



Ebola Outbreak, Sierra Leone:

Communication: Challenges and good practices

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INTRODUCTION

Box 1. Effective communication is critical from the onset of any humanitarian emergency. The information needs of people affected by crises often remain largely unmet, however, and not enough capacity and resources are dedicated to address them meaningfully (BBC World Service Trust, 2008, Internews, 2011, CDAC/ACAPS, 03/2014).

After the Ebola outbreak was declared in Sierra Leone, in June 2014, early messages about the high mortality rate of Ebola were met with fear and denial by many communities (BBC, 14/06/2015). At the peak of the outbreak, the government's order to place more than one million people under quarantine further damaged trust between affected communities and responders (ACAPS, 10/2015) As the outbreak spread, it was important to find appropriate ways to tell people how to minimise the risk of catching the disease and what to do if it affected them and their families. The way messages were developed and disseminated evolved with the epidemic. In Sierra Leone cases spread silently until May 2014, then uncontrollably until November 2014, before slowly getting down to zero in November

2015. Now that the country has been declared Ebola free, communication remains a key aspect of community mobilisation efforts to address remaining Ebola-related issues, such as survivor stigma and complacency towards prevention measures. This is the second of two reports that ACAPS is producing with the aim of identifying lessons learned and good practice in community-led communication processes. This report focuses on Sierra Leone and the first covers Liberia. The grey boxes indicate content that relates to communication in emergencies in general and is common to both reports. The report covers:

- + changing behaviours of the affected population;
- + most effective channels for reaching communities; and
- + most trusted actors for delivering information and adapting messages to the needs of affected populations.

KEY FINDINGS

"Sierra Leone is a difficult environment to engage with and the channel of communication is very important partly because of the mistrust around the messages and around the messengers" - Communication officer, NGO

- + Increasing community-led communication and social mobilisation were instrumental in achieving behaviour change.
- + Radio was the preferred means for receiving information for 85% of the population, followed by house-to-house visits, televisions and religious venues.
- + The opinion of faith leaders was held in high regards. Mosques and churches, became critical channels for the dissemination of Ebola messages.
- + In a context of widespread quarantines and emergency measures that aimed to minimise large gatherings, mobile phones became a valuable tool to collect and share information with blocked off communities .

The ACAPS Ebola Project aims to support strategic decision making, programme design and advocacy work surrounding the Ebola outbreak by providing analysis on current priority needs and ongoing issues. Funded by the European Commission's department of Humanitarian Aid and Civil Protection (DG ECHO), it builds on the contextual knowledge and sectoral analysis forged through the ACAPS Ebola Needs Analysis Project (ENAP).

SOURCES AND LIMITATIONS

SOURCES FOR COMMUNICATION MESSAGES:

As part of the analysis conducted in this report ACAPS has identified messages that were disseminated throughout the crisis. These messages came from the following sources:

- + Roving ambulance exhibit report, 05/2015
- + CDC brochure, Visit your nearest Ebola Treatment Centre for high quality care, 07/2014
- + CDC brochure, Get early treatment for Ebola, 11/2014
- + CDC brochure, Go to the Community Care Centre closest to you to receive care, 01/2015
- + CDC brochure, What happens at an Ebola Treatment Centre?, 01/2015
- + CDC brochure, Get early treatment for Ebola, 05/2015
- + CDC, Improving Burial Practices and Cemetery Management During and Ebola Virus Disease Epidemic, 09/2014
- + CDC/NERC brochure, Allow for a safe burial when someone dies at home – Sierra Leone, 01/2015
- + CDC/NERC brochure, Ensuring a safe and dignified burial for your loved one, 05/2015
- + Focus1000, Training of religious leaders, 12/2014
- + Kinsman and al, A set of empirically-derived Ebola messages for Sierra Leone, 04/2015
- + MoHS brochure, Ebola workers use chlorine spray to kill viruses like Ebola, 05/2015
- + MoHS, Sierra Leone Emergency Management Program SOP for Safe, Dignified Medical burials, 02/2015
- + MSF, Interactive: Explore an Ebola Care Centre, 09/2014
- + MSF, Interactive: Learn about our Ebola protective equipment, 11/2014
- + MSF, Message guide: Ebola virus disease, 08/2014
- + President announcement in Sierra Leone Labour congress update on the Ebola disease on workers in Sierra Leone, 30/07/2014
- + SMAC brochure, Ebola survivors and champions, 12/2014
- + Social mobilisation pillar/SMAC, Consolidated Message Guide for Ebola Communications in Sierra Leone, 03/2015
- + Social mobilisation pillar/SMAC, Consolidated Message Guide for Ebola Communications in Sierra Leone, 05/2015

- + Social mobilisation pillar/SMAC, Consolidated Message Guide for Ebola Communications in Sierra Leone, 06/2015
- + UNICEF, Ebola prevention and control communication strategic plan, 04/2014
- + Women of Hope International, Ebola lesson, 08/2014
- + WHO/UNICEF, Guidance package, 09/2014

LIMITATIONS

- + This report is not an independent evaluation on the impact of information and communication initiatives during the Ebola outbreak. It does not measure the reach of messages, an essential aspect of the response. Further research on this topic could be valuable to the humanitarian community.
- + This report provides key messages from authorities and international NGOs. Messages from the early stages of the outbreak were especially hard to find, limiting the extent to which a comparative analysis is possible.
- + The timeline presents a concise depiction of key events and figures pertinent to the topics discussed in this report. It does not aim to present a comprehensive overview of the response. Communication is just one of the factors which contributed to containing the outbreak. This report does not go into each of these factors, but recognises the role they played in the course of the epidemic.

PROMOTING BEHAVIOUR CHANGE

Box 2. The importance of behaviour change in breaking Ebola transmission

Lessons learned during the Ebola outbreak revealed that several factors were crucial in containing the outbreak in Liberia, Sierra Leone and Guinea (WHO, 08/2015, WHO, 04/2015, ACAPS, 26/08/2015). Among others, these included efforts to:

- + Rapidly isolate symptomatic individuals,
- + Trace their contacts,
- + Safely bury or cremate infected corpses,
- + Change attitudes and conducts related to protective practices and hygiene.

Ebola was new in West Africa. Populations did not understand why the disease suddenly arrived and what they could do to prevent infection. At times, and especially in earlier months, the prevalence of a number of “high-risk” behaviours helped the virus stay hidden and elude containment measures (WHO, 01/2015). Changing these behaviours was crucial. In Liberia and Sierra Leone for instance, some mourners bath in or anoint others with water used to wash corpses, believing that doing so transfers powers (WHO, 01/2015). Funeral and burial practices in West Africa are therefore exceptionally high-risk in an Ebola outbreak context. Addressing such “high-risk” behaviours was particularly difficult, as it sometimes implied proposing changes to deeply rooted practices, traditional beliefs and customs which had been practiced for thousands of years (PI, 02/11/2015). The way to greet one another, to bury the dead and to care for the sick are practices closely linked to religious and cultural heritage, territory and identity (PI, 05/10/2015). It was therefore important to identify and build outreach strategies which would successfully bring about change and reduce the risks of spreading the disease.

