Psychosocial considerations in the Ebola response and promoting resilience in post-Ebola programming

Roundtable Report

1st October 2015

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Overview

The Resilience and Transition Research Group at the School of Applied Psychology, University College Cork, Trócaire and the Development Studies Association of Ireland co-hosted a roundtable discussion on 1st October 2015 in the Council Room, University College Cork. The Irish Research Council funded the event. The roundtable discussion was devised to create an opportunity to reflect on how Irish organisations contributed to a complex response led by the Sierra Leone authorities following the Ebola outbreak of 2014 which to date has taken the lives of 3,955 people, from a total of 13,982[1] diagnosed cases in the country. While the discussion focused on Sierra Leone, it was acknowledged throughout that Ebola was an international crisis, which resulted in 11,314 lost lives in ten countries, with Guinea, Liberia and Sierra Leone accounting for the vast majority of cases.

Ireland's collective response has been and continues to be substantial. Ireland has a long connection with Sierra Leone and the role of the Irish Embassy, Irish Aid and the specific role of Irish non-governmental organisations in responding to the crisis must be acknowledged. Concern, Trócaire, Oxfam Ireland, World Vision Ireland, UCC, MSF, GOAL, and the former Ebola Coordinator of the Department of Foreign Affairs came to together to share insights from their work, observations on the wider response and importantly, pooling ideas and recommendations for future responses, as there is little doubt that a similar response will be needed again.

In an attempt to capture the essence of the day, we have highlighted some of the key observations and recommendations from the presentations and the discussions that took place.

Summary

The first session, "Psychosocial protection in Ebola Affected Communities", examined the experiences of people directly affected by Ebola, including child and adult survivors, orphans and bereaved people and burial workers. The three presentations highlighted persistent psychosocial difficulties brought about by the outbreak and by the response. In particular, the focus of the session was on how to design context-appropriate interventions that support and strengthen processes of resilience at family and community level. The presentations and discussions highlighted that psychosocial aspects of the Ebola outbreak and

[1] http://apps.who.int/ebola/ebola-situation-reports (sourced 16/10/2015)

response were neglected, despite significant "lessons learnt" from emergencies over the past decades. Community based psychosocial support, which is a contextualised response, drawing on social and cultural resources, is essential as part of a first-phase response to protect against and mitigate the harm caused by emergencies and humanitarian responses to them. Psychosocial considerations should be mainstreamed as a cross cutting theme informing the design of basic services and programming across sectors. In the plenary discussion one participant described community based psychosocial support as the foundation on which all other programming is built. This approach is attentive to existing family, social and community supports and seeks to promote and strengthen these resources in emergencies to promote longer-term adaptive processes.

The second session, "Programme adaptation to respond to the Ebola outbreak / building resilience practices," examined the experiences of five international agencies in responding to the outbreak in a highly constrained context. The Ebola outbreak was highly politicised, both within affected countries and internationally. The politicisation of the issue resulted in panic and paralysis in the system, which significantly complicated and impeded the response. INGOs were operating in a complex and rapidly evolving context where there was very little understanding of the crisis and very little funding during the first six months of the crisis. Presenters emphasised that INGOS must do more to influence donor funding to ensure funding and programming decisions reflect needs and existing systems of response, to avoid undermining community mechanisms that exist before and after a crisis. Organisations adapted existing programmes and continued to refine approaches and practices as the crisis evolved, in line with the adaptive strategies of affected communities.

Overarching recommendations were compiled based on the presentations and discussions, which are presented at the end of the paper. These recommendations, agreed by the participants, will hopefully serve as a useful platform for further discussion and importantly for reflecting on some lessons learned from these tragic and devastating events.

Panel Session 1: Psycho-social protection in Ebola-affected communities

Participatory research conducted in Kambia, Bombali, Port Loko and WARD from March to June 2015 engaged with children (52% girls) and adults (60% women) directly affected by Ebola in order to inform the design of programming to support their psychosocial resilience. **Fiona Shanahan, School of Applied Psychology, UCC** and a Visiting Fellow at Fourah Bay College, University of Sierra Leone led the research team in partnership with Trocaire, Access to Justice Law Centre, Justice and Peace Commission, Centre for Democracy and Human Rights. In each of the four districts, psychosocial programme staff members supported local researchers engaged in participatory research with boys, girls, women and men directly affected by Ebola to examine persistent psychosocial difficulties and patterns of resilience and positive adaptation. This research identified ways in which participants draw on locally available family and community supports to feel safe, feel calm, strengthen their relationships, feel in control and have a sense of optimism or hope about the future. At a systemic level, humanitarian responses potentially support individual and collective resilience by providing access to resources in culturally meaningful ways. The research also identified aspects of the Ebola response that negatively impacted psychosocial wellbeing and may have undermined processes of resilience, as noted below;

- There was a failure to take socio-cultural narratives and meanings seriously, which severely impeded infection prevention and control.

