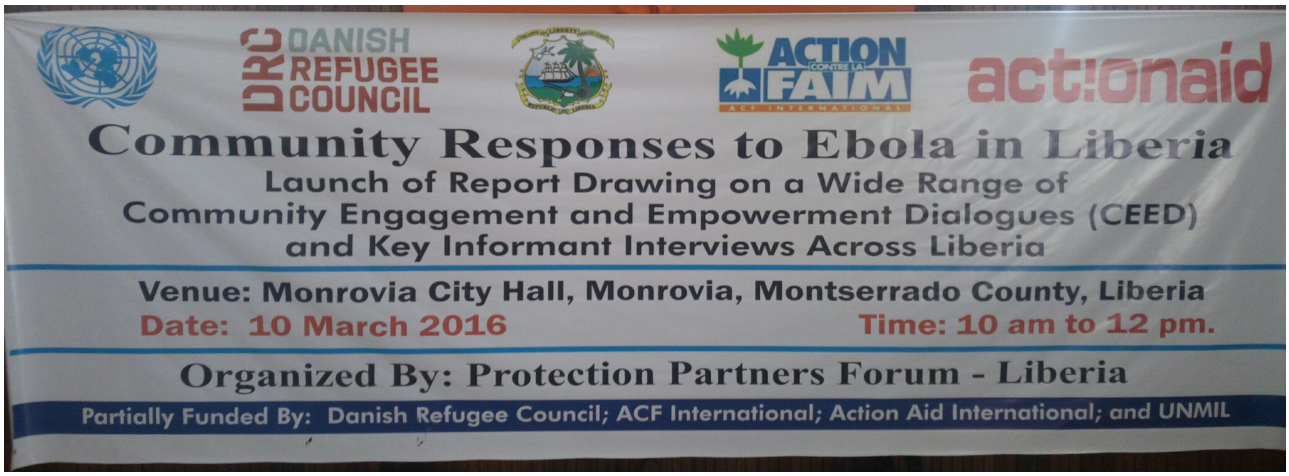
# Community Responses to Ebola in Liberia

**A Report Drawing on a Wide Range of Community Engagement and Empowerment Dialogues (CEED) and Key Informant Interviews across Liberia from March to October 2015**




## Protection Partners Forum
## Liberia

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# Executive Summary

The report is based on community dialogues held across the country as the Ebola crisis receded and takes an unusual perspective from the point of view of individuals and communities most directly affected by Ebola, presenting their voice. It finds that the crisis, at least in Liberia, reflected more a failure of governance, rather than simply a public health emergency with weak infrastructure and health systems. Therefore, post-Ebola health system strengthening must address these governance issues.

Chapter 2 of the report looks at how communities themselves responded to the Ebola crisis from early disbelief on its source and modes of transmission, with fear and distrust of health services, through to acceptance of the need for changed hygiene practices and creation of community level structures to contain the virus. Hand washing, not touching and elements of self-quarantine were more readily accepted than changing burial practices and not eating bush meat. Traditional and religious leaders set examples in changing normal practices and communities that lacked the means of protection adopted their own solutions and support mechanisms for those affected. Public health messages on Ebola were strongly driven by professionals at the centre, lacking recognition of context. Cremations were imposed against strong cultural opposition. Traditional and religious leaders did much to change Government policy, backed by the WHO guidelines for safe and dignified burials.

The following chapter addresses the impact of the Ebola response on the rights of communities. A gender and Human Rights approach, which seeks to understand the priorities and concerns of affected populations including women and children and to protect their rights, was lacking in the Government's emergency response. As a result of the failure to comply with a Human Rights approach, there were a number of Human Rights violations, not all of which can be justified as intrinsic to the State of Emergency and a humanitarian crisis response. Violations included children's rights including rights to education, to play and to adequate food and nutrition; rights to health, particularly maternal health services and access to treatment for non-Ebola pathologies; rights to water and sanitation; right to physical integrity, right to freedom of movement; rights to freedom of expression and to information. There was no clarity in what rights needed to be derogated, effectively withdrawn or withheld, and Government did not formally inform other States Parties to the ICCPR through the UN of such derogation as it is obligated. The chapter also addresses the discrimination and stigmatisation, which have been widespread against Ebola survivors and front-line responders in a range of roles, and notes that Government has yet to address them.

