over the possible integration of traditional and scientific medicine. It is concluded that outright integration would be too ambitious and practically impossible but that some form of cooperation is possible, given political will. Regardless of the official government policy on the issue, the two traditions are complementary and Nigerians patronise both of them.

African traditional healers have been variously referred to as herbalists, native doctors, native healers, traditional doctors, medicine men, witch doctors, among others. The title of "witch doctors" suggests that the singular role of this category of African specialists is to detect witches. Far from it; they do much more. Traditional healers are often the main source from which a large segment of African population receive their health care, especially since "healing" is far more than the curing of disease or illness.

The Place of African Traditional Religion in Interreligious Encounters in Sierra Leone Since the Advent of Islam and Christianity

Conteh P. 2008. PhD thesis, University of South Africa.

<http://uir.unisa.ac.za/handle/10500/2316>

This study which is the product of library research and fieldwork seeks, on account of the persistent marginalisation of African Traditional Religion (ATR) in Sierra Leone by Islam and Christianity, to investigate the place of ATR in inter-religious encounters in the country since the advent of Islam and Christianity.

As in most of sub-Saharan Africa, ATR is the indigenous religion of Sierra Leone. When the early forebears and later progenitors of Islam and Christianity arrived, they met Sierra Leone indigenes with a remarkable knowledge of God and a structured religious system. Successive Muslim clerics, traders, and missionaries were respectful of and sensitive to the culture and religion of the indigenes who accommodated them and offered them hospitality. This approach resulted in a syncretistic brand of Islam.

In contrast, most Christian missionaries adopted an exclusive and insensitive approach to African culture and religiosity. Christianity, especially Protestantism, demanded a complete abandonment of African culture and religion, and a total dedication to Christianity. This attitude has continued by some indigenous clerics and religious leaders to the extent that Sierra Leone Indigenous Religion (SLIR) and its practitioners continue to be marginalised in Sierra Leone's inter-religious dialogue and cooperation.

Although the indigenes of Sierra Leone were and continue to be hospitable to Islam and Christianity, and in spite of the fact that SLIR shares affinity with Islam and Christianity in many theological and practical issues, and even though there are many Muslims and Christians who still hold on to traditional spirituality and culture, Muslim and Christian leaders of these immigrant religions are reluctant to include Traditionalists in interfaith issues in the country. The formation and constitution of the Inter-Religious Council of Sierra Leone (IRCSL) which has local and international recognition did not include ATR. These considerations, then beg the questions:

- Why have Muslim and Christian leaders long marginalised ATR, its practices and practitioners from interfaith dialogue and cooperation in Sierra Leone?
- What is lacking in ATR that continues to prevent practitioners of Christianity and Islam from officially involving Traditionalists in the socio-religious development of the country?

Muslim and Christians have given several factors that are responsible for this exclusion:

1. The prejudices that they inherited from their forebears
2. ATR lacks the hallmarks of a true religion
3. ATR is primitive and economically weak
4. The fear that the accommodation of ATR will result in syncretism and nominalism
5. Muslims see no need to dialogue with ATR practitioners, most of whom they considered to be already Muslims

Considering the commonalities ATR shares with Islam and Christianity, and the number of Muslims and Christians who still hold on to traditional spirituality, these factors are not justifiable.

Although Islam and Christianity are finding it hard to recognise and include ATR in interfaith dialogue and cooperation in Sierra Leone, ATR continues to play a vital role in Sierra Leone's national politics, in the search and maintenance of employment, and in the judicial sector. ATR played a crucial part during and after the civil war. The national government in its Truth

and Reconciliation Commission (TRC) report acknowledged the importance and contribution of traditional culture and spirituality during and after the war.

Outside of Sierra Leone, the progress in the place and level of the recognition of ATR continues. At varying degrees, the Soci  t   Africaine de Culture (SAC) in France, the All Africa Conference of Churches (AACC), the Vatican, and the World Council of Churches, have taken positive steps to recognise and find a place for ATR in their structures.

Much about the necessity for dialogue and cooperation with ATR can be learnt in the works and efforts of these secular and religious bodies. If nothing else, there are two main reasons why Islam and Christianity in Sierra Leone must be in dialogue with ATR. Firstly, dialogue of life or in community. People living side-by-side meet and interact personally and communally on a regular basis. They share common resources and communal benefits. These factors compel people to be in dialogue. Secondly, dual religiosity. As many Muslims and Christians in Sierra Leone are still holding on to ATR practices, it is crucial for Muslims and Christians to dialogue with ATR practitioners.

Ethnobotanical survey and antibacterial activity of some plants used in Guinean traditional medicine

Magassouba F et al. 2007. Journal of Ethnopharmacology; 114

<http://www.sciencedirect.com/science/article/pii/S0378874107003297>

African traditional medicine abounds in medicinal plants, and the tribal people, wherever they exist, still rely chiefly on herbal medicines. In many parts of Africa, herbal medicine still plays a vital role in health care delivery systems especially in remote places where clinics and hospitals are sparsely located. In these communities, traditional herbalists operate closer to the people, taking advantage of the biodiversity of plant species in such areas to cure various diseases and ailments.

In Guinea, in addition to herbalists who enjoy great prestige as the "real" practitioners of traditional medicine, divine healers and witch doctors also employ medicinal plants that are supposed to have either special spiritual or exorcising powers.

Providing Care and Facing Death: Nursing During Ebola Outbreaks in Central Africa

Hewlett B & Hewlett B. 2005. Journal of Transcultural Nursing; 16 (4)

<http://tcn.sagepub.com/content/16/4/289.full.pdf+html>

Few studies have focused on describing the experiences of health care workers during rapid killing epidemics. In this article, the views and experiences of nurses during three outbreaks of ebola haemorrhagic fever (EHF) in Central Africa are examined. These three outbreaks occurred in Kikwit, Democratic Republic of Congo (DRC, 1995); Gulu, Uganda (2000-2001); and Republic of Congo (ROC, 2003). Open ended and semi-structured interviews with individuals and small groups were conducted during the outbreaks in Uganda and ROC; data from DRC are extracted from published sources. Three key themes emerged from the interviews: (a) lack of protective gear, basic equipment, and other resources necessary to provide care, especially during the early phases of the outbreaks; (b) stigmatisation by family, co-workers, and community; and (c) exceptional commitment to the nursing profession in a context where the lives of the health care workers were in jeopardy.

The aim of the current study was to provide new insights and background into a major health care crisis that made headlines around the world. No other study could be found that examined the experiences of nurses during an ebola epidemic. The findings reported in this article are taken from a larger study of survivors of EHF, health care workers, community members, and traditional healers in villages with large numbers of EHF cases. Only the experiences of nurses caring for EHF patients and their families are reported here.

It is reported that local nurses in Africa tend to be embarrassed by their so-called traditional beliefs, and international health workers often view local beliefs and practices as problematic. The authors hope the descriptions of cultural models demonstrate to local nurses that there may be value in these beliefs and practices and that nurses who come from the international community can build on the models in providing care.

Knowledge of local and biomedical models can contribute to the eventual control of an outbreak. Local nurses and other health care workers whom are aware of these models and were in a position to negotiate the cultural models more readily than members of the international teams sent to control the outbreaks. Unfortunately, those ascribing to the biomedical model tended to reject or view indigenous knowledge and practices systems (i.e., culture) as problematic and something to overcome because they were seen as serving to amplify rather than control the outbreaks. Often health educators and local, national, and international medical personnel were not aware or did not consider the possibility that existing traditional beliefs and practices actually contribute to ebola control efforts.

Cultural models are important to understand; however, it is also important to listen to, and build on the views and experiences of nurses during these outbreaks.

Cultural Contexts of Ebola in Northern Uganda

Hewlett B & Amola R. 2003. *Emerging Infect Diseases*; 9 (10)
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3033100/>

Technical guidelines for the control of ebola indicate that understanding local views and responses to an outbreak is essential. However, few studies with such information exist. Thus, we used qualitative and quantitative methods to determine how local residents of Gulu, Uganda, viewed and responded to the 2000–2001 outbreak of EHF. Results indicated that Acholi people used at least three explanatory models to explain and respond to the outbreak; indigenous epidemic control measures were often implemented and consistent with those being promoted by healthcare workers; and some cultural practices amplified the outbreak (e.g., burial practices). However, most persons were willing to modify and work with national and international healthcare workers.