- In the first 6 months of the response, burials were conducted in a ways that were culturally inappropriate, caused severe distress to grieving families and damaged trust and confidence

in the response.

- Several international agencies implementing psychosocial support programmes used external international consultants to conduct short training-of-trainers workshops, which the IASC guidelines explicitly advise against. These trainings were not adequately adapted to the Sierra Leone context and focused excessively on trauma and clinical approaches.

- Local organisations that had been implementing programmes in Ebola hotspot communities were in some cases alienated or excluded by international agencies, particularly in the provision of basic services and psychosocial support.

- There were significant child protection issues affecting children who had been treated for Ebola; in one region there were 20 cases of families who were unable to establish the whereabouts of their children who had been taken by ambulance for treatment several months prior, children in Western Area reported that they had not been returned to their communities up-country following discharge from the treatment units, and there were several reported cases of children who were separated from their extended families and kept in Interim Care Centres(ICCs) or orphanages when this was not warranted by their circumstances or appropriate.

- Ebola survivors were targeted explicitly and publically for support, which caused resentment and potentially hindered their social integration into communities.

This research resulted in changes in practice and has informed the development of community based psychosocial programming to support resilience at family and community level.

Using participatory research to inform psychosocial programming

Following the research, community dramas were developed by partner agencies to illustrate the research findings and stimulate discussion in hotspot communities; depicting difficulties and how people had attempted to respond and adapt**. Ella Foy from Trócaire Sierra Leone** outlined how the dramas led to very open and honest conversations at community level regarding specific difficulties people had experienced and brought about deeper understanding and improvements in relationships. The research also led to the establishment of an inter-agency working group, under the Child Protection, Gender and Psychosocial Support Pillar of the National Ebola Response Centre, to draw on existing practice in Sierra Leone and international evidence to develop and evaluate a range of socio-culturally adapted psychosocial interventions for use in the post-Ebola context. This process will lead to the development of a toolkit of empirically supported interventions in order to ensure that agencies in Sierra Leone have access to context appropriate resources to build resilience and respond to future crises.

Psychosocial aspects of safe and dignified burials

As 80% of Ebola transmission were related to the handling of dead bodies, medical burials were a necessity within 24 hours of death. **Nina Ghem from Concern Worldwide** discussed the safe and dignified burial programme in Western Area. Inappropriate burials were a source of considerable

distress, for bereaved families, and also the extensive network of support workers from doctors and nurses to burial teams, pastors, communities and NGO workers. Dignified approaches were developed facilitating small numbers of families and friends to witness the burial, say prayers for their loved one and mark the grave. Today, Concern manages 20 burial teams with 240 staff in total.
Burial workers themselves were deeply and severely affected by their experiences and extensive stigmatization due to their role. Burial workers now avail of a 12-week psychosocial intervention run by Community Association for Psychosocial Services (CAPS). In addition, burial workers avail of an 18-week support group facilitated by CAPS, which has resulted in measurable improvements in family cohesion, family acceptance and family interaction.

Panel Session 2: Programme adaptation to respond to the Ebola outbreak/building resilience practices.

The gendered impact of the crisis was emphasised, in particular acknowledging that systematic discrimination against women and girls is both a cause and a result of the inequality that drives poverty. **Tess Dico-Young from Oxfam** focused on the centrality of gender equality to recovery and resilience. To assist communities to recover, it is essential to support them in replenishing their stocks (physically, psychologically and materially) and build resilience to be better able to cope with future shocks, Tess shared a number of recommendations:

- Community engagement and social mobilisation designed to reduce stigma and blame levelled at women and affected families.

- Community members should be active participants in the development of targeted interventions.