In Chapter 4, the report looks at lessons learned from the Ebola crisis. It finds that taking a rights-based approach would have improved public health messaging, hygiene practice, handling of safe burials with dignity, quarantine and addressing stigma and discrimination. Public health messaging should always be a result of a two-way communication between health professionals and communities, not multi-media IEC campaigns telling people what to do, but mutual listening and respect that will lead to changed behaviour as much by health staff as by individuals. Not until Government met with traditional leaders in October 2014 did they listen to views against cremation. Cremation resulted in non-compliance and possibly increased the spread of Ebola. Liberian traditional and religious leaders, through back channels, influenced the development of the WHO guidelines on safe burials with dignity, which finally became Government policy at the end of 2014. Hygiene messages, apart from avoiding bush meat, were well accepted, but initial lack of materials such as

soap, chlorine, gloves and faucet buckets, made it hard to fulfil. Government failed to make arrangements for provision of water and food for quarantined populations, which undermined the effectiveness of quarantines. Government should urgently put in place a strategy for emergency preparedness and for post-emergency recovery and reintegration. Ongoing dialogue between Government and communities, including respected traditional and religious leaders, was needed from the onset of the outbreak in order to build trust, to promote accountability to affected populations and to prevent the disease from spreading as widely as it did. The report produces the evidence for the need to strengthen community participation, non-discrimination and inclusion in any future similar types of humanitarian emergency and to institutionalise the structures for this now. Partnerships should be broadened to include not only the skills and experience gained by front-line responders, but also the new community structures and other partners such as motorcyclist unions, drawing on their mobility and networks for public health gains. Community based monitoring can assist with service accountability and responsiveness and also help with disease surveillance.

Finally, the report puts forward several recommendations. There is a real opportunity now to generate an “Ebola Dividend” in governance and service delivery. However, simply strengthening the health system infrastructure and technical capacity, without strengthening accountability and responsiveness to local communities, will fail to address the overall institutional weakness of the Liberian health system. The recommendations focus on Government-community partnerships, building on existing and new structures that were created to respond to the crisis. It offers a full set of recommendations on emergency preparedness, which could reduce the extent of any similar future crisis, including improved WASH services. It ends with clear recommendations on the protection of individual Human Rights and the protection of human rights Institutions in future crises.

This is a report for action and transformation, based on reflection from real experiences of communities and individuals directly affected by the Ebola crisis.

## Acknowledgments

This report is the result of the commitment of many agencies and individuals members of the Protection Partners Forum (PPF), which is comprised of local civil society organizations, INGOs, and government ministries, among others, and is led by **the Ministry of Justice** and co-led by the **UNMIL-Human Rights and Protection Section**. Members of the PPF worked with communities and key informants to learn from their experience of the 2014/15 Ebola crisis and the breadth of response to this. The initial process of Community Engagement and Empowerment Dialogue (CEED) was carried out by the Protection Cluster and communities providing their time and resources in a voluntary capacity.[1] The Human Rights and Protection Section of UNMIL, Action Contre la Faim (ACF) Liberia (through the OFDA-funded IRC-led Montserrado Consortium), Action Aid and the Danish Refugee Council provided financial support and advice for the report and its validation workshop. PPF thanks its members in the field who are the primary and main contributors of this report and also, Dennis and Jonathan Pain of ACTS Consultancy who analysed and put in a report format hundreds of data collected by PPF members often in very remote location. Our appreciation also goes to the communities that generously gave their time in the hope that lessons could be learnt and services improved by their experience. Many individuals shared their perspectives from their roles as leaders or responders, most having risked their lives in responding to the spread of Ebola. The views expressed here draw on these many sources, including a validation workshop organised by the Protection Partners Forum, but are not necessarily those of every member of the PPF, nor of the UN or Government staff.

***PPF Coordination***

[1] The CEED was an initiative of the Protection Cluster, which was active from October 2014 to June 2015. The Protection Cluster was led by OHCHR/UNMIL-Human Rights and Protection Section and co-led by the Ministry of Justice. The majority of the dialogues were conducted by Cluster members, who later became members of the Protection Partners Forum, which was formed in July 2015.

## Introduction

The report is based on community dialogues held across the country as the Ebola crisis receded and takes an unusual perspective from the point of view of individuals and communities most directly affected by Ebola, presenting their voice. It finds that the crisis, at least in Liberia, reflected a failure of governance, rather than simply a public health emergency with weak infrastructure and health systems. Therefore, post-Ebola health system strengthening must address these governance issues.

A gender and human rights-based approach, which seeks to understand the priorities and concerns of affected populations and to protect their rights, was lacking in the Government's emergency response. As a result of the failure to comply with human rights based approach, there were a number of human rights violations, not all of which can be justified as intrinsic to the state of emergency and a humanitarian crisis response. Taking a rights based approach would have improved public health messaging, hygiene practice, handling of safe burials with dignity, quarantine and addressing stigma and discrimination.

Ongoing dialogue between Government and communities was needed from the outset of the outbreak in order to build trust, to promote accountability to affected populations and to prevent the disease spreading as widely as it did. The report produces the evidence for the need to strengthen community participation, non-discrimination and inclusion in any future humanitarian emergency and to institutionalise the structures for this now.

There is a real opportunity now to generate an "Ebola Dividend" in governance and service delivery.