The term traditional healers are used here because it is commonly used by WHO and other international agencies. In the Gulu area, however, such healers are often referred to as witch doctors. Both terms misrepresent the nature of what they do. The term traditional gives the impression that their practices have not changed since time immemorial, when, in fact, such healers are always changing their practices. For instance, as mentioned, they no longer suck out yat with their mouths because some healers who did so contracted and died from HIV/AIDS. Today such healers use a local sponge or type of grass to extract yat. The term witch doctor is even more misleading because witches (called night dancers or lajok) are relatively uncommon in this area by comparison to the Bantu-speaking areas to the south, and few healers know how to treat witchcraft. Indigenous healer may be a more appropriate term.

Before this study was conducted, WHO and other international and national health workers felt that traditional healing practices of some healers led to the amplification of the outbreak. A female healer and some of the earliest EHF patients were often mentioned as examples. In September, a healer travelled from Gulu town to her rural village a few days after treating a known EHF patient. The healer became ill and reportedly treated patients by cutting and sucking poisons, such as yat, from ill patients, and thus infecting her patients with her bodily fluids. The healer died, and >10 deaths were subsequently associated with her healing. But village sources indicated that she did not treat people in the rural village and she did not have any of her healing tools (e.g., spear and rattle) because rebels in the rural areas kill healers caught with these implements (rebels view the work of healers as contrary to the ways of God). Rather, the healer infected many people because she was a prominent and powerful

healer. Consequently, when she became ill in the rural area, many people assisted in her care, several different persons slept with her during the night to watch after her, and once she died, several persons assisted in the traditional washing of her body. This case occurred early in the outbreak, and misunderstanding led health authorities to ban all traditional healing. Traditional healers were stigmatised, which may have been unfortunate as all those we interviewed wanted to help in control efforts. As mentioned above, healers rarely cut the skin to remove yam or to insert medicines or herbs because of HIV/AIDS health education programs and the loss of several healers to that infection.

Traditional African beliefs and customs: implications for AIDS education and prevention in Africa

Van Dyk A. 2001. South African Journal of Psychology; 31

http://reference.sabinet.co.za/sa_epublication_article/sapsyc_v31_n2_a8

Many Western-based AIDS education and prevention programmes have failed dismally in Africa and they may only succeed if traditional African beliefs and customs are taken into account. This article discusses relevant aspects of the traditional African worldview by explaining what health, sickness and sexuality mean in traditional Africa. Traditional African perceptions of causes of illness (including AIDS), perceptions of sexuality, and cultural beliefs inhibiting the usage of condoms are described in terms of the influence of the macro-cosmos (the ancestors), the meso-cosmos (witches and sorcerers) and the micro-cosmos (everyday life). The implications for AIDS education and prevention in Africa are discussed and suggestions are offered for the development of such programs.

Medical anthropology and Ebola in Congo: cultural models and humanistic care

Hewlett B, Epelboin A, Hewlett B & Formenty P. 2005. Anthropologie Médicale.

<http://www.pathexo.fr/documents/articles-bull/T98-3-2761-2-7p.pdf>

Seldom have medical anthropologists been involved in efforts to control high mortality diseases such as ebola. This paper describes the results of two distinct but complementary interventions during the first phases of an outbreak in the Republic of Congo in 2003. The first approach emphasised understanding local peoples cultural models and political-economic explanations for the disease while the second approach focused on providing more humanitarian care of patients by identifying and incorporating local beliefs and practices into patient care and response efforts.

3. Burial attendants

Sierra Leone: a traditional healer and a funeral

Global Alert and Response. 2015. WHO.

<http://www.who.int/csr/disease/ebola/ebola-6-months/sierra-leone/en/>

The first confirmed case in Sierra Leone was a young woman who was admitted to a government hospital in Kenema following a miscarriage on 24 May, 2014. A health worker suspected ebola, given the outbreak in neighbouring Guinea. She was tested for Ebola on 24 May and placed in isolation on 25 May; the results were positive. WHO was notified about the ebola outbreak in Sierra Leone by the Ministry of Health and Sanitation almost immediately.

All the right precautions were taken. No one else at the hospital, neither patients nor medical staff, contracted ebola virus disease. Fortunately, the young woman made a full recovery.

Tracking of her source of infection pointed to an earlier event and told a very different story. The vicinity around Kenema was home to a well-known and widely-respected traditional healer. Her famous healing powers were also known across the border in Guinea. As the outbreak in Guinea continued to swell, desperate patients sought her care.

Predictably, the healer became infected with the ebola virus and died. Mourners came by the hundreds, also from other nearby towns, to honour her memory by participating in the traditional funeral and burial ceremony. Quick investigations by local health authorities suggested that participation in that funeral could be linked to as many as 365 ebola deaths. Meanwhile in Guinea, 60% of all cases had been linked to traditional burial practices.

By mid-June, an explosive outbreak was clearly under way in Kenema, and the government hospital could no longer cope. Several nurses working there were quickly infected, and 12 of them died.

As in Guinea, the virus spread quickly and widely, with a large proportion of doctors and nurses among the dead – severely depleting response capacity. As in Guinea, the virus marched into the capital city, Freetown, where it took advantage of overcrowded living conditions and fluid population movements to grow in explosive numbers.

A breakthrough in the scientific understanding of Sierra Leone's outbreak came on 28th August, when the journal Science published the results of a major surveillance study of ebola virus genomes, involving 99 complete virus sequences, which traced the start of the outbreak and its further spread. No such massive study had ever been undertaken before.

The study confirmed the healer's funeral as a seminal event at the outbreak's explosive start, demonstrated that the virus's genome is changing fairly quickly and pinpointed 2004 as the year when the virus changed. The study also demonstrated a pattern of adaptive mutation; the authors called for an urgent scaling up of control measures – lest the virus adapt to establish permanent residence in the affected areas.

The study was not, however, designed to determine whether changes in the virus were linked to either the epidemiology or the severity of this outbreak. Nonetheless, understanding of the outbreak now has cutting-edge science on its side; this can only contribute to response efforts in affected countries.

Today, Sierra Leone's most urgent needs include opening up more ebola care facilities – which means more trained staff to meet a severe shortage. Controlling the spread of the disease will also require stronger district surveillance and epidemiology, contact tracing and burial teams.

Ebola outbreak: how witch doctors and corpses being kissed are spreading the disease

Lodge C. 2014. Christian Today

<http://www.christiantoday.com/article/ebola.outbreak.how.witchdoctors.and.corpses.being.kissed.are.spreading.the.disease/41118.htm>

Traditional healers and witch doctors in West Africa are contributing to the spread of ebola, the Times reports. According to the newspaper, a significant number of people are claiming to be able to heal the virus through witchcraft, and are encouraging locals to eschew Western medicine in favour of their own costly techniques. Terrified at the looming threat, hundreds of people from Liberia, Sierra Leone and Guinea have therefore been handing over large sums of cash in return for spells, potions and advice from those claiming to have the antidote to the deathly disease, which has killed over 3,000 people this year. The Times reports of a man in Nigeria going by the name of Dr Zack Balo, who says he can cure ebola using animal parts – providing he is given payment of £200.

Others have cashed in on the epidemic by handing out suggestions including eating raw onions, using anointed water and bathing in salt water at certain times of day. Cases of people flocking to see these so-called healers has resulted in the disease spreading further,

as the witch doctors themselves often contract ebola, which is spread through contact with the bodily fluids of an infected person.

The director of the London School of Hygiene and Tropical Medicine last week warned that other traditional practices, such as touching and kissing the corpse during the funeral, is also contributing to the spread of the disease. Peter Piot, who was among the first to identify ebola in the 1970s when it broke out in the Democratic Republic of Congo, said that dead bodies are able to host the virus and transfer it to the living.

The World Health Organization (WHO) has warned that fluids outside the body, which leak out of a corpse upon the failure of the immune system, remain highly contagious for at least three days after a victim has died. Families therefore significantly increase their risk of contracting the disease by entertaining traditional funeral rites.

For this reason, WHO released a document encouraging those working in areas of infection to "Help the family understand why some practices cannot be done because they place the family or others at risk for exposure...Explain to the family that viewing the body is not possible .The first ebola victim in Sierra Leone was a faith healer, whose funeral resulted in over 350 more people contracting the virus after touching her dead body.