- It is recommended that Oxfam continue to offer/strengthen training on intersectionality and social justice to gender focal points at every level. This approach recognizes that social inequalities built on sex, class, or race also harm men and boys--while acknowledging that these same structures disproportionately harm women and other minorities. Rather than homogenizing “men” and “women,” an intersectional approach looks at the context-bound, cross-cutting structures that produce social exclusion and vulnerability for different groups.

- Support and facilitate the community to develop their own contingency and disaster preparedness plan to feed into the chiefdom and district level plans, ensuring meaningful participation of women, reflecting women’s and men’s different needs, capacities and contribution to disaster preparedness plans.

- Strengthen accountability by developing more creative ways to give people a voice, particularly focusing on feedback from people who would otherwise be overlooked in difficult-to-reach locations.

- Advocacy - Must be explicit on tackling constraints, addressing structural barriers to progress.

- Coordination – with in the sector and the government and donors looking at the different services, social mobilisation (interpretations, indicators).

Adapting programmes and adopting new practice

Organisations adapted existing programming and adopted new programming in response to the crisis. **Magnus Conteh of World Vision** outlined how the organisation used their Maternal Nutrition and Child Health programme, interfaith approaches and strong civil society partnerships to engage in social mobilisation and supporting radio education programming following school closures. In addition, World Vision adopted new programming leading the SMART Consortium to conduct 30,000 safe and dignified burials in 12 districts, managed the Ebola response fleet and are participating as a partner in the Johnson and Johnson vaccine trial. These adaptations to ongoing programmes allowed flexibility and agility in responding to the crisis.

During the nine month period when schools were closed, *1,000 teachers were trained* in psychosocial first aid for children; *7,000 hygiene kits distributed* to 200 schools and *30,000 radios distributed* to children to support broadcast education.

Responding to the crisis within a highly constrained and complex system

From the first confirmed cases in Guinea in March 2014, MSF repeatedly attempted to highlight the unprecedented spread of the virus and were dismissed as alarmist. **Jane-Anne McKenna of MSF** gave a potted history of these attempts and reported that MSF has been engaged in a process of reflection to identify learning at an organisational level; in particular reflecting on whether MSF were too slow to mobilise at the beginning, despite committing Euro 90 million of private funds, and were perhaps too particular in restricting staff to those with previous Ebola outbreak response experience. Duty of care to staff was an important consideration, particularly given that 28 staff were infected, 14 of whom died. Three international staff were infected and were medically evacuated at MSF own cost as no standard evacuation response was available. The politicization of the outbreak and international travel restrictions meant that the agencies had to prioritise non-medical aspects of the response such as negotiating with Brussels Airlines to maintain flights. The high turnover of staff had a big impact on programmes. Key innovations included new protocols for the treatment of pregnant reduced mortality rates, which were at 100% in previous outbreaks, the development of chlorine proof google tablets for sharing and updating data in real time and the development of a bio-bank for future research and development.

Socio-ecological approaches to mobilising adaptive responses at community level

The response to the Ebola outbreak was severely impeded by unnecessary blockages. One key issue highlighted by **Fiona Gannon of Goal** was the lack of funding until September 2014, 6 months after the outbreak began and that reflections on practice should be made in light of this fact. In partnership with Kings Hospital, Goal established triage centres to help existing health centres to stay open. Through the DFID rapid response fund Goal established an Ebola Treatment Centre with support from

MSF. The Social Moblisation Action Consortium implemented social mobilisation with knowledge management principles and drawing on experience in Community Led Total Sanitation developed a programme on Community Led Ebola Action. The framework for this response drew on Brofenbrenner's socio-ecological model, as outlined in Fig. 1