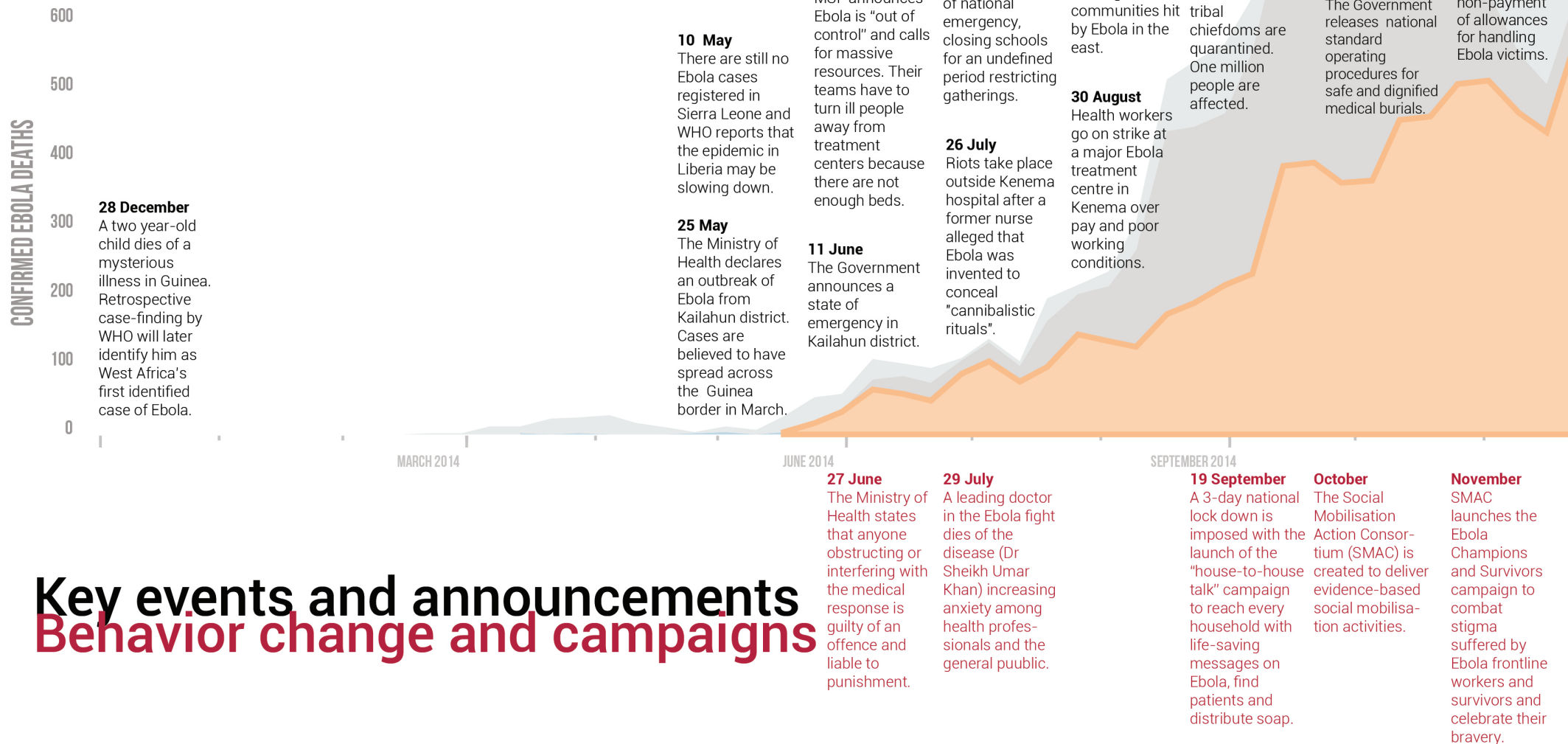
See the timeline on pages 4 and 5 for an overview of key events and announcements linked to behaviour change and information campaigns.

- + **Early perceptions and fears:** In Sierra Leone, the outbreak began slowly and silently, gradually building up to a burst of cases in early June. At the onset of the

outbreak unclear and inconsistent messages from health officials, and a general mistrust of authorities and public services, contributed to the spread of the disease (Information need p.15). This was compounded by misconception and denial of Ebola spread through local media, who, in some places, relayed the population’s belief of Ebola as being witchcraft, a hoax from the government or that international organisations and health workers were somehow responsible for the outbreak (IFRC, 14/08/2014, PanAfrican Med journal, 10/10/2015) By mid-June, an explosive outbreak was under way in the Kenema, and weak systems could no longer cope.

- + **“High-risk” behaviours:** WHO estimated that 80% of cases in the country were linked to traditional burials and funeral practices (WHO, 01/2015). Fear among authorities led to extreme decisions that profoundly disrupted people’s cultural habits. Massive quarantines were set into place, the practices of traditional healers were outlawed as part of emergency and severe fines and by laws were enforced to attempt to closely monitor transgression (RFI, 18/11/2014). Unrespecting the prohibition, to host strangers and hide sick people, could amount to a considerable fine or one month of jail (Welthungerhilfe, 04/2015). However, efforts to undermine and ban traditional practices were often unsuccessful, with practices continuing in secret (CAFOD, 07/2015).
- + **Shift in public opinion** Public attitudes evolved significantly, around the nature of the crisis and the importance of changing traditional burials/funeral rituals, between October–December 2014 (Focus1000, 03/2015, CDC, 02/2015). In addition to an increase in medical services, this corresponds to a time when communities community mobilisers were supporting affected communities to take action against Ebola and a series of wide-scale communication campaigns were launched to inform the public, specifically designed to counter rumours and raise awareness of Ebola (UNICEF, 20/11/2014, PI, 30/09/2015). As cases began to decrease, the focus of much of the Ebola reporting became community mobilisation and the empowerment of affected communities in their fight against Ebola (Plan international, 02/2015). Through a ground-up approach, initiatives engaged community leaders and influential community members to discuss behaviour changes with their communities. Starting January–February 2015, isolated pockets of the disease periodically emerged until the outbreak was declared over on 7 November 2015 (WHO, 20/11/2015).

Sierra Leone-Ebola outbreak timeline



Key events and announcements Behavior change and campaigns

Sources: International media, local media, Healthmap, President of Sierra Leone, NERC, SMAC, internews, Anyway WHO, UNICEF, CDC, GOAL, Focus 1000, CAFOD, BBC Media Action.