## 1. Background

### Protection Cluster Community Dialogues

As the Ebola crisis waned[2], the Protection Cluster, which later became the Protection Partners Forum, involving Government, international agencies and civil society, initiated an extensive range of Community Empowerment and Engagement Dialogues (CEED) across Liberia. A total of 202 CEED across 13 Counties and 36 Districts and 14 communities across Greater Monrovia[3], with approximately 2,245 participants, were facilitated by some of the key members of the Protection Cluster and by Town Chiefs and Community Chairmen/women. Participants varied between mixed groups of all ages, women and men, to youth groups and women's groups, and included community leaders, workers, professionals, traders and students. The CEED enabled those most affected by the Ebola crisis to articulate their concerns and priorities, which were to a great extent ignored or given low importance during the crisis itself. These CEED Focus Group Discussions (FGDs) were carried out from late March to May 2015 and by ACF in Monrovia/Montserrado from July to October 2015, together with interviews with key stakeholders in the response to Ebola. Key Informant Interviews (KIIs) were also held with the Sande women's traditional leader, a leader of the Muslim Council and the chair of the Inter-Religious Council of Liberia, health workers, burial teams and survivors. The

[2] Liberia reported 10,675 Ebola cases (suspected, probable and confirmed), with 3,160 laboratory-confirmed cases and total deaths of 4,809. WHO first declared Liberia free of Ebola virus transmission on 9 May, 2015. The country subsequently experienced a cluster of six Ebola cases in June 2015 and was declared free of transmission again on 3 September, 2015. A second cluster of three cases was reported in November 2015, and WHO declared the country free of transmission for the third time on 14 January, 2016. Source: CDC in conjunction with WHO and based on information reported by the ministry of health: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html accessed 27 Jan 2016

[3] See Annex: CEED Districts and Validation Workshop Participants

validation workshop, involving 53 representative participants, took place in February 2016. Sources of statements are given in brackets.

**Objective**

Much has been written from national and international perspectives on the failures and successes of the technical response to Ebola in Liberia, Sierra Leone and Guinea. Much less has been written from the perspective of communities affected by Ebola[4]. This report aims to understand how communities responded to the crisis and to the demands placed on them by the authorities and social and medical NGOs and the support that they received. Were community views heard and concerns addressed appropriately? What gaps in provision do communities identify? What impact on human rights did the crisis and its handling have? What are the recommendations from communities to national and international agencies and health service provision? The report identifies lessons learned and makes recommendations, including that Government would benefit from taking human rights based approach in emergencies.

**Examples of Communities Surveyed**

1. *Foya Town, Lofa County*, on the border with both Guinea and Sierra Leone, where the first confirmed case of Ebola in Liberia was reported in March 2014 and where 36 people died and 32 survived.
2. *Yankoitahun village near Bolahun, Lofa County*, a small rural community with 23 Ebola deaths and 18 survivors.
3. *Crab Hole, St Paul Bridge, Montserrado*, where 9 died, including 5 children, and 7 survivors; 35 children orphaned; 28 people quarantined.
4. *Zumah Town, West Point, Monrovia*, where more than 30 people died in two outbreaks (August to November 2014 and January to February 2015); four survivors.
5. *Kanweaken town, River Gee County*, a border town with people from neighbouring Guinea and Côte d'Ivoire where most of the youths and women who are not formally employed are involved in farming and illegal gold mining.
6. *Nyella, Bomi County*, a scattered population of 512 involved in trade and illicit diamond mining in neighbouring Gbarpolu, predominantly Muslims from Guinea and Sierra Leone, where five persons, including an 18-month-old girl, one man and three women, all from the same household, died as a result of Ebola.
7. *Gayah Hill, Bomi County*, with population of 2,025 close to Sime Darby Plantation, where Ebola led to the death of 9 family members of an infected health worker (PA).
8. *Joseph Town, Bomi County*, a densely populated community of over 3,000 from a diversity of ethnic and national backgrounds, characterized by social problems and informal sector activity – reported 17 Ebola deaths.
9. *Totoquelle, Gbarpolu County*, a small town of 2,500 with its own clinic and school had no cases of Ebola, despite lack of a hospital in the county and poor roads preventing access to other hospitals.
10. *Central Airfield Zone 1, Saniquelle City, Nimba County*, which had no confirmed Ebola cases, although in other zones of the city there were 13 or 14 confirmed cases and 9-11 deaths reported.
11. *Raymond Field, Montserrado County*, an urban community of 2,000 where out of nine people that contracted Ebola, only one survived and a quarter of the households were placed under quarantine for two consecutive periods of 21 days.

**Examples of Personal Stories**

[4] One exception is the JHU/CCP Health Communication Collaborative (a USAID funded project) report compiled by Najmeh Modarres: *Community Perspectives about Ebola in Bong, Lofa and Montserrado Counties of Liberia: Results of a Qualitative Study*, Final Report, Jan 2015, which carried out 39 key informant interviews and 14 focus group discussions in 6 communities. It covers much common ground with this report, focusing on knowledge, beliefs, information, leadership and action, including stigma against survivors. See http://ebolacommunicationnetwork.org/wp-content/uploads/2015/02/Liberia-Ebola-KAP-study_Research-Report_FINAL_10-Feb-2015.pdf accessed 23 Feb 2016

Lofa County was where the first case was reported and initial awareness was lacking as the following two first-hand testimonies from the beginning of the outbreak illustrate (Yankoitahun, Kolahun, Lofa and Balakpalasu, Voinjama, Lofa):