Traditions, Rites, and the Deadly Virus

EducAid. 2014. EducAid, UK.

<http://www.educaid.org.uk/traditions-rites-and-the-deadly-virus/>

'Safe and dignified burials' have been a top priority of the international and government agencies of the past months; with more reports of insensitivity by government burial teams – a lack of clarity as to grave locations, and a lack of religious formality to ceremonies – it is becoming a point of contention at both a localised and widespread national level.

Traditional burial rites have long been attributed as a cause for the virulent spreading of ebola, with ceremonial body washing recognised as the main vehicle of transmission.

The importance of stopping these practices is incredible. As many as 350 ebola deaths, and attributed as the main source of ebola in Sierra Leone, have been linked back to 1 funeral – a traditional healer. However, what is of equal, if not greater importance, is to ensure that Sierra Leone is unified by the counter-ebola programmes, and not divided by them. With the very recent history that this troubled country has dealt with, it cannot be allowed to slip back in to civil divisions. This factor demands us to address the problems that are currently being faced, which in turn brings the following questions in to focus: what is the importance of the religious ceremonies, and what are the social and spiritual implications of forgoing them? By identifying and addressing these things, the aid and government agencies may be able to pacify and win over an increasingly angered and alienated population.

As mentioned before, 'Safe, and dignified burial' has become a common phrase to have come out of the ebola outbreak, particularly from government agencies and large NGOs. Contained within this succinct axiom is a socially and politically charged context. The government and NGOs had come under popular criticism over the insensitive handling of burials, and that they would need to achieve the appropriate balance between swift and decisive burials, as well as accountability and sensitivity.

There are two issues addressed by the aforementioned phrase. The first is obvious – safety; ebola-infected bodies are at their most contagious at the point of death, and they need to be contained and buried quickly in order to avoid any further unnecessary contagion. The second is more of a social issue – dignity; there is a responsibility on the burial teams and coordinators to maintain the religious respect for the deceased, and their families.

A common justification for the virulent spread of ebola has been the much-criticised 'traditional burial practices'. Death in African religions is one of the last transitional stages of life requiring passage rites, and this too takes a long time to complete. The deceased must be "detached" from the living and make as smooth a transition to the next life as possible because the journey to the world of the dead has many interruptions. If the correct funeral rites are not observed, the deceased may come back to trouble the living relatives.

From a Western perspective we govern the division of our soul and body in death by the philosophy of Cartesian Dualism, meaning that the two selves occupy different realms of existence distinct from one another. Following this thinking, the ceremony of the funeral is therefore not one to liberate the soul, for it exists separately, but one for remembrance and tribute. In Animist belief, this is not the case; the soul is carried in the body and requires these specific rites and rituals to be enacted in order to send the soul on its path to the afterlife.

Regarding the majority of these traditional practices, there is sufficient evidence that points to Animism as their source. However, there is some contradiction and confusion surrounding the origins of the ceremonial body-washing that takes place in West Africa. The practice is common in Islam, and many speculate that it is an African adoption that stems from the spread of Islam to sub-Saharan Africa. The practice is of sufficient importance that some Imams have issued statements to local communities to dissuade them from undertaking the traditional practice of ghusl.

Many of the other burial practices, which as a result of ebola are unable to be enacted, hold a significant spiritual meaning for these communities. Due to the mixed nature of spirituality in the country, it is easy to see that one religious group's absolution would not suffice. The prevalence of these religious practitioners, and, ironically, the importance of controlling these burial methods, is no better typified than in one of the greatest single events to have spread ebola in to Sierra Leone. Early on in the ebola outbreak, one child's death was traced back to a Kailahun funeral. The vicinity around Kailahun was home to a well-known and widely-respected traditional healer. Her famous healing powers were also known across the border in Guinea. As the outbreak in Guinea continued to swell, desperate patients sought her care.

Predictably, the healer became infected with the ebola virus and died. Mourners came by the hundreds, also from other nearby towns, to honour her memory by participating in the traditional funeral and burial ceremony. Quick investigations by local health authorities suggested that participation in that funeral could be linked to as many as 365 ebola deaths.

The interruption of the traditional funeral ceremony must be a troubling thing for these communities. Aside from the inevitable trauma that in an ebola death, the inability for a family and community to bury their dead with the proper rites must be a deeply troubling thing. It has led to instances of stigmatisation of the dead that brings dishonour to the family.

Strategies for containing Ebola in West Africa

Pandey A, Atkins K, Medlock J, Wenzel N, Townsend J, Childs J, Nyenswah T, Ndeffo-Mbah M & Galvani A. 2014. *Science*; 21 (346)

<http://www.sciencemag.org/content/346/6212/991.full>

The ongoing ebola outbreak poses an alarming risk to the countries of West Africa and beyond. To assess the effectiveness of containment strategies, we developed a stochastic model of ebola transmission between and within the general community, hospitals, and funerals, calibrated to incidence data from Liberia. We find that a combined approach of case isolation, contact-tracing with quarantine, and sanitary funeral practices must be implemented with utmost urgency in order to reverse the growth of the outbreak.

Ebola transmission is exacerbated by traditional West African funeral practices that may involve washing, touching, and kissing the body. Given the current lack of licensed therapeutic treatments and vaccines, near-term measures to curb transmission must rely on non-pharmaceutical interventions, including quarantine, case isolation, contact precautions, and sanitary burial practices that consist of disinfecting the cadaver before enclosure in a body bag that is further disinfected.

To stem ebola transmission in Liberia, it is imperative to restrict traditional burials, which are effectively serving as superspreader events. Also to be considered is the impact of feasibility, human behaviour, and likely adherence to recommendations on the effectiveness of intervention strategies when making policy recommendations. As the epidemic unfolds, funeral attendance and traditional burial practices may decline with increased awareness of the disease, facilitating the enforcement of sanitary burial practices. In contrast, other behaviour changes may hinder intervention efforts.

Understanding the dynamics of Ebola epidemics

Legrand J, Grais R, Boelle P, Valleron A, & Flahault A. 2007. *Epidemiology and Infection*; 135 (4)

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2870608/>

Ebola is a highly lethal virus, which has caused at least 14 confirmed outbreaks in Africa between 1976 and 2006. There is evidence that individuals (health-care workers, relatives) may become infected following contacts with patients' body fluids or direct contact with patients during a visit at the hospital or participation in traditional burial ceremonies. Traditional burial ceremonies may have played a more important role in DRC and less so in Uganda where community transmission may have been a more significant source of infection.

Hemorrhagic Fever Viruses as Biological Weapons

Borio L et al. 2002. *Journal of the American Medical Association*; 287 (18)

<http://jama.jamanetwork.com/article.aspx?articleid=194908>

The objective of this paper is to develop consensus based recommendations for measures to be taken by medical and public health professionals if haemorrhagic fever viruses (HFVs) are used as biological weapons against a civilian population. The authors recommend a prompt burial or cremation of the deceased, with minimal handling. Specifically, no embalming should be done. Surgery or post-mortem examinations are associated with increased risks of transmission and should be done only when absolutely indicated and after consultation with experts.

The production of witchcraft/witchcraft as production: memory, modernity, and the slave trade in Sierra Leone

Shaw R. 1997. *American Ethnologist*; 24(4)

<http://onlinelibrary.wiley.com/doi/10.1525/ae.1997.24.4.856/epdf>

This article examines how memory is entailed in the constitution and representation of global modernity. During four centuries of Atlantic slave trading in Sierra Leone, Temne witch finding developed as a technique for the ritual production of slaves. Today, Sierra Leone's integration into an earlier Atlantic world is "remembered" both in witch finding ritual and in cosmological images of an ultramodern witch-city built from the extraction of human life and value.