 **Guinea**
Liberia
Sierra Leone

2 December
Tonkolili district is put under quarantine, taking to six the number of districts under lockdown, affecting more than half of the country's population.

22 January
The government lifts all quarantine measures after a drop in transmission.

28 February
Travel restrictions are reintroduced as cases rise.

March
Sierra Leone now has over 2000 Ebola survivors, many of who are working as community mobilisers in the response.

19 April
CDC reviews its guidelines on Ebola transmission and urges Ebola survivors to abstain from all forms of sex or use condoms every time until more information becomes available.

14 April
Schools reopen after more than eight months of closure.

12 June
New travel restrictions and a 21-day curfew are imposed on Kambia and Port Loko districts to counter Ebola resurgence.

16 September
New Ebola infections in Bombali and Kambia raise suspicions of transmission from Ebola survivors.

7 November
Sierra Leone is declared Ebola-free after undergoing 42 days without a transmission of the virus.

DECEMBER 2014

17 December
BBC Media Action launches the "Mr Plan-Plan and the People" radio series that explores Ebola prevention through drama

December-January
Religious leaders are trained in using faith messages for Ebola prevention and control and agencies develop a facilitator's guide to promote their engagement.

MARCH 2015

27 March
The national "Zero Ebola" Campaign is launched, aimed at re-energising Sierra Leoneans to fight complacency and bring Ebola cases down to zero. It involves a 3-day national lockdown and one on one sensitisation campaigns.

JUNE 2015

16 June
NERC launches Operation Northern Push in the northwest to get to zero Ebola cases as quickly as possible.

SEPTEMBER 2015

COMMUNICATION CHANNELS

Box 3. Understanding available communication in an emergency channels

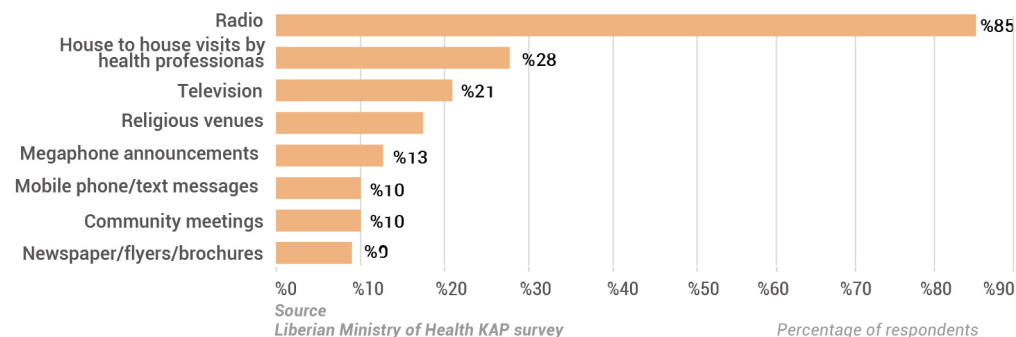
Studies have shown that the more humanitarian actors know about how people receive, give, share and trust information in a community, the better they will be able to decide which communication channels to use and which initiatives to prioritise in the response (CDAC/ACAPS, 03/2014). Depending on the country context there could be a range of methods by which people access information, from mass media such as radio or television, to the more traditional channels such as word of mouth or community leaders. Certain communication channels may have implications in terms of trust and reliability, which are important to consider in community mobilisation activities (CDAC/ACAPS, 03/2014).

The goal of two-way communication is not only to spread the information, but to enable populations to give information on their needs to stakeholders, and respond in return by giving them better services.

Basically, we try to use communication for accountability. – Communication expert, international organisation

In Sierra Leone mass information campaigns played an integral part of social mobilisation efforts, improving people's knowledge of the Ebola virus. These campaign made use of a wide variety of channels, understood as strategic, to reach affected populations (GoSL, 09/2014). Communities' most trusted source of information and their awareness of important health messages were assessed through three qualitative Studies of Public Knowledge, Attitudes and Practice ("KAP Studies") published in September 2014, December 2014 and January 2015 (Focus1000, 03/2015). The KAP studies revealed that radio was by far the most preferred means for receiving information about Ebola, followed by house to house visits, televisions and religious venues (Focus1000, 03/2015).

Graph 1: Preferred means of receiving information about Ebola



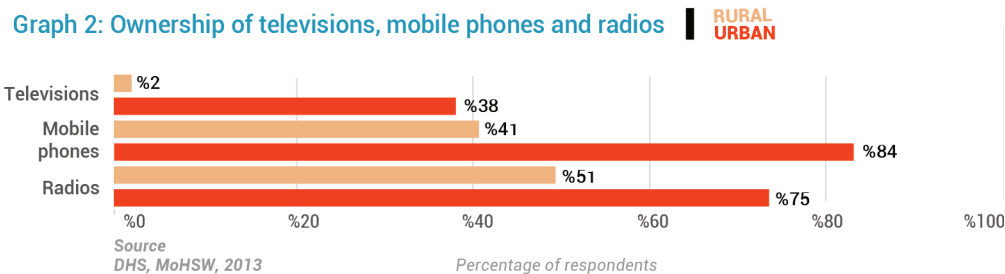
Surveys revealed that early mass information campaigns led to a high level of awareness of the virus but poor change in practices, an essential element of preventing the continued spread at community level (Focus 100, 11/2015). Lessons learned from the response revealed that changes in practices need to happen at the grassroots level and bring into the response community opinion leaders and influencers through consultation with paramount chiefs, section and village leaders, women leaders and youth groups and traditional leaders (ICG, 28/10/2015, The Guardian, 29/09/2014). To achieve understanding and behaviour change, greater emphasis should be placed on creating opportunities for dialogue and participation through more direct and durable interpersonal communication.