*We did not believe in Ebola in the beginning. One boy went to attend a graduation party; when he returned he started to get sick. The whole day people went to see him and to comfort him. We did not believe Ebola existed. After the sickness started to be serious they put the boy on the motorbike to take him to the clinic. But the boy vomited on the bike driver and the driver refused to take him. One man helped the boy to go back to his house. The clinic in Bolahun was informed and a healthcare worker and other two people came to examine him. He asked for assistance from Foya. Unfortunately the boy died next morning before the assistance arrived. By the time the assistance arrived they (the family) had buried the dead body. The health team sprayed the house and all who attended the funeral. One week after, everybody who was in contact with the boy started to be sick. The three who came from Bolahun and the other people from our village. The motorbike driver died after a week. We all got scared and called for the burial team to assist from Kolahun. Before they arrived the first victim's mother and the motorbike driver's mother also died. When the burial team arrived they called all the people with symptoms to come to them. Almost 20 came, but they could only carry six of them in the ambulance. Two days later they came back and carried the rest of the sick. In the meantime another girl died. We were all scared. When the health team took away a sick person they burned all the household items from that house (clothes, bed sheets, towels, mattresses, kitchenware, furniture etc.). We really suffered. Even today, nobody ever helped us to replace our household items.*

*……*

*One lady from the neighboring town (Zango's Town) went to Guinea. When she returned she started to have fever. She was taken to the Telewoyan Hospital in Voinjama, but they could not help her. They sent her back. She was still feeling sick and her condition worsened. When she was identified as a suspected Ebola patient, she escaped to Konia. She was taken back and she died. We did not believe it was really Ebola. At that time most of us denied the existence of Ebola. The healthcare workers came to Balakpalasu to raise awareness. They told us to wash our hands with soap and not to touch each other especially the sick. However, because of the denial, most of us did not listen and we did what we were told NOT to do. We kept on attending burials and to touch the dead. It took us about three weeks to realize Ebola was real. By that time it was too late.*

## 2. Community Responses to Ebola

### 2.1. Understanding the Message on Ebola

**Early Reactions to Spread of the Crisis**

From the outbreak in March 2014, it took most of four months for the gravity of the crisis and corresponding response to bring about changes of behaviour in service provision and of community behaviour. As those affected in Lofa at the beginning of the outbreak reported, there was also denial and resistance to changing behaviour. Not only did attitudes need to change, but the means to do so, in terms of safe hygiene and burials. Many communities reported the poor availability and quality of water impacting on safe hygiene. While hand-washing as precautionary hygiene practice was adopted, there was reluctance to end the practice of washing the bodies and plaiting hair of those who died and traditional views about healing and burial were hard to change in the initial days. As awareness of transmission and effect of Ebola increased, fear became strong until confidence increased in taking precautions through hygiene; through avoiding hand-shaking and handling the dead; and through quarantines and restrictions on mobility. *Fear was widely felt: I kept all my children inside the house during the crisis. I was the one going around getting food. I feared for their lives. After a while I got sick myself. I was down for almost two weeks. It was terrible. I thought I would die. I was not able to do anything* (Gbegbedu, Lofa). Fear was a commonly expressed reaction to Ebola in the initial stages of the crisis.

Early in the Ebola crisis, some people took traditional medicine, before they learnt the reality of the virus. People in Grand Gedeh believed in the existence of the Ebola virus, but thought that most deaths were caused not by the virus but through water poisoning or through other sicknesses such as malaria, typhoid etc. Fear of contaminated water also included suspicion that others might be the cause behind Ebola Virus Disease (EVD) - *Our community organised youth groups to found a watch team to protect our wells from being poisoned at night* (elderly, Bolola Road, Benda, and Margibi).

People, including health workers, initially did not understand the danger of Ebola and its transmission through bodily contact, and consequently many health workers were infected and died – and the public came to believe that it was health workers who were spreading the virus, resulting in negative attitudes towards health workers. More generally, people believed that the virus was transmitted from clinics by health workers. As a consequence, the community avoided going to get treatment at health centres until awareness on the virus was carried out in their communities[5]. However, going for treatment was feared to carry an increased risk of infection, particularly as patients with different infections were presumed to be waiting together - s*uspected Ebola cases should be separated from confirmed cases at the Ebola treatment unit (ETU)* (Nippy Town, Old Road, Montserrado). Such separation occurred, or should have been occurring, but fear and rumour dominated over assured knowledge.

Traditionally, such an outbreak of disease would have been handled through a regular community meeting (Crab Hole, St Paul Bridge, Montserrado), but this went against the prohibition on public meetings, leaving a gap in traditional communication systems. Fear was widespread during the crisis and not all fears were allayed. Fear was mentioned in 23 per cent of the dialogues in the CEED, but was exceptionally high in Kakata (Margibi County), where it was mentioned in 56 per cent of all dialogues.