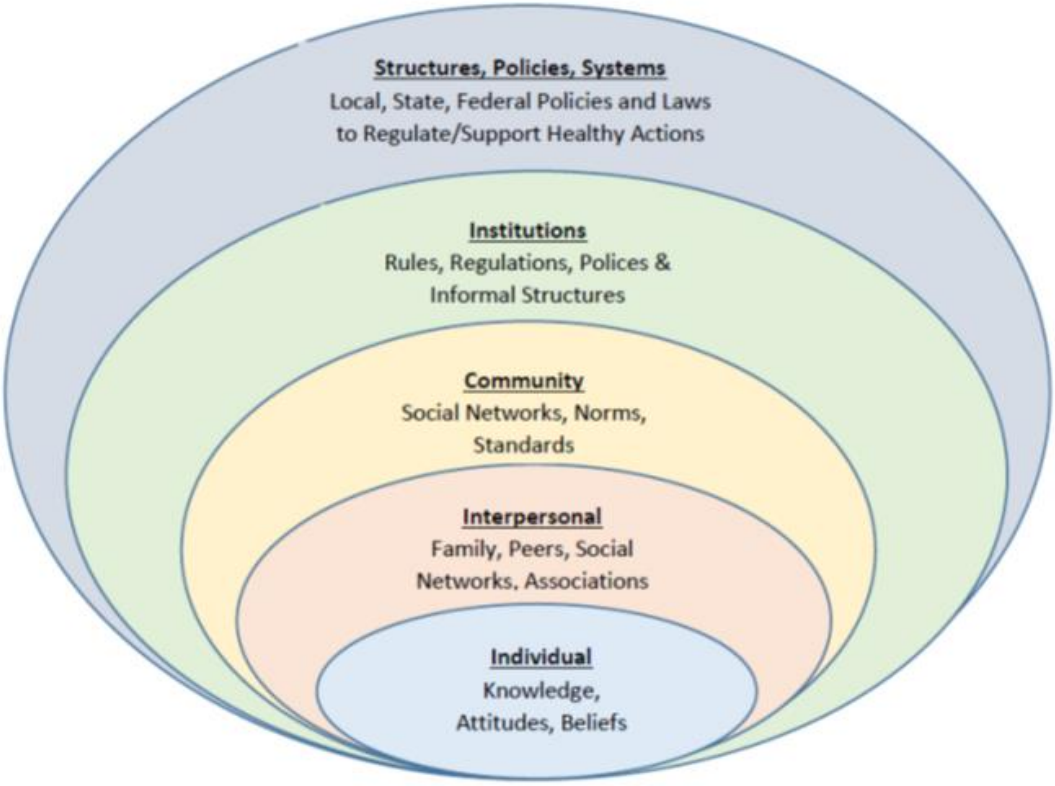

Fig. 1. Socio-ecological conceptual framework, Goal Community Led Ebola Action.

The intervention involved developing a toolbox on behaviour change to be delivered in communities and conducting regular radio talk shows with call-in segments. These were essential for accountability and partners could monitor radio shows and respond to misinformation at an early stage. As Peter Piot, then Executive Director, UNAIDS said in relation to HIV and AIDS 'communities are not only the frontline of the response. They are the frontline.'

The impact of international political considerations on the humanitarian response

The complex nature of the crisis required a cross-departmental response in Ireland involving many government departments and public bodies. **Kevin Carroll, who was Ebola Coordinator at the Department of Foreign Affairs and Trade**, outlined how across the European Union people were reluctant to volunteer for work in the worst affected countries given their concerns about the health risks and the lack of assurances about medical repatriation in the event of someone contracting Ebola. In addition, some countries found that only a fraction of those who were volunteering were felt to have the right skills mix. Medical evacuations became an important political priority for all member states and eventually a centrally coordinated mechanism was established at EU level which, while unable to provide an absolute guarantee, gave an important level of assurance to those working in affected areas. WHO was very late in declaring a public health emergency of international concern

and was ill prepared to handle the outbreak. A subsequent review of WHO highlighted a number of challenges, including the absence of rapid, independent and courageous decision making at early stages of a crisis, capacity limitations, competing public health and humanitarian crises, problems with data collection and disincentives for countries to report on outbreaks quickly and transparently. However, more than 40 countries imposed travel restrictions and many airlines stopped flying to the worst affected countries, which created huge problems in these countries. WHO noted that almost 25% member states issued trade and travel restrictions that were not called for.

One important lesson was the failure of some of the 'bigger' players to sufficiently engage with local communities. There were significant cultural and other barriers to a successful response. Poverty was an important factor, as were weak health systems. Health system strengthening is critical, especially in fragile states. Most importantly, it is essential to really understand the local context –to listen to local communities who are at the front line. International organisations are often not good at this. We must respect the principle of 'Do No Harm'.

Findings and Recommendations

1. Psycho-social support is an important pillar in the first-phase of a response, especially when social norms and practices are suspended and traditional mechanisms that help individuals to cope are depleted or no longer available.

   Recommendation: Agencies with adequate capacity and skills should increase programming of psycho-social support and funding for psycho-social activities should be included in budget allocations by donors to ensure psycho-social support is included as a first-phase response rather than an after-thought.