MEDIA AND TELECOMMUNICATION CHANNELS

Before the outbreak

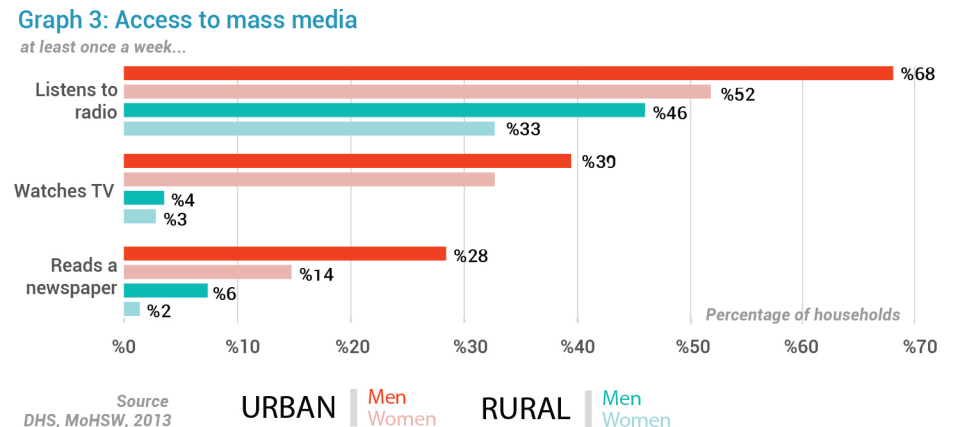
Popularity of the radio: Radio is an effective way of getting information in Sierra Leone, with the majority of people having access to a radio and listening to it almost daily (DHS, 03/2015, BBC Media action, 2007, PI 25/11/2015). Studies suggest that listeners value radio news as accurate and a trustworthy source of information, with news and music the most frequently mentioned programs preferred by the population (BBC Media action, 2007). All major cities in the country run their own radio stations and there are many local commercial radio stations (Search for Common Ground, 05/2012). Radio formats have been shifting, with radio dramas, phone-in programmes and other interactive types of programming evolving in many places (Search for Common Ground, 05/2012). Language and place of residence are two important factors influencing how often and to which radio stations Sierra Leoneans listen to (Search for Common Ground, 05/2012).

Community engagement with the radio: Since the end of the civil war in 2002, broadcasting has played a critical role in dealing with social tension, political violence and community empowerment. During the 2007 elections, some radio stations became a tool for mobilising young people in support of political interests and a driver of tensions and violence, through biased news stories and propagation of hate speech (Search for Common Ground, 05/2012). However, programs like “Talking Drum Studio” provided a platform for dialogue around post-war reconciliation, HIV/AIDs and accountability (Search for Common Ground, 10/06/2008, UN, 10/2007). In past awareness campaigns, UNICEF project evaluations have found that using the radio and setting up listener groups was an effective strategy for community engagement and empowerment, particularly for women who often lack access to other means of communication (UNICEF, 2014).



Mobile phones: Mobile phones are the second most-accessed communication device in Sierra Leone, after the radio (DHS, 2013, Search for Common Ground, 05/2012). The proportion of households with a mobile phone increased from 28% in 2008 to 55% in 2013, as a result of better access to affordable devices and wider network coverage (DHS, 2013). There are three main mobile phone providers and services, which are currently expanding to different parts of the country. A lot of information is circulated on WhatsApp, West Africa’s most popular smartphone application for sharing photos and messages among personal contacts and groups (International media, 14/10/2014). By using mobile phones, in combination with other channels, humanitarian actors have increasingly been able to set up ways to communicate with affected people. For example, based on lessons from other humanitarian disasters, the IFRC teamed up with the telecommunication industry in Sierra Leone to provide the Sierra Leone Red Cross Society developed a system capable of sending warnings of impending fires, floods, or outbreaks of disease (BBC, 14/10/2014). In 2013, the system was piloted as part of a monthly prevention campaigns covering everything from cholera, tuberculosis and child health information to flood and fire prevention advice (ICRC, 11/12/2015).

Access: Information in Sierra Leone is centralised in Freetown, where the seat of the national government and a quarter of the population reside (Search for Common Ground, 05/2012). The capital is home to all of the newspapers, 35% of the radios and most of the internet points in the country. There are great differences between urban and rural contexts, and between men and women. 41% of urban households have electricity compared with only 1% in rural areas, greatly limiting the use of some of these channels (NDHS, 2013). Sierra Leone’s low literacy rate is a key determinant in the manner in which information flows. The literacy rate for urban women in Sierra Leone is 59%, compared with 23% in rural areas. Literacy rates for men in urban and rural areas are 78% and 39% respectively (NDHS, 2013). Poverty continues to be a barrier to growth of many other channels, such as televisions, internet and print media (Search for Common Ground, 05/2012). As a result, over 56% of women and 43% of men have no weekly access to radio, newspapers, television, or internet (NDHS, 2013).



During the Ebola outbreak

During the Ebola outbreak messages were blasted from speakers on cars, disseminated on billboards, posters, leaflets, newspapers, radio, TV and via SMS and call-in hotlines (Internews, 26/03/2016). As the epidemic progressed, more targeted and informed messages were put through these channels. This corresponded to a

period where more funding was available, more staff were dedicated to communication and the number of Ebola cases was rising exponentially.

Popular media initiatives: During the outbreak misinformation often hampered efforts to tackle the outbreak, as rumours and speculation exacerbated the epidemic (The Guardian, 29/10/2015). In such a climate, national and local radio stations conducted live talk shows discussing the Ebola virus, preventative measures and ways communities could work more closely to protect populations (AWDF, 09/12/2015). In July 2014, BBC Media Action created a radio programme called *Kick Ebola Nar Salone* (Kick Ebola out of Sierra Leone), to provide information, counter stigma and misinformation, and promote working together in the Ebola response (BBC Media Action, 17/11/2014). Other long-running question and answer shows, such as *Tok Bot Salone* (Talk About Sierra Leone), brought people face-to-face with their leaders, recording episodes in town and village halls, schools and market places (BBC Media action, 29/07/2014). Because emergency measures brought in to tackle Ebola sought to minimise large gatherings, shows pre-recorded questions from audiences – including people in the quarantined districts – and played them to representatives from the Health authorities. (BBC Media action, 29/07/2014). Viewers were encouraged to participate by submitting questions and contributions via text messages and Facebook. In order to overcome access challenges in isolated communities, the Red Cross provided 3,000 radio solar power and built listener groups at the village level. Volunteers at the district level went to the villages every month to monitor the listener group activities (PI, 11/12/2015).

Using mobile phones: Mobile phones were leveraged in different ways, in combination with other channels. They were used to collect data and send it to response coordination structures, as health workers were equipped with mobile phones provided through a partnership between agencies and private phone companies (Focus1000, 2015, UNFPA, 11/08/2014). Through SMS, social mobilisers could send alerts for specific events such as death, suspected case, quarantine issues, survivors, and orphans (Focus 1000, 2015, PI, 11/12/2015). By making use of its Trilogy Emergency Relief Application, the IFRC also sent messages to people all over the country, advising them how to avoid getting infected, and to seek immediate treatment if they do (Reuters, 11/05/2014). People called radio lines to give their opinion, and to provide with feedback using SMS. For the first time, the BBC used WhatsApp as a breaking news service for its 20,000 regional subscribers. Users received push alerts 1-2 times a day, with valuable information compiled from local sources (BBC, 15/10/2015). Following the height of the Ebola outbreak, the results of a six-month survey by GeoPoll and FHI 360, collected via SMS messages, provided information about the long-term impacts of the outbreak on local and national economies (GeoPol,30/09/2015). In the

recovery phases, these surveys focused on economic recovery, including quarantine restricted areas.