On funeral practices, the author explains six bearers, carried a bier on which was placed either the deceased or the latter's clothes; the ritual power of the corpse or the clothes controlled the bearers' movements. At the gravesite, a friend or kinsperson stood before the bier, held up a reed, and addressed the funeral litter; "[a]nd then he asks him what made him die—whether he knew of his own death, or whether it was caused by witchcraft or poison"—

to which the deceased answered either affirmatively by propelling the bearers forward involuntarily, or negatively through "a rolling motion" (Matthews 1961 (1788]:122-123). Such burial divinations were "constantly practised" (Matthews 1961 (1788]:129). Afterward, distinctions of position and privilege determined the scope of the consequences for the kin of the accused: "the culprit is then seized, and if a witch sold without further ceremony: and it frequently happens if the deceased were a great man, and the accused poor, not only he himself but his whole family are sold together" (Matthews 1961 (1788]:124). Those accused of poisoning, however, were usually permitted the chance—apparently slim, in contrast to what obtained in Alvares's time—to exonerate themselves by taking the "red water" poison ordeal. The accused would be confined "in such a manner as he can release himself" (Matthews 1961 [1788]:125) and would then "escape" to the next town, declaring to its headman that he wished to prove his innocence by drinking the water. If the poison killed him he was declared guilty; if he vomited it up he was provisionally declared innocent—but, if he then defecated within a day he was described as having "spoiled the red water" and was accordingly sold (1961:126). It was not only those accused by corpses who had to undergo this ordeal: Matthews was told that in the interior, "suffering the people to drink red water upon every trifling occasion, was attended with such fatal consequences as would in time depopulate the country" (1961 [1788]:129). Writing 15 years later, at the beginning of the 19th century, the traveller Thomas Winterbottom similarly states that explanations in terms of witchcraft were almost universally given for death, and describes the divinatory interrogation of the corpse as a standard part of burial practices (Winterbottom 1969(18031:260, 236).

4. Secret society leaders

The significance of death, funerals and the after-life in Ebola-hit Sierra Leone, Guinea and Liberia: Anthropological insights into infection and social resistance

Fairhead J. 2014. Draft.

<http://www.ids.ac.uk/files/dmfile/IDSOpenDocsStandardTermsOfUse.pdf>

The aim of this briefing paper is to consider the various ways in which widely reported fear and resistance to the ebola response can be understood, and what each way of understanding offers to those battling with the current epidemic. As far as this paper is concerned, there is no single 'right way' to comprehend resistance to educators, medics and burial teams, as this is a very complex social phenomenon. The aim instead is to outline the variety of ways in which resistance can be (has been) conceived and what each might suggest for better communication and response. The paper couches these different modes of understanding within a wide repertoire of perspectives that social theorists take to understanding social phenomena, as this provides an analytical framework that is as encompassing as possible.

Drawing on research by MacCormack in the late 1970s, the author argues that if a decision must be made between spending limited funds on hospital care or a decent mortuary ceremony, the latter usually ranks as first priority. If seriously ill people do enter hospital, staff must allow 'chaplaincy' visits from lineage and secret society elders, who are highly respected members of the community. Impending death is a time for ensuring that all is well in relationships between the living and those about to make their final transition. Peace must be made lest they become wrathful ancestors. Hospitals must allow for visits of extended kin, and for ceremonies of reconciliation to be carried out on hospital premises. Otherwise the elderly patient may be taken away from hospital before a course of treatment is completed. Such 'escapes' of ebola patients from hospitals with the support of their kin, have been a well reported feature of resistance within ebola treatment centres. Long before global concern with ebola arose, MacCormack recommended that in planning all health provision in this region "that lineage and secret society chiefs must participate in the planning and implementing of primary health care initiatives. They have been the health educators,

herbalists and midwives for millennia, and their concern for the health and fertility of their people in genuine.

Whilst some people now have a Christian burial, the traditional secret societies will also do essential rites. Highly respected chiefs and secret society elders may have used their power in hidden ways to anti-social ends. The power to do good is also the power to do harm.

Ebola and Poro: Plague, Ancient Art, and the New Ritual of Death

Carey N. 2015. Poro Studies Association.

<http://www.porostudiesassociation.org/ebola-and-secret-societies/>

As of this writing West Africa is in the midst of an ever-spreading epidemic of ebola, a haemorrhagic fever caused by one of the deadliest viruses known. Lack of initial containment was due, among other factors, to the people's ignorance about the disease, believing it to be caused by witch magic, curses, or malicious spirits. Their fear-induced lack of cooperation and their distrust of both the Government and healthcare workers delayed treatment, spread the virus, and resulted in outright violence and even murder.

Disease transmission was further enabled by the influential Zoes (traditional healers, ritual specialists) of the secret societies, who not only denied ebola's very existence, but continued to hold public village gatherings and secret Poro activities within their Sacred Groves.

This paper first discusses the epidemic in the context of its initial presentation, and looks at the cultural realities that facilitated its spread. The adverse influence of traditional secret society rituals upon modern infection control efforts are explained. Utilising thirty-three selected examples of sacred Poro art and artefacts, it can be seen how secret society activities facilitate the transmission of the virus. Some of the emerging effects of ebola on traditional healing rituals and ancient socio-religio-political practices are explored. Finally, in Part II, the influence of the growing ebola epidemic upon the art and culture of secret societies is then explored against the background of historical social upheavals.

Liberia Suspends Poro and Sande Practice in Wake of Ebola

AllAfrica. 2014. AllAfrica

<http://allafrica.com/stories/201409051185.html>

The Ministry of Internal Affairs [Liberia] says its attention has been drawn to reports of the continued operation of Poro and Sande societies in several parts of the country, and declares this as a violation of the moratorium placed on the operation of Poro and Sande Societies on June 2, 2014.

The Ministry of Internal Affairs through its Bureau of Customs and Culture and in collaboration with the National Council of Chiefs and Elders recently announced the immediate suspension of all Poro and Sande activities throughout Liberia.

The Ministry said its decision then and now was intended to ensure that there was no outbreak of the ebola virus in any Poro or Sande grove in Liberia. This would be a disaster, the Ministry said in its statement, and continue, it must be prevented in the interest of saving additional lives of our fellow citizens. The Ministry states that in spite of its demonstration of understanding and accommodation, some individuals have continued to operate Poro and Sande Groves and conduct cultural festivals.

The Ministry, in a press release signed by Minister Morris Dukuly, said the continued operation of Poro and Sande Societies in the face of the ebola epidemic exposes citizens increase incidents of the virus and untimely death, and therefore directs that all such practices must cease and be seen to have ceased by September 17, 2014.

The Ministry of Internal Affairs say any grove which operates or reopens its doors to initiate persons will be seen to be in defiance of its General Circular No. 13 and its most recent statement reaffirming the provisions of the General Circular. The Ministry of Internal Affairs says the two-week extension it is granted under this statement is to allow the smooth closure of all Poro and Sande Societies operating in Liberia, and not an extension of the term of existing groves.

In the statement, the Ministry therefore says that any grove or society found operating beyond the September 17, 2014, date would be ordered immediately closed in keeping with cultural, traditional practices, and its guidelines and regulations, while persons operating such groves will be prosecuted under the laws of Liberia.

The Minister of Internal Affairs is therefore authorising all county Superintendents, District Commissioners, County Inspectors, and other appropriate local government officers to ensure full compliance with this directive, and to close uncooperative Sande and Poro Societies upon the expiration of the two-week extension period.

Concluding, the press release states that the Minister of Internal Affairs has written to inform Chief Zanzan Karwor, Chairman of the National Council of Chiefs and Elders, of the directive, and request the full cooperation of his council.

Sierra Leone News: Secret Society banned in Makeni

Kamara J. 2014. Awoko

<http://awoko.org/2014/08/19/sierra-leone-news-secret-society-banned-in-makeni/#signup>

Paramount Chief Bai Sebor Kassangha II of Bombali Sebor Chiefdom, Northern Sierra Leone has said that activities of all secret societies in Makeni and the entire Bombali district have been temporarily banned as a result of the ebola outbreak, writes Jonathan Abass Kamara. This means that the Bondo, Poro, Gbangbani, Ojeh and Hunting societies are to adhere and help raise awareness by sensitising their various communities about the deadly ebola virus disease.

Presenting the By-Laws at the official launching ceremony of the Unite Against ebola Awareness Campaign organised by Health For All Coalition civil society in partnership with the Bombali district and City Councils at the Wusum Stadium in Makeni, Paramount Chief Kassangha told his audience that the By-Laws instituted are within the general consensus of the Ministry of Local Government, Council of Paramount Chiefs and the Sierra Leone Parliament.

Dilating on the By-Laws, the Paramount Chief said public gathering, trade fair (Lumors), sale of bush meat, hunting bush animals, and burial ceremonies are all temporarily banned until further notice. Defaulters he said, are liable to both punishment and fines, with the least being Le500,000.