In the early days, without good information and the resources to respond to the public health messages that were being promulgated, some people had to make their own judgments of what to do: *I and my family went on a voluntary quarantine for 21 days; When my niece got sick I was confused; I did not know how to take care of her; I put chlorine on her vomit before I cleaned it up. One day, when I went to the farm, I had diarrhea - I was scared and I told my children not to touch me and not to come near for a*

[5] Oxfam e-mail communication 23 May 2015

*few days, but thank God it was not Ebola* (Gbegbedu, Lofa). The weakness of clear information on how and what communities should do and communicated by trusted community leaders and professionals working together undermined public co-operation. Early messaging in Ebola and its fatality presentation also affected people's access to treatment. The fact that infected people knew that this fatality rate was the norm served as a disincentive to treatment and an incentive for rumour mongering during the crisis.

The combination of poor communication messages by Government and failure of communities to understand the danger of Ebola led to a high death rate in the early stages of the crisis (Validation Participants).

**Understanding resulting in cooperation**

As understanding spread, people recognised the need to avoid touching and, in particular, handshakes, which stopped completely. *When the awareness team came, they told us not to touch a dead body and sick person; Do not bury the dead person by ourselves; Wash hands with clean water and chlorine - We still do it today* (Gbegbedu, Lofa).

Communities began to contribute to awareness-raising. Households cooperated well in contact tracing and collaborated with the contact tracing teams supported by organizations such as ACF, ActionAid and the other active case-finding teams. Community mobilization teams and psychosocial workers provided information and support services; other NGOs, UN agencies and groups also distributed food and water. Information backed by materials proved more acceptable and enabled people to change their behaviour towards the virus and to let go of some traditional practices, which initially had been difficult.

Initially, traditional and religious leaders at community level are said by some to have encouraged conformity to traditional practices and religious attendance as sufficient protection, before realising that Ebola required hygiene measures to prevent its spread. The Council of the Muslim Community in Liberia, after theological reflection, became involved in training Imams on preventive measures so that they could reach out through their congregations with safety messages.

*This issue of Ebola has to be dealt with from the community level before things can really be done the right way. Getting the Traditional People involved in this fight is key. They are the ones that are in the rural areas and they deal with the majority. We are just a handful of people in Monrovia; the vast majority is in the rural areas. And seeing their own Traditional Chiefs and Zoes coming to talk to them will be a sign of relief for them, because these are people they believe in*[6].

## 2.2. Public Health Messaging & Responses - Precautions and Hygiene

Messaging about precautions to avoid infection with Ebola, particularly regarding hygiene, enabled communities to apply these to their own contexts. Hygiene is critical for Ebola containment and it was mentioned in 13 per cent of the dialogues and in 55 per cent of the districts covered by the CEED. *We washed our hands with soap even before the NGOs came; we used to buy our own chlorine and shared it; we also carried some with us, so it was always available to clean our hands* (Gbegbedu, Lofa). Some who lacked provision of soap and chlorine in the early days started using ash to wash their hands (e.g. Toffoi, Konebo, Grand Gedeh).

Where gloves were not made available, people used plastic bags for protection when handling the sick: *A nurse at Redemption Hospital innovated with two black plastic bags*

[6] Personal communication from an NGO to author on 16 Oct 2014

*from a local shop, which she tied on to her hands, when her father was sick with Ebola and an ambulance failed to come. Her brother and a sister also got infected. She used plastic bags to protect herself and then it got spread widely through TV and radio and WCI took the approach to women in the villages* (WCI interview 6 July 2015). A*s community dwellers, we set our own preventive measures although we never had access to gloves or hand sanitizer and we used plastic bags to protect our hands* (Nippy Town, Old Road, Montserrado).

Regular hand-washing was readily accepted as it did not confront traditional values, but lack of clean water and soap and chlorine, with hand-washing faucet buckets, initially made this hard to fulfil. *The church in our community prepared a highly concentrated chlorine solution for affected families at the entrance of the church* (Raymond Field, Montserrado). The Muslim Community added to their practice of regular hand-washing the use of a mixture with chlorine or detergent and leaders informed Muslims *to use protective jackets or gears, whilst in the process of bathing a dead body; … not to touch their relatives even when a member of their relatives is ill, unless they are protected, or call the Ebola Response Code number 4455 or call the health workers who know more about the preventive measure of the virus* (Head of Council of the Muslim Community in Liberia, 17 Sept 2015).

### 2.3. Public Health Messaging & Responses - Movement of People and Quarantines

In the early period, some communities took their own action to reduce movement and risk of transmission. Some in rural areas of Nimba reported avoiding contact by working in their fields and even sleeping on the farm (e.g. various FGDs in Nimba). Several reported placing children in community safe areas, effectively a quarantine of the healthy: *sande groves were safety for us; so we took our children there for safety* (Bomi – Harmon Hill). Traditional leaders changed their position from welcoming strangers to constraining outsiders coming into a community. *Before the Ebola outbreak, anyone who rejected strangers or visiting friends or family members, were summoned by the traditional leader/elders in our community to justify why he or she rejected the person* (Bomi – Harmon Hill; Gayah Hill and others), but in response to Ebola Virus Disease (EVD), the traditional elders rejected all outside visitors and reported any seeking to come into a community. These were, in effect, self-imposed quarantines or visitor exclusion zones, which were widely enforced by communities once local leaders had provided explanations. *A group of men served as watchmen at night, but this did not stop the spread of Ebola* (UYPETDL: Margibi – Benda Women).