TRUST BUILDING AND FACE TO FACE COMMUNICATION

“One-off” messaging will not work - it has to involve a discussion. Good community health happens in small group discussion because someone has to point out discrepancies, through a facilitated discussion session” – Head of an international NGO

Research suggests that early messages designed to change community behaviour were often counterproductive, as they failed to take into account deep rooted cultural practices and beliefs (PI, ICG, 10/2015; CAFOD, 2015). This pushed these practices underground, contributing to the spread of Ebola (PI, 05/10/2015; ICG, 10/2015; CAFOD, 2015). There were many calls to strengthen engagement between a largely secular and biomedical health response with a community-owned response, in which community leaders could use their position of trust and respect to combat the spread of the virus and support those that had been affected (CDAC, 28/10/2014, IRC, 01/20/2014). This required a significant scale up of resources, as face-to-face communication is more expensive and logistically challenging than other approaches (PI, 28/10/2015). For many KIs, this focus on “bottom-up” activities came too late and more should have been done to address this issue at the beginning of the outbreak (PI, 28/10/2015, PI, 18/10/2015, PI, 07/09/2015, 25/11/2015).

Pre-crisis

Languages: English is the official language of Sierra Leone, although its regular use is limited to approximately 20% of the population (including 13% of women) (HPG, 06/2015). Mende is the principal vernacular languages in the south, Temne in the north. Krio is an English-based Creole, spoken by the descendants of freed Jamaican slaves who settled in the Freetown area. It is the first language for 10% of the population, mostly in Western Area, but is understood by 95% of the population (CIA factbook, 19/11/2015).

Religious and/or ethnic affiliation: Religious and ethnic plurality is an important aspect of Sierra Leonean culture where 78% of the population are estimated to be Muslim and 21% Christian (SLDHS, 2013). These religions often merge and overlap with the over 20 ethnic groups present in the country: 35% of the population are Temne, 31% Mende, 8% Limba, 5% Kono, 2% Kriole/Krio, 2% Mandingo and 2% Loko (NDHS, 2013). Faith leaders are generally held in high regard and play a very visible role in daily life. Two inter-faith groups are particularly active in Sierra Leone, the Inter-Faith Council, an umbrella body for coordination and advocacy matters, and the Inter-Religious Council. The former was created in 1987, with support from the Ministry of Health and UNICEF, to undertake social mobilisation activities to promote child immunisation (CAFOD, 07/2015). These inter-faith groups have since been involved in basic education, water and sanitation, family planning and HIV/AIDS prevention. Faith-based organisations also frequently run health clinics operate alongside the public health systems (ACAPS, 03/2015).

Rule of law: Sierra Leone has a long history of war, displacement and breakdown of trust. More than 90% of Sierra Leoneans, surveyed by Transparency International in 2013, said that they had to bribe police and/or judicial or government officials for all aspects of daily life, from avoiding unwarranted traffic tickets to evading false arrest (Transparency International, 2015, Foreign Policy, 10/12/2014). The legacy of the brutal tactics used during the civil war, including murder, torture, rape, abduction of children, amputation and mutilation of civilians continue to affect the state's ability to function or to maintain the rule of law (HRW, 11/04/2012, ACAPS, 17/12/2014). Due to gaps in the provision of state policing other policing agencies have arisen, offering localised protection of various levels of legality, effectiveness, availability, cost, methods and services (Journal of Contemporary African Studies, 2005). The diamond trade and the involvement of external actors have played a central role in fuelling conflict, as various parties funded their war activities through mining (HRW, 11/04/2012, BBC, 21/05/2012).

During the Ebola outbreak

Challenges:

- + Political tensions rose during the Ebola epidemic, with rumours that the government was using Ebola and emergency measures to return the country to its authoritarian past (ACAPS, 28/05/2015). For instance, a journalist in Sierra Leone who criticised the government's handling of the outbreak was allegedly beaten then jailed under emergency laws, meant to help bring the epidemic under control (The Guardian, 5/11/2014).
- + Language was one of the main obstacles faced by humanitarian workers responding to the crisis. Information and messages about Ebola were at first

primarily available in English or French, leading to a gap in material which could be used as part of sensitisation campaigns.

- + Preliminary data suggests that women died in greater numbers than men, at the beginning and peak of the outbreak, in part due to their role as caregivers (UN Women, 10/2014, Huffington Post, 15/10/2014). They were less likely to access both telecommunication channels and traditional channels relaying information, or to be included in communication campaigns targeting community of faith leaders (UN Women, 12/2015, CAFOD, 2015).

Community-based communication: The increasing use of community-based communication marked a turning point in the response (SMAC, 2015). The Social Mobilisation Action Consortium (SMAC) which was created in October 2014 was the largest and most comprehensive social mobilisation intervention in Sierra Leone (GOAL, 2015). Its network included staff from the five SMAC agencies, over 36 radio stations, 4000 religious Leaders and thousands of community mobilisers on-the-ground, and Ebola Survivors (humanitarianresponse, 25/10/2015). Through its "Community Led Ebola Action" (CLEA), SMAC moved away from pure awareness raising towards community-led behaviour change and face-to-face communication (humanitarianresponse, 25/10/2015, Restless Development, 11/2014). SMAC was created by various organisations including GOAL, CDC, BBC Media Action, Restless Development, and FOCUS 1000 in order to support and strengthen the National Social Mobilisation Pillar (ERAP, 2015). Working through existing local community structures, SMAC empowered communities to assess the outbreak themselves, its effects and likely impacts. This created a sense of urgency to develop community-led action plans supported by community mobilisers and health workers (ERAP, 2015).

Engaging faith leaders: Engaging faith leaders: The support of and Imams was key as they were uniquely positioned to reshape religious burial norms and discourage practices that involved touching and washing of deceased victims. According to a survey conducted by CAFOD, the adoption of the "Channels of Hope" methodology, at the end of 2014 helped engage community leaders as agents of change (CAFOD, 2015). The Channels of Hope model is a World Vision methodology that mobilises faith leaders to respond to development issues in their immediate environments. In response to the Ebola crises, they applied years of experience working on HIV to developed a curriculum focused specifically on Ebola (World Vision, 2015) During Ebola, Islamic and Christian scholars were consulted to incorporate faith elements to public health messages and provide examples from religious texts to support them (CAFOD, 2015). Religious venues, such as mosques

and churches, were leveraged as critical channels for the dissemination of Ebola messages (GoSL, 10/2014). As important influencers, Imams, pastors, koranic teachers, Sunday school teachers and evangelists were engaged in using Kutubas and sermons, Home Cell Worship Groups with relevant citations from the Quran and the Bible, to discuss with their congregations the adoption of preventive actions and prompt medical seeking practices (GoSL, 10/2014).