The Paramount Chief added that harbouring suspected or positive cases of the ebola, Spreading false rumour and disseminating misleading information, failure to report deaths and burials, drug peddling and treatment of patients at home are crimes punishable by law. Paramount Chief Kassangha strongly warned Herbalists and Spiritual Healers to avoid treating patients at home or in their shrines, pointing out that defaulters would face the full penalty of the Law both by a fine or expulsion.

The Resident Minister North Alex Kamara, expressed dissatisfaction over the unreasonable hiking of prices on commodities, and called on the Police to help enforce the law on what he referred to as an unacceptable action by traders and some cross-section of the business sector. Kamara told his audience that the ebola outbreak is beginning to dwindle in his region, and that denial is being almost buried with a satisfactory sense of awareness in the

district. The Resident Minister commended the Police, the Military and the District Health Management Team in Bombali for the effective partnership and team work in the fight against the spread of the disease.

The District Medical Officer, Dr. Tom Sesay disclosed that the first ebola case in the district was in July 23, 2014 from Gbomsamba Village, adding that seven cases have been reported in the district as at launching time of August 17, 2014 with five confirmed deaths. He said New London in Makeni is the other affected area, and appealed to the Makeni people and the entire Bombali district to cooperate with the medical team by helping them with information that would benefit both the community and the Contact Tracers and Surveillance Officers.

Health For All Coalition Executive Director, Charles Mambu reiterated President Koroma's clarion call for all to be involved in the fight to contain the outbreak, and commended the Resident Minister and team for being proactive in the fight, adding that the By-Laws would go a long way in complementing their efforts and that of the government. Other speakers include the Inspector General of Police Francis Munu who was from a joint security assessment mission with the Military Chief of Staff in the Kailahun and Kenema districts. He highlighted major key issues on the current security situation and encouraged the general public to take the necessary precautionary measures against the ebola virus disease.

Medicine, fetish and secret society in a West African culture

Jedrej M. 1976. *Africa*; 46 (03)

<http://www.jstor.org/discover/10.2307/1159397?sid=21105504501071&uid=3739256&uid=2&uid=4>

Certain aspects of van Gennep's (1908) analysis of the structure of ritual symbolism have in recent years been elaborated by E. R. Leach in a series of articles dealing with such topics as magic, the symbolism of time as well as initiation rites. This development has followed two related courses. Firstly, Leach has tended to emphasise the critical significance of rites of separation rather than van Gennep's overall schema involving rites of separation, rites of transition and rites of incorporation in effecting changes in the ritual status of persons (Leach 1970). Secondly, attention has been directed instead to the symbolic importance of the residues of such rites of separation (hair, foreskin, etc.) (Leach 1958) and, to a lesser extent, the agent effecting the separation (Leach 1961). The primary purpose of this article, however, is ethnographic rather than theoretical but in so far as the results of this empirical work tend to confirm the emerging analytical schema it is not without general interest and especially as the manner of this confirmation is not quite straightforward. It will be useful first of all to consider further and in general terms the issues indicated in these opening remarks.

Structural Aspects of a West African Secret Society

Jędrej M. 1976. *Journal of Anthropological Research*; 32 (3)

<http://www.jstor.org/discover/10.2307/3629561?sid=21105539826291&uid=3739256&uid=4&uid=2>

Secret societies in West Africa have largely been considered from the point of view of their social function. In this article an analysis is made of the relevant collective representations from a structural standpoint. It is argued that this is not as innovatory as current debate might suggest but it is implicit in the work of a number of authors. The Sande society initiation ceremonial is examined in relation to three dominant dimensions: that people, space and supernatural spirits. Each is shown to be dichotomised as women and men, forest and village, invisible spirits and visible maskers in a configuration encompassing and specifying the representations involved. This allows a comprehension of several features which have been problematic, such as the question of secrecy and the issue of the masked figure.

5. Payment of traditional healers, witch doctors, burial attendants

Africa's medicine men key to halting Ebola spread in Guinea

Hussain M. 2015. Reuters

<http://www.reuters.com/article/2015/03/02/us-disaster-risk-ebola-idUSKBN0LY0E120150302>

In a land where witchcraft is sought after more than science for curing illness, medicine men in Guinea say the ebola epidemic would be over by now if they had been properly included in the outbreak response. From broken bones to impotence to madness, these traditional healers say they have a potion, spell or touch for many ailments Western doctors can't treat. But there's only one cure for ebola they say: knowledge. In the forest region of south eastern Guinea, where the virus was detected last March, disseminating information using modern technology has proved challenging, resulting in the disease outstaying its welcome.

Karamoko Ibrahima Fofana, president of the association of traditional healers in the town of Macenta, said guérisseurs, as they are known, have unique access to remote villages. "Guérisseurs are often the first port of call for the sick," said Fofana, 69, who is also an imam at the central mosque in Macenta, a hot, dusty town carved out of the forest. "We could have spread information on how to protect against ebola or told people with symptoms to seek help in the treatment centres."

Instead, the traditional healers were sometimes accused of spreading the deadly virus. After all, it was the claim of a guérisseur in Sierra Leone that she could cure ebola that drew the first Guinean victims across the border, Fofana recalled.

Fofana admits the guérisseurs in his association didn't know what ebola was at first, but after training from United Nations staff they're keen to spread information - and not the virus. "If a guérisseur has been trained on ebola and is then caught treating a suspected case, they are fined 50,000 GNF (\$7), stripped of their membership and reported to the police".

The main message from this outbreak is that communication must be adapted to fit the local culture, Dangou said. Word of mouth may be a better way of getting information out than modern methods in parts of the world where broadcast signals are weak and power for electrical appliances is scarce.

At the start of the outbreak, traditional healers were viewed as part of the problem, rather than being recruited to help halt the disease. In a shift in policy, community leaders, including healers, are given information and asked to act on it as they see fit. As a result, many have appropriated the "Stop Ebola" messages. Traditional healers are also supplementing disease surveillance and helping response teams that search for cases.

Given their important role in efforts to stamp out ebola, the services of traditional healers should come at a price, said Joseph Souro Mamadou, 58, a Catholic guérisseur from Macenta. "Ebola is here today, but it could be cholera tomorrow. We can spread health messages, but the government should cover costs of transport, food and the time we take off work," said Mamadou, who also works at the local agriculture school.

According to the healers' association, some 2,000 herbal practitioners in Macenta, a district with a population of around 300,000 close to the Liberian border, are out of pocket as a result of the ebola response. Ebola shares symptoms with less serious diseases traditional healers say they can treat: fatigue, fever, headache, vomiting and diarrhoea. But now these cases are referred to hospitals.

Some people are fearful of turning ebola into an industry. "I'm not in favour of incentives, because it looks like we are in an ebola business. These people should become agents of

change, in their own community, without any kind of payment," said Jean Marie Dangou, head of the World Health Organisation (WHO) in Guinea.

6. Changing their behaviour

Turning to traditional healers to help stop the Ebola outbreak in Sierra Leone

Mueller K. 2014. IFRC

<http://www.ifrc.org/en/news-and-media/news-stories/africa/sierra-leone/turning-to-traditional-healers-to-help-stop-the-ebola-outbreak-in-sierra-leone-66529/>

In a land where voodoo, witchcraft and curses are the norm, traditional healers are sought-after. People turn to them for treatment before they even consider crossing the threshold of a hospital or health care clinic.

There are more than 200 traditional healers in Kailahun district, Sierra Leone, all of whom use a combination of concoctions, powders, plants and touch to heal the aches and pains of people in their communities. For a traditional healer called Fallah James, all that changed when the ebola virus disease arrived. "Upon the outbreak of ebola in Sierra Leone, when I got the information that you can get it through contact, I, as the head of the traditional healers in this district, have stopped treating patients," says James. "And I have been advising my colleagues that they should stop for now, until we get training and proper information about ebola, so that it cannot infect so many people in our community."

As a Muslim, James is not allowed to eat monkey, a customary meal for many in this part of Sierra Leone, and a possible source of the ebola virus. Instead, he feeds his two wives and nine children on other bush meat like deer, antelope, squirrels and porcupine. But with messages being shared by the Sierra Leone Red Cross Society and other organisations to avoid preparing and eating bush meat, James has radically changed his diet, opting to refrain from touching any bush meat, feeding on fish instead. "It is challenging to find enough fish for us to eat," says James. "It has to come from some distance away."