River Gee communities traditionally enforced their own quarantine as part of traditional "*Boka*" protection of their communities when faced by sickness or evil affecting the whole community. Every member of the community takes part in a ceremony, following which no-one leaves the town until the sickness passes[7]. This suggests a possible avenue for collaboration in future epidemics between traditional leaders and health officials, for those communities that exercise their own form of quarantine or exclusion zones, preventing visitors from entering, providing the right to movement or other rights are not arbitrarily violated, as is discussed later with regard to protocols invoked in any state of emergency.

However, for practical reasons, not all community leaders agreed with quarantine as an effective approach that communities will accept. Failure to provide food supplies for quarantined households led to some people slipping out of quarantine sites. Where basic needs were met, quarantine could be effective - *the family was quarantined; the task force was there to collect food, water, clothes to give to the family and they were also giving*

[7] Oxfam e-mail communication 23 May 2015

*update reports to the community leaders* (Iron Factory, District 3, and Montserrado). The Ministry of Health primarily or the Contact Tracing Team or the community Task Force team, but occasionally an NGO, in conjunction with the community chairman, was responsible for deciding which households and communities would be quarantined. In some cases, the military was brought in to enforce quarantine, but in West Point, Monrovia, people did not want to be quarantined and were afraid and "thought they were being placed in a concentration camp without food and water" – and tension ensued. At their best, quarantines were introduced by community leaders appointing their own community task forces. Although most accepted the necessity of quarantining as in their own interest and the interest of the country, a few felt that it was done more for political reasons or the benefit of the international community. Where communities felt neglected, there was a minority view that Government was more interested in protecting outsiders than those within affected communities.

Despite cooperation from communities in maintaining the quarantines, Government proved unprepared for managing quarantines, particularly providing food and water to those isolated. Government's failure undermined the integrity of the quarantines. *Some people left on their own secretly in search of food*, *sometimes with the consent of the Community Task Force* (Flamah Community, Monrovia, with similar reports from elsewhere). *I tried to leave the quarantine area at night along with my sister because no one was catering to us; I tried leaving the quarantine area at night and I jumped in the river behind my house* (Clara Town, Monrovia). Some received nothing, apart from neighbour or community support, until after the quarantine was over. *The chairman, women and youths collected food in the neighbourhood and drew water from the wells for us* (Neezoe Community, District 3, Montserrado). If it were not for Community Task Forces and NGOs, working with community leaders, religious institutions or philanthropists and providing inputs such as food, water, chlorine and gloves, the quarantine would have been unsustainable. Communities dependent on trade and business had their source of income removed – eight months later, the impact was still being felt.

Although communities accepted quarantine as a necessary protection from the spread of Ebola, quarantine could have been managed better *if people were provided with incentives and health practitioners were assigned to communities* and ambulances provided rather than expecting people to carry their sick to a health facility (Daybreak Mouth, Montserrado). There was a feeling of being *abandoned by Government* and that *Government didn't follow-up on the well-being of quarantined people* (Daybreak Mouth, Montserrado). Government lost credibility from its poor handling of quarantines and failure to respect the rights of those affected. Although many reported that quarantines had been a major factor in stopping the spread of Ebola, others complained that it was undermined by the lack of effective supervision by a monitoring team, which they felt should be set up in the community, and by the lack of provision of food and water. At the other extreme, some communities held daily roll calls for monitoring compliance.

A quarantined community in Kpelleh Town, Montserrado, suggested that putting a ban on gatherings in public place such as stopping public meetings in places like video clubs, churches and social gatherings, could be an alternative to imposing quarantines[8]. Another suggestion was to use a more acceptable word than "quarantine", which was seen as rather negative.

The issue of border closures to reduce the international spread of Ebola or similar public health risks was also raised with similar concerns as with quarantined (e.g. FGDs in Monrovia's Flamah Community; West Point; People's United Community; Freeman

[8] ACF, FGD 72nd Community, Kpelleh Town, 11 Aug 2015 – reflecting on quarantines in their community from 1st Sept to 23rd October 2014.

Reserve, Careysburg). In addition, the economic impact of Ebola and its controls resulted in an increase in illegal cross-border trade, often by youth, in areas such as Whipa, Bain-Garr, Nimba, on the Guinea border. Young boys were also reported to be returning to illegal gold mining (Kanweaken, River Gee).