2. Communities are the frontline in every crisis and INGOs and local authorities must do more in the immediate onset of a health crisis to assist responses that come from within communities who must cope, regardless of outside help. It is essential to support and strengthen existing resources and structures in communities, for example women's groups, youth groups, and spiritual and religious groups.

   Recommendation: INGOs must do better to listen, to support existing initiatives which are culturally and socially appropriate, rather than mount donor-led responses that can alienate communities and undermine practical and sound local responses.

3. Poor preparedness of international organisations, including WHO, UN agencies, donors and INGOs resulted in unnecessary delays, limited funding availability and complicated bureaucratic decisions which cost lives and livelihoods. The cost of inaction in the Ebola response is yet to be calculated but it is most certainly being felt by families and communities who were forced to use all available resources to cope with the rapid and increased stresses of the crisis.

Recommendation: Accountability of decision-makers, responders, and policy makers requires further examination, to go beyond lesson-learning and provide appropriate support mechanisms for families and communities who are still reeling from the response to the Ebola crisis.

4. Politicisation of a human crisis resulted in bureaucratic blockages, policies that were poorly conceived and implemented and ultimately unbalanced responses that did little to serve the needs of the population of Sierra Leone and more to do with extreme panic across Europe. Rapid response policy-making was inward and defensive, creating logistical challenges for agencies trying to respond and causing enormously negative environments where people were struggling to cope with the crisis.

Recommendation: the politicisation of a health and social issue resulted in paralysis of systems that in some cases worked in contradiction of the policies and values of donor contributors.

5. The nature of the Ebola crisis reinforced the need for programming to be responsive and appropriate to the needs and individual strengths and weaknesses of affected communities. A homogenous response to a crisis with varying impacts in different parts of a country (and in different countries), different impacts on livelihoods in rural and urban settings, differing approaches to grief based on cultural beliefs and practices is not appropriate or impactful.

Recommendation: Programming can only have an impact where it is appropriate and reflective of the needs identified by people within specific communities. INGOS must do more to influence donor funding to ensure funding and programming decisions reflect needs and existing systems of response, to avoid undermining mechanisms that exist before and after a crisis and are a lifeline for individuals within their own communities.

6. Multifaceted aspects of programmes required to respond to a crisis that has health and social consequences across an entire country.

Recommendation: organisations should document how existing programmes adapted under pressure and continued to refine approaches and practices as the crisis evolved, in line with the adaptive strategies of affected communities.

7. Contribution of religious leaders to strengthening responses – INGOs supporting existing coping mechanisms and systems in place – not recreating the wheel but adapting models – balancing the need to respond with the need to support existing coping mechanisms. It is useful to replace fear-based messages with messages consistent with acceptance and in

some cases to ground behaviour in religious teaching or texts, particularly in cases where people consider infection control measures to be irreligious and therefore do not observe them.

> **Recommendation:** Open dialogue with religious leaders is important to develop messages consistent with, and accepting of, the values of various groups.

8. Collective psychosocial capacity/resilience, including local staff as part of the local system.

> **Recommendation:** Organisations should examine the staff support services available to their national staff and volunteers, particularly in relation to medical care, medical care for family members in the case of infection, psychosocial support and security policies.

9. Investing in people & communities to heal/support livelihoods & overburdened households is key to recovery, not just livelihood recovery but supporting systems and approaches that allow people to grieve, recover from shocks (social, financial).

> **Recommendation:** Country strategies must include psycho-social considerations, budgetary support for programmes and approaches in place by communities and in communities that can provide consistent support to individuals, families and communities impacted by the crisis.

10. Infrastructural investment is needed – including rebuilding health facilities, re-establishing basic services at a higher standard as is investment in families & communities

> **Recommendation:** There is a need for integrated programming across sectors, due to the emergency restrictions and the outbreak, a range of sectors are severely depleted, in particular economic activity, health, education and social services.

11. U5s and how some groups most vulnerable when this collective psychosocial capacity hit. The health system wasn't functioning and so we would suspect that maternal mortality and infant mortality have risen as for a number of months mothers weren't delivering at health centres or attending clinics with their children. In addition, depleted support systems were less able to provide resources**.**

> **Recommendation:** there is a need for significant investment in support for parents and under 5s, in particular through Early Child Development groups and parenting support groups.

Participants

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