Admitting he knows very little about ebola, James welcomes an opportunity to learn, and has offered to gather his fellow traditional healers for an awareness raising discussion with the Sierra Leone Red Cross Society. As a traditional healer since birth, "I was born with leaves in my hand, following on a tradition inherited by my father and his father," people listen when he speaks. He and his colleagues are revered leaders in their communities. With many isolated communities still shunning anyone remotely connected to the ebola outbreak, either those who are infected or those who are there to help, the Red Cross hopes that engaging this group of traditional healers will assist in sharing the right kind of information. "Having people accept and understand information about ebola is key to stopping this outbreak," says Raul Paredes, deputy head of ebola operations for the International Federation of Red Cross and Red Crescent Societies (IFRC) in Sierra Leone. "We cannot do it on our own, which is why it is critical to engage with community leaders, be they traditional healers or religious leaders."

Ebola- local beliefs and behaviour change

Grant C. 2014. HEART Helpdesk

<http://www.heart-resources.org/wp-content/uploads/2014/11/Final-Ebola-Helpdesk-Report.pdf>

This report focuses on the local beliefs and practices around illnesses and death, the transmission of disease and spirituality, which affect decision-making around health-seeking behaviour, caring for relatives and the nature of burials. It also considers how this can inform effective behaviour change interventions for preventing ebola in Sierra Leone. Four key transmission pathways are considered; unsafe burial, not presenting early, care at home and visiting traditional healers.

Reports have emphasised the problematic role of traditional beliefs and practices assumed to be unchanging and favoured by local populations. A blog in the Economist described Ebola's spread in these terms "Many people in Sierra Leone, where an ebola epidemic has gripped the country for the first time, refuse to accept that the disease can be tackled by Western medicine. They prefer to use traditional healers instead. This may make it spread faster.....The Sierra Leonean authorities are therefore up against both a health-care problem and a cultural one. Traditional healers and herbalists are popular across West Africa. With secret recipes of herbs and potions, they claim to cure everything from the common cold to malaria."

'During the first outbreak, described by Peter Piot in various places, they had to rely heavily on local traditions of handling the ill, including isolation with a single caregiver if I recall correctly. There also is the reverse cultural anthropology of nosocomial and healthcare associated illnesses that involve ebola ("study back"). Sometimes there is a form of fetishised scientism that, like the nuns reusing needles in 1976 can be lethal; especially when these fetishised practices are not critically evaluated for whether they are appropriate and work; or have the conditions to work' (Daniel Cohen, email communication, 2014).

A village studied by Annie Wilkinson in her PhD research 'had TBAs, an Imam, plus healers at various points on the "traditional" and "biomedical" scale (categories we know aren't mutually exclusive). For example, there was a man who had worked as an assistant in a pharmacy in a larger town who had married into the village and was now the de facto village doctor, providing biomedical treatments. He accepted deferred payment or rice (and sometimes nothing), and tied by kinship, he seemed genuinely to work hard for the community. He was greatly respected and appreciated and was building up a network of patients in surrounding villages too. In contrast another man would turn up once a month with a suitcase selling both herbs and pharmaceuticals. People were more disparaging about him though they also bought his produce, presumably out of lack of other options. This was a much more financial transaction. Attitudes to him were similar to attitudes about the government facilities which were also seen as primarily a financial interaction. Urban settings, I think, also work on networks of authority and personal relationships for both the formal (government and private) and informal sectors, and sometimes between them. Certain practitioners definitely have renown and people will travel far to see consult them especially (Annie Wilkinson, email communication, 2014).

How this affects health seeking behaviour

If people believe that sorcery causes the illness they will not limit the victim's personal contact with others, they will be less likely to seek biomedical treatment at a clinic or hospital. This is because sorcery illnesses are not transmitted by touch and must be cured spiritually, usually by a healer who extracts the poison darts or identifies who sent it (Hewlett and Hewlett 2008). In Congo a person can go to a church and ask God to extract the sorcery. In both Congo and Gabon, local people treated symptoms of sorcery with medicine and antibiotics (Hewlett and Hewlett 2008, p117).

'There are cultural attitudes ("western") that affect decision-making around health-seeking behaviour. I mentioned to others that Chippaux is too polite about sex, not using the word "semen". Although it would be nice if the very few observations of viral persistence in semen (40 days after recovery, CDC recommending 90 days abstinence) had been repeated by others, which really would not be that hard to do, and breast-milk as well. No one, to my knowledge has mentioned anal sex, or oral sex with mouth sores or other practices that have higher likelihood of infection for ebola (as found for AIDS). Maybe even post discharge. Politeness can kill. We could at least increase our anecdotal knowledge by monitoring the western survivors' (Daniel Cohen, email communication, 2014). 'However, even the most remote rural populations should not be assumed to be unfamiliar with concepts of modern medicine, however their engagement with them may be mediated by other logics. People are accepting of Western medicine but are ambivalent about the formal health system. The

history of Lassa fever, another viral haemorrhagic disease which has been recognised as endemic in the area for decades, is relevant. For example, there are longstanding rumours about medical staff administering lethal injections. Patients have been known to avoid the Lassa ward in Kenema.

Underlying health seeking patterns, is the fact that people hold multiple models for interpreting and responding to sickness. In Mende areas, there are general categories of big and small fever, and ordinary and hospital sick, as well as specific biomedical diseases. Lassa was classified a 'big fever' and ebola may well be too. Diseases can be understood as caused by multiple things, including germ theory or 'witchcraft'. These causes are not necessarily mutually exclusive. A diagnostic test which 'proves' someone has an illness may not be viewed as conclusive. Key to understanding health seeking is to understand how disease categories shift as the illness progresses. The way people and those around them have behaved, the events leading up to the illness and circumstances surrounding its onset all influence the model which is applied and the treatment sought' (Wilkinson, 2014, <http://steps-centre.org/2014/blog/ebola/>).

What modifications can be made to change behaviour?

All healthcare workers should be aware of and expect a sorcery explanation for ebola, especially at the beginning of an outbreak. Respect and understanding for the social economic-spiritual context can develop rapport and build trust. Also, people are often open to biomedical treatment even though they believe sorcery is the cause. Being able to use local criteria to distinguish sorcery from epidemic illness is useful.

What is the potential for mobilising/supporting informal health workers in providing more/better care for patients with suspected/confirmed ebola and for other conditions?

'It is traditional healers' capital, networks and institutional ties which hold potential if mobilised/trained/sensitised/linked in to the response. They might be useful in referral, surveillance and prevention communication. Also for providing care, which of course they are already doing, but if and when the government officially move to home and community care then I think these health workers could be invaluable for supporting, staffing and lending legitimacy to those (if they want to, which is another issue!). Might also need to think about unintended consequences here – destroying the few trusted care networks there are if things go very wrong.

However, for all my talk of legitimacy, perhaps ebola is being perceived in such a way that these providers are not seen as legitimate care providers? I'm unsure about this, but we do know that the hospitals are not seen as legitimate either. There is also, in Mende areas at least, diseases which are understood as 'ordinary sick' and ones which are 'hospital sick'. But there are also ones which are definitely NOT hospital sick, which are caused by other things (faults, transgressions, bad intent) and where care is sought out of the hospital system. In these cases biomedicine can't help and may make it worse. I suspect in some cases ebola is fitting into this last category (not helped by the health messaging which said so clearly at the beginning that there was no treatment for ebola) (Annie Wilkinson, email communication, 2014).

What are the broader considerations that should be borne in mind should an external organisation wish to do so?

'Basically as above, they are not all the same, some are trusted and others are not. Some are well networked and others are not. They might not all want to help, and they may not all have communities best interests at heart. There may be friction between different providers and institutions. Finding out about well known providers in particular localities would be a good start – also asking them who they work with (perhaps they refer to a particular doctors or

pharmacist – or one of the private laboratories). Also about any associations they may be part of which could be another network to tap into, e.g. if pharmacists have professional associations? Even the informal ones'. (Annie Wilkinson, email communication, 2014).

Would the approach be different for informal health workers who broadly offer biomedical treatment modalities, and those who broadly offer non-biomedical treatments?

I don't think it is necessarily hugely different. The main thing would be to engage in a respectful way as we have been advising elsewhere. More important might be how you do it in a village setting and an urban setting. Saying this, for some providers and the institutions they are embedded within, there may be particular sensitivities i.e. for TBAs there will be sensitivities about gender and secret knowledge, but this does not mean they are impenetrable. (Annie Wilkinson, email communication, 2014).