Face-to-face communication: Interpersonal communication, in particular house visits, was the second most preferred channel by KAP study respondents (Focus1000, 03/2015). Surveyed community members identified the need for a platform to interact, ask questions, and get clear answers – especially around preventive actions they could take to reduce the risk of transmission and understanding the medical care and treatment options available for infection persons. The communication channel most likely to reach caregivers and individuals were one-on-one communication channels, such as counselling from community health volunteers and interactions with health workers at the health facility or during their outreach visits. Some of these outreach tools included flip charts, flash cards, visual testimonials, photographs, community based signs and symbols and signals (Restless Development, 11/2014). As highlighted in Sierra Leone's communication strategy, the use of community signs, symbols, songs and approaches were popularised at village and community levels. Town criers were used as an important link in the delivery of correct information to village households (GoSL, 10/2014).

MESSAGE CONTENT AND GUIDELINES

Box 4. Public opinion during the Ebola outbreak:

Public opinion changed considerably during the outbreak. In popular culture and international media coverage, Ebola was often portrayed in the early months as a biological apocalyptic threat rather than a containable public health crisis with a need for international support (New York Times, 5/10/2014, HPN, 15/10/2014). This was particularly the case when foreign nationals were affected or got treatment in their own country (The Guardian, 20/10/2014). Fear-mongering and alarmist outbreak narratives were reminiscent of early coverage of HIV/AIDS in the mid-1980s, and played on collective fears and traumas (HPN, 15/10/2014). This was also the case in affected countries, which dealt with the news of an outbreak with fear, disbelief and an abundance of inconsistent messages.

Some of these fears and reactions sprung from realistic dangers, such as the fear of being sick, dying and not having access to care.

Many reactions and behaviours were also born out of rumours and misinformation (IFRC, 14/08/2014). In response to these concerns efforts were made to communicate clearer messages around Ebola, focusing on protective practices and hygiene.

INFORMATION NEEDS

The KAP surveys, launched in August 2014 and July 2015, helped refine the strategies, activities and messages for Ebola communication by measuring the effectiveness of social mobilisation and behaviour change communication efforts, and identifying areas of information needs (UNICEF/CRS/Focus 1000, 09/2014). They informed the development of the national Consolidated Message Guides in 2015. These key documents referred to a range of message topics, which evolved throughout the outbreak, depending on the needs of communities. They can be classified into several main categories:

- + Overarching messages about Ebola (awareness, cause/origin, modes of transmission, signs and symptoms, perceived risk)

- + Ebola prevention (including messages on 117, contact tracing, quarantine, protecting one's family while waiting for help, vaccination and borders)
- + Ebola medical care (including information on early treatment at treatment centres, ambulances and chlorine)
- + Safe, dignified, medical burial practices (including information on burial teams)
- + Stigmatisation and discrimination (including information on celebrating survivors, understanding the risks of breastfeeding and sexual transmission and understanding negative EVD test results)
- + Post-Ebola (including messaging in campaigns to fight Ebola complacency and safe school reopening)

OFFICIAL MESSAGING AND GUIDANCE

- + **Initial guidance:** Until August, the main source of information in Sierra Leone was the Ministry of Health and Sanitation (MoHS) (PI, 18/11/2015). In April 2014, MoHS developed an Ebola prevention and control communication strategy, in collaboration with stakeholders and partners, under the National Advocacy and Social Mobilisation Committee. Its aim was to develop messages to inform districts and communities bordering Guinea and Liberia – where Ebola cases had already been confirmed – about the nature of Ebola and the necessary containment measures to avoid the expansion of the virus into Sierra Leone (MoHS, 04/2014). Beyond this strategy, some sample messages were shared across the three Ebola-affected countries, by UNICEF, CDC and WHO, and adapted by local organisations operating at district-level. Some messages were also suggested by stakeholders working with Sierra Leonean health authorities, based on their understanding of communication needs, but each time had to be validated by MoHS (PI, 11/12/2015). At the start of the response, public messages on prevention were often reported to be untargeted, insufficient and uncoordinated. They were often driven by fear and did not engage with communities, directly to help them understand the link between changing their behaviour and stopping the spread of the virus (Goal, 10/2014).
- + **Coordination of the response:** Starting August 2014, the official response to the Ebola outbreak in Sierra Leone became organised into seven pillars of intervention, led by ministries and supported by international organisations. The social mobilisation pillar, led by the Health Education Department of the MoHS and supported by UNICEF, was tasked with promoting full community engagement in the fight against Ebola. The pillar developed standard operating procedures (SOPs)

to guide social mobilisation activities in the country, and describe the roles and responsibilities of relevant actors (NERC, 03/2015). The development of an SOP on safe, dignified and medical burials, in October 2014 contributed to improving the practice around safe burials and their acceptance by communities (NERC, 06/2015).

- + **Messaging :** In coordination with other pillar, the social mobilisation pillar developed a range of brochures to relay official messages. They were adapted to different audiences and translated into some of Sierra Leone's local languages, when they were shared on the radio. In March 2015, the social mobilisation pillar developed, in collaboration with SMAC, a Consolidated Message Guide to provide a reference of accurate, standardised information in simple language and key message format to support social mobilisation efforts. The guide was updated six times, with the last developed in December 2015 (Social Mobilisation Pillar, 06/2015, PI, 23/12/2015)). All agencies involved in Ebola activities were encouraged to share these messages as widely as possible in their communication about Ebola.

ADAPTING MESSAGING DURING THE OUTBREAK

Based on publically available guidelines and guidance packages distributed throughout the epidemic, we have looked at how messages around two particularly significant communication needs evolved at three different stages of the outbreak in Sierra Leone. First, "*What is the process for being treated when someone is sick?*" and second, "*What to do if someone dies from Ebola*", both crucial elements for containing the disease. Looking at the evolution of both the key messages, transmitted by a range of actors, and the rumours and fears among communities around these communication needs provides an insight into some of the most significant adjustments made to the messages to meet those needs.

(See the charts below for an outline of the evolution of different types of messages, rumours and fears during three different phases of the crisis)

- + **Integrating more positive and engaging messaging:** Rather than messages about Ebola being a disease best treated through swift hospitalisation and care, the pervading narrative about Ebola in the months that followed the outbreak was that

it was a malevolent force spread through touch and for which no cure could be found (CAFOD, 2015; PI, 11/12/2015). These approaches did not fully take into account the context in which they were delivered and were often reported as extreme. As highlighted in the table below, early messages often seem to imply that trained professionals in Ebola Treatment Centres (ETCs) could only provide supporting care to “relieve patients from the pain” (MSF, 11/2014; MSF Message guide, 08/2014). This triggered widespread fears and rumours, requiring agencies to rebuild trust to reduce transmission by encouraging people to seek early treatment. Families preferred to care for the sick themselves rather than banish them to treatment centres for seemingly guaranteed death (ICG, 10/2015). As the outbreak progressed, messages moved on to be more supportive and encouraging. Early messages which were perceived as “If you catch Ebola, you will die” became “If you catch Ebola, you can survive” (PI, 11/12/2015). As highlighted in the table below, trained professionals were later referred to as “caregivers” and “champions”, who increased patients’ chance of survival by caring for them in treatment centres (SMAC, 12/2014; NERC, 01/2015; CDC, 11/2014). The same evolution happened with regards to safe burials. Early messages focused on the risks of contagion by urging people not to touch, kiss, clean or wrap dead corpses when people died at home. Messages later became more supportive by emphasising the things that people could do, such as pray from a safe distance and provide clean clothes to be buried with their loved ones (UNICEF, 09/2014; CDC/NERC, 01/2015; CDC/NERC, 05/2015).