### 2.4. Public Health Messaging & Responses - Handling the Dead: Cremations & Burials

**Imposition of Cremations**

Cremations were unilaterally imposed by Government for five months from the start of August 2014, but strongly opposed by communities, resulting in avoidance of medical treatment and under-reporting of Ebola. *They acted very badly by burning our dead bodies* (West Point, Monrovia). *The Government's policy to cremate Ebola patients was also a mistake: Not every person who died was an Ebola patient. The cremation of bodies was completely against the cultural practices of Liberians. People, therefore, did not want to subject family members to that kind of humiliation* (Health Worker KII). *The Islamic Community did not accept [cremation] … because we believe in burial not burning of dead body. We believe that if this is done you are putting them into hell fire before they reach to GOD. And we appeal that our people be buried instead of cremated* (Head of Council of the Muslim Community in Liberia 17 Sept 2015). Cremation Teams felt under threat and there was even a plan to attack the crematorium site, but the Police Support Unit (PSU) intervened. Cremation policy caused further resentment when a doctor who died from Ebola was buried while community members, including non-Ebola deaths, were cremated.

Until a meeting of traditional leaders was held with Government in Gbarnga from 1st October 2014, the traditional leaders were not regarded as part of messaging development. They had not been called to discuss the imposition of cremation. The public were afraid as a result of the imposition of cremation, because if they went to the ETU and died, then the body would be cremated, so people avoided saying that they were sick or going for treatment (Interview with Mama Tomah, head of the women's Sande societies). Bodies were removed from homes in black body bags without regard for traditional burial practices including consideration of practices that carried zero risk of infection transmission, such as a covering of a white cloth or the ability to view the body, which could have been afforded by transparent body bags.

As one NGO worker put it: *On the issue of cremation: it really needs to be revisited. Our culture in Liberia is to bury our dead and not burn them. This is another key reason why this virus is spreading. When our people get sick, be it of Ebola or malaria, and that person dies, they are taken to the crematory so there is no grave for that person to be remembered. This is very difficult for the people to accept - that is why you see they will always hide the sick. … When we get into communities we hear a lot and get the real picture of what is going on*[9]*.* Another commentator suggested that: *The fact that funerals and burials are still performed shouldn't be explained according to categories of "legal / illegal" or "safe / unsafe". In (Liberian) society the concept of death is strictly related to the identity of the living. The Western notion of "individual" (that brings to individual protection versus family protection) per se does not exist. Here the self is collective, socially shaped by family and lineage networks. The dead are honoured because they are still part of this network (and therefore identity)*[10]*.*

[9] Personal communication to author on 16 Oct 2014

[10] Anthropologist - personal communication to author on 15 Oct 2014

When the traditional leaders at the Gbarnga meeting held in the first week of October 2014 said that they did not want bodies cremated, the Government listened, apologised and said that they would not repeat their mistake of not listening. Government purchased 56 acres of land for safe burial of suspected Ebola victims. However, it was not until late December 2014 that the Government rescinded its cremation order.

Following discussions with Mama Tomah in July and late September 2014, a few days before the Gbarnga conference, the views of the traditional leaders and communities, objecting to cremation, were communicated to the UNSG's Special Envoy on Ebola in New York and to a member of the WHO safe burial guidelines drafting team in Geneva. The new WHO guidelines were circulated in the second week in November, informed by anthropologists working with the UN and MSF among others and responding positively and sensitively to concerns of communities for safe burials with dignity.

The introduction of cremation seems to have led to a division between the National Muslim Council of Liberia and the National Imam Council of Liberia, with the latter seeking that cremation should only be applied in the case of proven Ebola victims while still asserting that all Muslims should follow the preventive measures put in place by Government[11]. The Inter-Religious Council of Liberia, through their international hierarchies as well as through their collaboration across the country, challenged the approach to cremations and the lack of sensitivity to cultural and religious differences. After five months, the WHO Guidelines for safe and dignified burial proved a major breakthrough in showing how cremation could be better replaced by safe burial, resulting in increased compliance with Ebola protocols.

**Safe Burials with Dignity**

The new WHO Guidelines on safe and dignified burials[12], launched in November 2014, reflected the concerns expressed by Muslim and Christian clerics and their lobbying of Government and the UN internationally and recognised the need for religious sentiments to be expressed in the care and burial of loved ones. They are a good example of a rights based approach. The guidelines recognised different requirements for Christian and Muslim burials and stated that: *Before starting any procedure the family must be fully informed about the dignified burial process and their religious and personal rights to show respect for the deceased. Ensure that the formal agreement of the family has been given before starting the burial.* ***No burial should begin until family agreement has been obtained.*** The guidelines recommended a transparent approach to decisions and actions, including the following:

- *Propose to one or two family members to witness the preparation activities of the body of the deceased patient on behalf of the other family members.*
- *Ask the family witness if there are any specific requests from the family or community, for example, about the personal effects of the deceased. The family should decide what to do with the personal effects of the deceased (burn, bury in the grave or disinfect).*
- *Allow the family witness, family members to take pictures of the preparation and burial. At the request of the family, the Burial team may take pictures on their behalf.*
- *Ask the family if they want to prepare a civil, cultural or religious item (e.g. identity plaque, cross, picture of deceased) for the identification of the grave.*

[11] News report of 26 Nov 2014 http://www.inprofiledaily.com/?q=article/challenged-national-imam-council-takes-grand-mufti-sumawolo-kaumba-konneh-task