1976 Ebola Outbreak's Lesson: Behaviors Must Change

Gholipour B. 2014. Live Science.

<http://www.livescience.com/48170-ebola-outbreak-in-1976-revisited.html>

Scientists involved in fighting the first outbreak of ebola in 1976 are pointing to a crucial difference between that outbreak and the current one in West Africa: the behavior changes among the affected communities. In a new study published today (Oct. 6), researchers revisited data from the ebola outbreak in the Democratic Republic of Congo in 1976 (then known as Zaire) to investigate why that outbreak was quickly contained, whereas the current outbreak rapidly spiraled out of control.

Scientists involved in fighting the first outbreak of ebola in 1976 are pointing to a crucial difference between that outbreak and the current one in West Africa: the behavior changes among the affected communities. .In a new study, researchers revisited data from the ebola outbreak in the Democratic Republic of Congo in 1976 (then known as Zaire) to investigate why that outbreak was quickly contained, whereas the current outbreak rapidly spiraled out of control.

The 1976 outbreak was confined to one village and affected 318 people, resulting in 280 deaths. Since the current outbreak began in early 2014, more than 7,400 people have been infected and about 3,400 people have died of ebola, according to the World Health Organization. In 1976, the outbreak was traced back to contaminated needles at a hospital, where only five syringes were used each day to treat all the patients. The closure of the hospital helped; however, the researchers found evidence that the rate of new cases decreased considerably even before that hospital closed.

The decline of the outbreak most likely resulted from changes in the community's behaviors, such as altering traditional burial practices so that people could avoid catching the virus from dead patients, the researchers said.

"Ebola is not something you can just contain with hospital-based measures alone," Dr. Peter Piot, director and professor of global health at the London School of Hygiene & Tropical Medicine (LSHTM), said in a statement. Piot had traveled to what was then called Zaire to investigate the first outbreak of ebola, an entirely unknown virus at the time.

"Getting the message out into the community and getting people to change their behavior is critical if we are to bring the current outbreak under control. Measures such as isolating patients, contact tracing and follow-up surveillance, and community education are all part of the response," Piot said.

In the new report, the researchers used data on the original 1976 patients, along with Piot's handwritten notes, to examine how the virus transmission unfolded during that first outbreak. Using a mathematical model, the researchers showed the rate of transmission at the start of that outbreak was high enough for it to have become an epidemic as large as the current outbreak in Liberia, Sierra Leone and Guinea, the researchers said. But it didn't, and that's because people changed their behavior to reduce the transmission of the virus.

"Crucially, we can see that this behavior change happened quickly — within a few weeks," co-author Anton Camacho, also of the LSHTM. Such a change in people's behaviors has not been seen in the current outbreak, the researchers said.

"As well as a huge international response, in-country efforts are needed to address the fear and mistrust of health workers and governments," Piot said. "We are a long way off catching up with the current outbreak, and even further from being in control of it."

The failure of Sierra Leone's strategy for fighting ebola may be down to a missing ingredient: a big shock that could change people's behaviour and finally prevent further infection. Bruce Aylward, the head of ebola response at the World Health Organisation, said Sierra Leone was well placed to contain the disease — its worst outbreak on record — with infrastructure, organisation and aid. The problem is that its people have yet to be shocked out of behaviour that is helping the disease to spread, still keeping infected loved ones close and touching the bodies of the dead.

Denial and ignorance are part of the problem but a weak healthcare system and logistics also play a part. Officials in Kono — where an explosion of infections was discovered this week — said the eastern district of 350,000 inhabitants had only one ambulance and no ebola treatment centre. WHO staff are visiting neighbouring West African countries to try to get people to change their ways in case ebola strikes, but worry there has been little change in remote border areas, Aylward said.

"The forest area of these three countries has got some really special and concerning practices, where they share meals with the corpse, where they sleep with the corpse," he said. "You know these are high, high risk behaviours."

In Sierra Leone, where as many as 365 ebola deaths may have been linked to a single traditional funeral early in the epidemic, Sierra Leone's Health Minister Abu Bakarr Fofanah said the government was considering banning some unsafe practices. He recognised however that it would be difficult to police such a law. Fofanah noted that some areas of eastern Sierra Leone that were hit hardest early in the epidemic — around the towns of Kenema and Kailahun — have seen a massive reduction in case numbers as people change behaviour.

The Crucial Role of Faith Leaders in the Ebola Response: Unrealised Potential?

Stephanie G et al. 2015. CAFOD, UK.

<http://www.cafod.org.uk/content/download/23465/164286/file/Ebola%20CAFOD%20Tearfund%20Christian%20Aid%20Briefing%20Feb%202015%20.pdf%20>

Faith leaders, as trusted and respected members of their community, have played a hugely significant, and often unsung, role in the ebola crisis. In the midst of confusion, fear and panic, communities have often turned to them for guidance. They have assisted in preventing an ebola outbreak spreading even further by disseminating key messages and mobilising their communities to do the same. Many pastors, priests and imams have worked tirelessly to change unsafe burial practices and other previously deep rooted cultural practices and attitudes which contributed so much to the spread of the virus.

A high proportion of the population of Sierra Leone and Liberia are believers and regular attenders at a place of worship. As experienced communicators, the regularity of religious gatherings such as weekly services at churches and mosques has provided faith leaders with a unique opportunity to speak to their congregations. The supportive teaching on love and inclusivity, found in religious texts, means they have been ideally placed to speak out against the destructive stigma associated with ebola. Faith leaders have invited recovered ebola patients to give testimony at religious services in order to address stigma and discrimination that recovered people have faced.

Many faith leaders have organised food assistance to families in 21 day quarantine and have set up programmes to care for orphans and help families rebuild their lives. They have often been a first point of call for those experiencing financial hardship. They have brought love and solace to people who are frightened, angry and bereaved, and to those who are sick and dying.

Ebola prevention plans and programmes, such as those facilitated by the WHO, must ensure faith leaders are involved as a pivotal part of the focus. Ebola recovery plans currently being produced, such as the UN, EU and World Bank Ebola Recovery Plan, as well as national level plans must include clear strategies for working with faith leaders. Faith leaders must be fully involved and represented in these high-level decision making processes.

Faith leaders and faith based organisations must be allocated dedicated funding for training and related material, and on-going mentoring, particularly in counselling. Beyond the community level, the President of Sierra Leone acknowledged the role of faith leaders and encouraged different religious denominations to work together in the fight against ebola. The Inter-religious Council of Sierra Leone (IRCSL) founded the Religious Leaders Task Force on Ebola in order to address the ebola crisis from a united interreligious perspective. At the international level, faith-based organisations such as Caritas Internationalis have been advising UN WHO experts on the revision of the Safe Burial Policy.

Ebola has caused huge disruption to people's well-being at an individual and a collective level. For many people their sense of security and well-being, built up slowly in the years since the terrible conflicts in Liberia and Sierra Leone ended, have been shaken to the core. As the ebola response moves into the recovery phase it is essential that faith leaders are proactively supported with the right training and related materials, ongoing mentoring and other resources to help them fully utilise their role in the ebola response. Given their influence in communities and the potential harm of wrong messages, well trained faith leaders, who receive ongoing mentoring and support, can be a crucial part of the countries' recovery and healing.

Independent, in-depth research should be prioritised by research institutions and donors to analyse the unique role of faith leaders in behaviour change including preventing the spread of ebola, and also of mitigating the devastating impacts of stigmatisation during the recovery phase.

One particular challenge is that although faith leaders are well trained to provide spiritual care, most have not been trained in counselling and therefore there is a strong need for skilled personnel in this area. This skill shortage should also be considered in Ebola Recovery Plans going forward.

As Ebola Recovery Plans are developed it is of the utmost importance that faith leaders are fully involved and represented in high-level decision making processes which occur at an international, regional and country level. Faith leaders should be involved in the drafting process and the plans should recognise faith leaders as a key target group to work with.

The role of faith leaders has often been overlooked and in many cases their potential contribution to the ebola crisis is still not being fully realised. There was a significant missed opportunity in not involving faith leaders further at the very start of the outbreak. Evaluations of the response to the current outbreak will need to consider whether the role of faith leaders has been fully utilised. They will need to consider what steps should have been taken to include them more in planning and to mobilise them from the very outset of the outbreak.