- + **Increasing transparency and accountability:** The health response to the outbreak brought new practices to affected countries, including the creation of treatment centres and the use of ambulances, personal protective equipment and chlorine by Ebola workers. In Sierra Leone, lack of information around these new practices at the beginning of the outbreak, combined with high mortality rates, fed fears and rumours that widely discouraged people from using these services, contributing to the rapid spread of the virus (PI, 30/10/2015). As people saw patients enter treatment centres but never leave, some believed that nurses were stealing their blood and organs to sell or perform cannibal rituals (Wigmore, 10/2015). Others believed that the chlorine used by Ebola workers was used to kill people (Kinsman and al, 04/2015). As of May, there were still rumours that buttons in ambulances sprayed chlorine on patients and killed them (CDC, 05/2015). These rumours were amplified by a widespread belief, rooted in corruption and distrust of authorities, that the government was injecting people with Ebola to increase the number of cases to obtain international funding (Wigmore, 10/2015; ICG, 10/2015; NYT,

12/2014). In response to these fears, agencies increased activities for people to be able to, for instance, “Explore an Ebola Care Centre” through an interactive guide (MSF, 11/2014), “Learn about Ebola protective equipment” (MSF, 11/2014), and understand why Ebola workers use chlorine sprays (MoHS, 05/2015). Guidelines for people about the use of ambulances were put out in June 2015, emphasising that drivers had been asked to turn off the sirens, that they were respectful, that ambulances were ventilated and that the smell of chlorine could not hurt them (National guidelines, 06/2015). Although not highlighted in the communication needs analysed below, some agencies questioned messages around new hygiene practices. In particular, the wide calls from the MoHS for populations to use chlorine water to wash their hands at the beginning of the outbreak, failing to capitalise on previous campaigns held in Sierra Leone to promote the use of soap and water. Rumours started to spread out about chlorine being the cure for Ebola, which led to overuse and sometimes misuse by populations (some drank or took bath in chlorine water) (PI, 25/11/2015). This practice was gradually seen as unsustainable and messages were put out to warn against the risks associated with chlorine. Since April 2015, people are now asked to only use chlorine water to wash their hands if soap and water are unavailable (CDC, 10/2014; CDC, 05/2015).

- + **Making messages more practical and credible:** Some reports highlighted that community health messaging were too focused on the virus itself (“*What is Ebola? How is it spread?*”), failing to provide the kinds of “higher order” practical information and training that communities needed (ODI, 2015). As highlighted in the table below, messages were lacking at the beginning of the outbreak about how patients could be transported to health facilities without promoting infection. Messages on ambulances only started to be put out at the end 2014, emphasising that they were the best and safest way to get to treatment centres and that people should refrain from using public transport (NERC, 01/2015; SMAC, 12/2014). At the same time, issues were raised about messages not matching the level of available services. For instance, when messages started to instruct people to isolate sick family members and call an ambulance, only a fraction of the necessary ambulance capacity was actually available in Sierra Leone (WHO, 01/2015; ODI, 2015).
- + **Avoiding confusion by changing messages:** Some KIs emphasised that messages and terminologies often changed throughout the outbreak, contradicting themselves and creating confusion (PI, 25/11/2015). For instance, early guidance was that people with Ebola symptoms should seek medical care at

a hospital or ETC, guidance at the second stage was that any ill person should go as early as possible to an ETC or a Community Care Centre (CCC), and guidance at the last stage was that patients with early symptoms of Ebola should go to an Ebola Treatment Unit (ETU) or a CCC (CDC, 07/2014; WHI, 08/2014; NERC, 01/2015; CDC, 01/2015; CDC, 11/2014; National guidelines, 03/2015). During an ACAPS focus group in Freetown, some students highlighted that conflicting or changing messages created distrust between Ebola patients and medical practitioners, which also contributed to the spread of cases (ACAPS focus group, 11/2015).

- + **Remaining challenges around messaging:** Although not highlighted in the communication needs analysed below, messages around the risk of sexual transmission by Ebola survivors also significantly changed, in part due to scientific advances made during the course of the outbreak. KIs emphasised that it created confusion and further stigmatisation of survivors (ACAPS focus group, 11/2015). Earliest messages advised against sex for seven weeks after recovery, while in February they advised to abstain from sex for at least three months or use a condom every time, and in October, they advised for safe sex to be observed until Ebola survivors' semen has twice tested negative or for at least six months after the onset of symptoms, if semen has not been tested (WHI, 08/2014; MoHS, 02/2015; CDC, 10/2015).
- + **Adapting messages to deep rooted cultural practices and beliefs:** Early messages designed to change behaviour counterproductive, as they failed to take into account deep rooted cultural practices and beliefs. Significant improvements in community perceptions of key messages came when Christian scholars were consulted to incorporate faith elements to public health messages, and provide examples from religious texts to support the messages (CAFOD, 2015). As highlighted in the tables below, religious leaders encouraged people to seek medical treatment early, when they were sick, to help eradicate the disease, as this was approved and commanded by both the Quran and the Bible. They warned against washing or touching of dead bodies in an unusual situation, such as the Ebola epidemic, while at the same time calling for burial teams to ensure the dignity of the dead was preserved during the burial (Focus1000, Training of religious leaders, 12/2014). Messages related to safe burials gradually evolved, with the move from Dead Body Management to Safe and Dignified Burial practices in the second and third parts of the outbreak, revealing the need to take the cultural context into account. They became more compatible with faith and

tradition as the new practice allowed families to make decisions with the burial teams about the funeral, and allowed a small number of family and community members, including religious leaders, to see the burial and pray from a safe distance (MoSH SoP, 02/2015; National guidelines, 03/2015). They became more engaging as burial teams were now required to explain the rationale for and the steps of safe burials to families. Safe burials were a way to show respect and honour for those who had died, rather than a way to protect oneself and one's family (CDC/NERC, 05/2015).