These lessons will need to be applied to help prevent future outbreaks occurring in the affected countries and should also be applied to countries that are currently unaffected. Future programmes centred on ebola prevention must ensure faith leaders are involved as a pivotal part of the focus.

Ebola: limitations of correcting misinformation

Chandler C. et al. 2014. The Lancet

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)62382-5/fulltext?rss=yes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62382-5/fulltext?rss=yes)

Communication and social mobilisation strategies to raise awareness about ebola virus disease and the risk factors for its transmission are central elements in the response to the current ebola outbreak in West Africa. A principle underpinning these efforts is to change risky "behaviour" related to "traditional" practices and "misinformation". Populations at risk of contracting ebola virus disease have been exhorted to "put aside, tradition, culture and whatever family rites they have and do the right thing

Should local activities be regarded as "exotic behaviour"? Caring for the sick is an intensely practical endeavour. Public health framings of ebola, however, often portray caring practices as irrational and immutable traditions. This perception reflects a lack of genuine engagement in the material, social, or spiritual implications of changing social practices. In many parts of Sierra Leone, Liberia, and Guinea, burial practices often incorporate procedures to distribute inheritance and ensure the deceased an afterlife. Failing to conduct funerals appropriately may cast family members as negligent, or foster suspicion of malicious causes of death; these concerns can override health considerations. To disregard such concerns and take an inflexible stance in negotiating mutually acceptable courses of action precludes any genuine demonstration of respect or empathy for that person's situation.

The key to containing Ebola

Ratzan S. 2014. CNBC

<http://www.cnbc.com/id/102102261#>.

The author of this article believes there is a risk of the ebola disease spreading further due to the fact many people are confused by what they are being told. In developing countries, the advice given to avoid the spread of ebola is not fully understood because it is often only available in western formats and also frequently in written form – pointless in countries where the majority of the population is illiterate.

The West could help affected countries by assisting governments in how to communicate more effectively with their people – village heads, imams, and traditional healers have the influence needed to drive protective behaviours such as hand washing, and proper burial practices. The West should help them get the information they need.

It is clear from the disease outbreaks that have occurred in recent years that health increasingly relies on behaviour. To modify behaviour requires direct, open, understandable and timely information from a single authoritative source, as well as providing intermediaries with the tools they need to reinforce the message.

Work with traditional healers to deliver care

Haagaard A. 2014. Open Ideo

<https://openideo.com/challenge/fighting-ebola/ideas/work-with-traditional-healers-to-deliver-care>

Much of the discourse about traditional healers has looked at them as hindrances to appropriate care-seeking by patients in West Africa. This thought piece calls for community teams assembled consisting of Western medical personnel and NGO representatives, and local government officials, religious leaders and traditional healers. The author believes local leaders could provide Westerners information about what is needed at ground level in terms of funding and equipment, as well as what sort of strategies might improve community trust. Western personnel could provide local representatives with information about how to recognise, contain and treat ebola, as well as equipment to help manage infections in the community (i.e. buckets and chlorine to set up hand washing stations at churches and healing centres; masks, gloves and other PPE to protect community members caring for those who are sick).

To date, much of the focus on local belief systems and healing practices has been paternalistic - framing it as something that is simply ignorant/nefarious and must be overcome. But there are deep, historical reasons why local belief systems exist, and it makes no sense to try and overturn them, when instead we could work within them to formulate protocols that make sense in the context of these communities. (This is essentially a paragon of the need for participatory design practices.)

Another important consideration that has been raised is how to develop language for the crisis that fits in with local beliefs. For example, some believe that uttering the name of the disease summons it - so it may improve care-seeking outcomes to work with the kind of language that villagers use when seeking traditional care.

Ebola: the power of Behaviour change

Sebastian Funk , Gwenan M. Knight & Vincent A. A. Jansen (2014) Nature.

<http://www.nature.com/nature/journal/v515/n7528/full/515492b.html>

Without including social, cultural and behavioural responses to the ebola epidemic, models may overestimate outbreak size. Behavioural response, triggered by an epidemic, can slow down or even stop virus transmission). Indeed, altered cultural perception in response to the disease enabled people's behaviour to change in ways that helped to contain outbreaks in the past.

Reports from Foya in Liberia indicate that the outbreak there is now in decline. A local information campaign to change funeral practices and other behaviours seems to have paid off. More aid and more personnel are urgently needed, but so is the involvement of local communities and the provision of information that can help to contain this epidemic.

Ebola crisis: Struggling to change behaviour in Sierra Leone

Harding A. 2014. BBC, UK.

<http://www.bbc.co.uk/news/world-africa-30279932>

For weeks it has been the same in Sierra Leone's capital, Freetown. Every day the ebola burial teams - now well organised and promptly dispatched - collect about 60 bodies from around the city and its crowded suburbs. Some days it is 50, sometimes as many as 80.

About 20% of those bodies turn out to be ebola cases. The rest are just the usual range of deaths you might expect in a large city in West Africa. Every death is now treated as suspicious.

"I can't leave my children here on their own" says Mariatu Kamara, a sick resident of Rogbangba village.

There is an air of brisk efficiency at the workers' base - the British Council offices, on a hill overlooking the Atlantic Ocean, now transformed into an ebola command centre for the western region of Sierra Leone. Calls are logged, white boards filled, statistics for the past month collated by close-knit teams.

Down the hill, at the municipal cemetery, bulldozers are busy clearing new ground, scraping away mounds of rubbish to give the gravediggers more space.

"At the moment we're having some success in holding on to the epidemic and I don't see the more astronomical predictions coming through at the moment," said British army Colonel Andy Garrow.

Dying at home

And yet, as the weeks go by and the body collection teams continue to bring in the same number of corpses, Col Garrow finds himself drawn increasingly to one particular conclusion.

"Behaviour change," he says. Or rather the lack of it.

Here is the problem: By now, everyone knows about ebola; and nobody with symptoms should, logically, be dying at home or on the street anymore.

They should all have been taken to hospital. But to understand why that is not happening, all you have to do is drive to any of the impoverished suburbs of Freetown. Mariatu Kamara had been hiding her illness for several days. When we found her outside her home in Rogbangba village only a few people knew she was sick - a headache, sore bones and boils on her head and legs. Perhaps it was not ebola. But if it was, her three young children - one tied to her back - were at grave risk.

Ebola burials

- Bodies still contain high levels of the ebola virus
- At least 20% of new infections occur during burials, WHO says
- Relatives perform religious rites including touching or washing the body
- Safe burial process involves observing rituals differently, such as "dry ablution"
- Volunteers with full protective clothing are trained to handle and disinfect bodies

7. Other resources identified

Village of Curers and Assassins

Bellman B. 1975. De Gruyter Mouton

<http://www.degruyter.com/view/product/2870>

8. Additional information

Authors

This query response was prepared by:

- Stephen Thompson, Institute of Development Studies – s.thompson@ids.ac.uk
- Mahua Das, University of Leeds - M.Das@leeds.ac.uk

Contributors

The following experts commented or contributed to this response:

- Paul Richards, Njala University College, Sierra Leone
- Fred Martineau, London School of Hygiene and Tropic Medicine
- Annie Wilkinson, Institute of Development Studies
- The Ebola Anthropology Response Platform

About Helpdesk reports: The HEART Helpdesk is funded by the DFID Human Development Group. Helpdesk reports are based on 2 days of desk-based research per query and are designed to provide a brief overview of the key issues, and a summary of some of the best literature available. Experts may be contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.

For any further request or enquiry, contact info@heart-resources.org

HEART Helpdesk reports are published online at www.heart-resources.org

Disclaimer

The Health & Education Advice & Resource Team (HEART) provides technical assistance and knowledge services to the British Government's Department for International Development (DFID) and its partners in support of pro-poor programmes in education, health and nutrition. The HEART services are provided by a consortium of leading organisations in international development, health and education: Oxford Policy Management, CfBT, FHI360, HERA, the Institute of Development Studies, IPACT, the Liverpool School of Tropical Medicine and the Nuffield Centre for International Health and Development at the University of Leeds. HEART cannot be held responsible for errors or any consequences arising from the use of information contained in this report. Any views and opinions expressed do not necessarily reflect those of DFID, HEART or any other contributing organisation.