LESSONS LEARNED

"In one month we've managed to change an entire culture -women were not touching their children anymore. If that can happen in just one-month time, why can't we be better today at teaching people to use soap and water?" – Trained nurse and head of international NGO

Timing: For many KIs, funding for social mobilisation and focus on "bottom-up" activities came too late (PI, 28/10/2015, PI, 18/10/2015, PI, 07/09/2015, 25/11/2015). Some of the most successful initiatives were the ones that 'triggered' communities to assess the outbreak themselves, its effects and likely impacts, creating a sense of urgency to develop community action plans and change their behaviours (CLEA, 11/2014). Lessons learned from this intervention are equally applicable to a wide range of priority issues in West Africa, such as addressing the stigma faced by communities exposed to Ebola and the prevention of other communicable diseases.

Telecommunication channels and media: In Sierra Leone radio was by far the most widespread means for receiving information (Focus1000, 03/2015). In a context of widespread quarantines and emergency measures that aimed to minimise large gatherings, mobile phones were a valuable channel to collect and share information with blocked off communities. As a result, practitioners should be trained to report effectively and responsibly through these channels and incorporate feedback mechanisms that encourage audience participation.

Language: Language was one of the main difficulties faced by humanitarian workers responding to the Ebola crisis (HPN, 06/2015). Information and messages about Ebola were first primarily available in English or French, leading to a gap in material which could be used as part of sensitization campaigns.

Messages: Early messages designed to change the behaviour were counterproductive, as they failed to take into account deep rooted cultural practices and beliefs and context-specific difficulties (ICG, 10/2015; CAFOD, 2015). The most efficient messages were adaptable enough to be culturally and regionally appropriate, repetitious and available in relevant languages.

Community leaders: Trusted members of communities serve as great role models for behaviour change. Significant improvements in community perceptions of key messages came when religious scholars were consulted to incorporate faith elements into public health messages, and provide examples from religious texts to support them (CAFOD, 2015).

Gender: Preliminary data suggests that women died in greater numbers than men at the beginning and peak of the outbreak, in part due to their role as caregivers (UN Women, 10/2014, Huffington Post, 15/10/2014). They were also less likely to access both telecommunication channels and traditional channels relaying information, and to be included in communication campaigns targeting community of faith leaders (UN Women, 12/2015). More effort should have been made to mainstream gender into health information campaigns (Harvard, 06/2015).

ANNEX

Information need 1: What is the process for being treated when someone is sick?

Information need 2: What to do if someone dies of Ebola

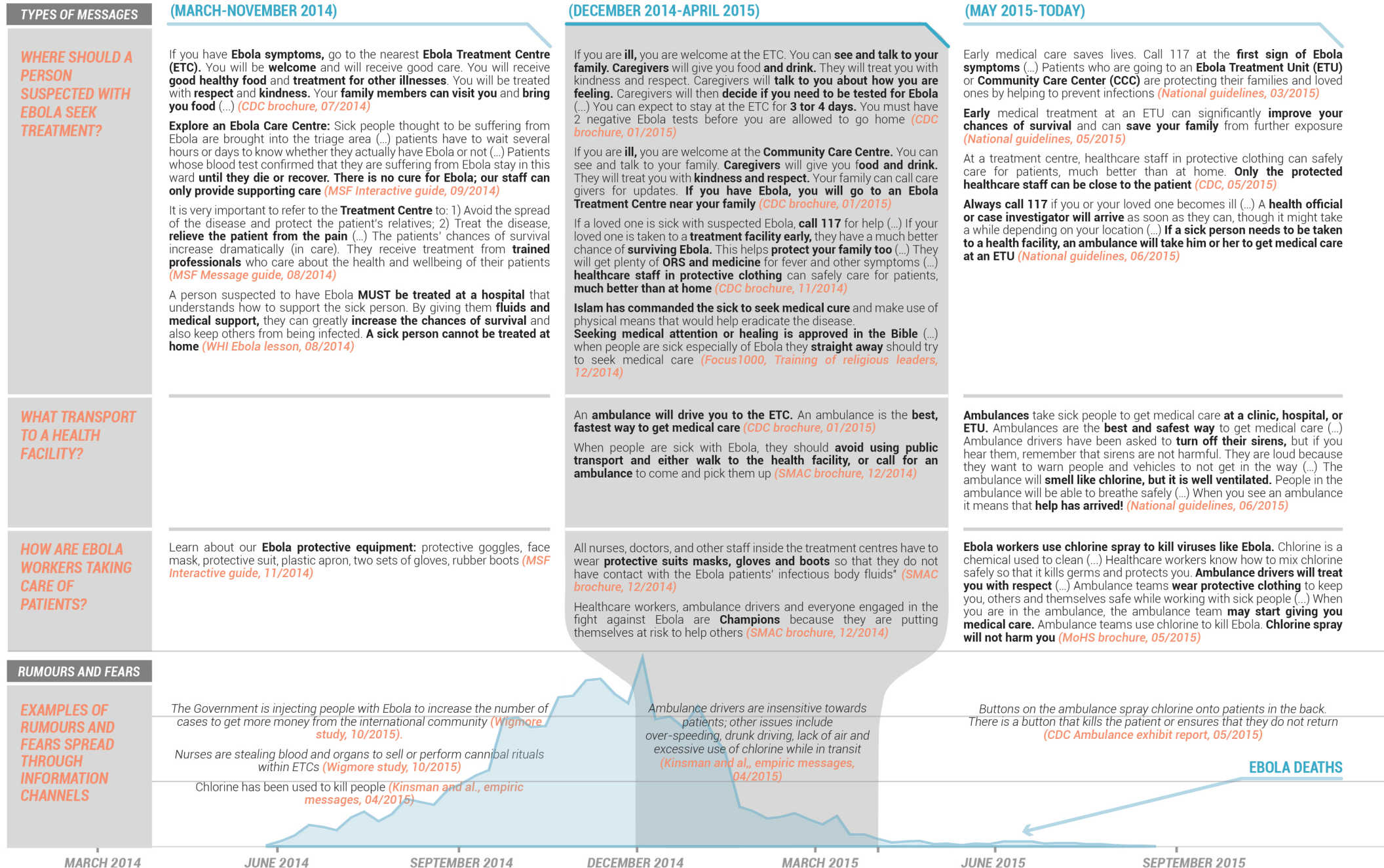


Humanitarian Aid
and Civil Protection

The views expressed in this report should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains

WHAT IS THE PROCESS FOR BEING TREATED WHEN SOMEONE IS SICK?

HOW OFFICIAL MESSAGES IN SIERRA LEONE EVOLVED DURING THE EPIDEMIC



WHAT TO DO IF A PERSON DIES OF EBOLA?

HOW OFFICIAL MESSAGES IN SIERRA LEONE EVOLVED DURING THE EPIDEMIC