[12] See Annex

- *Give the family opportunity to view and an alternative to touching and bathing the body - e.g. sprinkling of water over the body or reading a scripture - placing the written scripture verse on the body before closing the body bag… needs to be locally adapted and discussed*

- *Provide a symbol of dignity and clothing - e.g. a white cloth*

- *Identify a religious leader known or accepted by the family.*

And:

- *Identify a burial site the family can accept and ensure the grave is appropriately labelled.*

- *Allow the family members the opportunity to be involved in the digging/preparation of the grave, if that is their custom or preference.*

- *Once the body/coffin is in the grave, allow the family members the option to throw the first soil in/on the grave according to local practice, hierarchy or tradition.*

- *If the family would like certain items to be buried with the deceased, they should identify them to the Burial Team who will ensure this is done. (Family must not handle items themselves that have been in recent close contact with the deceased).*

The guidelines were adopted by the Government in December 2014 and cremations ceased when a public cemetery was opened outside the capital. *From October to December* [2014]*, the estimated proportion of Ebola virus–positive cadavers in Montserrado County declined from 35% to 5%. However, the proportion of all bodies collected by burial teams was estimated at <50%, even lower outside of Montserrado County*[13]. Even with the end of Ebola, CEED participants reported that families continued to call the burial response team in order to check the cause of death before handling dead bodies. However, by February 2016, validation participants noted that the safe burial mechanism was losing initiative; the delayed response by the health services to conduct testing/swab of dead bodies means that burials are delayed resulting in communities being reluctant to call them.

[13] Tolbert Nyenswah et al, *Ebola and Its Control in Liberia, 2014-2015*, Perspective, in Emerging Infectious Diseases (EID) Journal Vol 22, Number 2 – February 2016, CDC http://wwwnc.cdc.gov/eid/article/22/2/15-1456_article

## 3. Impact on Rights of Communities[14]

### 3.1. General

The Ebola crisis impacted on almost every aspect of society and the functioning of its institutions, both informal and formal. *Ebola break down the entire structure of our society;* and resulted in *poor access to basic social services* (Harmon Hill, Bomi). Access to general health services was severely curtailed; schools were closed; marriages deferred; community meetings ceased. It eroded community cohesion, traditional greetings and visiting and comforting the bereaved. People avoided touching a person who was sick from malaria or other diseases. Food production, trade and employment were all affected. School closures affected children's education and social interactions. Belongings that were burnt or buried after the death of an Ebola victim, such as mattresses, clothes and cooking utensils, were not replaced or compensated. A silver lining, at its best, communities felt empowered: *Restored our hope because we as community members were involved in the response process; relieved fear because we were directly involved with the preventive mechanism and we encouraged each other in the community* (Nyella and Joseph Town, Bomi).

Some communities appear to have gained in confidence and resilience, while others reflect greater dependency and reliance on food aid. Although most noted no increase in conflict, a few reported conflict within their families arising from quarantines and food insecurity (e.g. Students at Capitol Hill). *There was a little confusion that broke out in the community concerning food - later it was put under control as WHO, CONCERN and other NGOs brought in food* (Zumah Town, Bushrod, and Montserrado). Elsewhere, conflict arose over access to water points if arrangements had not been made by the community to supply water to quarantined households – *conflict came about when we who were quarantined were denied to draw water from the pump* (Kamaso, District 17, Montserrado). West Point became notorious in August 2014 for the heavy-handed approach of Government attempting to enforce quarantine without carrying out sufficient awareness-raising in the community about Ebola causes and risks – *the Police/AFL* [Armed Forces of Liberia] *were shooting at us because we wanted to go and look for food* (West Point, Monrovia). In contrast, *everybody was kind and abided by the rules put in place; We were all united; Our unity was very strong; We encouraged one and another* (various at Raymond Field, Montserrado).

[14] To ensure a better coordination and effective impact of the humanitarian response to the Ebola outbreak,, the UN activated the cluster approach. The Protection Cluster, one of 7 clusters, was activated in October 2014 to advocate for the protection of the rights of affected populations. OHCHR/UNMIL-HRPS was designated as the lead of the Protection Cluster and the Ministry of Justice the co-lead. The Protection Cluster led a number of initiatives to address human rights concerns, including advocating for the protection of survivors of Ebola from stigma and discrimination. In March and May of 2015, it held trainings for Cluster members, including Ebola-affected populations, on combating stigma and discrimination in communities and workplaces. HRPS advocated for the establishment of the Ebola Survivors Association of Liberia and held a National Ebola Survivors Conference in December 2014, which focused on addressing stigma and the fundamental rights of survivors, identifying EVD survivors, and on strengthening data collection, mapping and case management. In response to the State of Emergency, curfew, and quarantine measures implemented by the government of Liberia, HRPS launched the Ebola Rights Watch (ERW) and conducted active monitoring and reporting on human rights abuses and violations, and produced a weekly report, which was used as an advocacy tool with national authorities to redress human rights abuses. HRPS also facilitated trainings of the Armed Forces of Liberia, Liberia National Police, and officers of Bureau of Immigration on human rights compliance during the State of Emergency (SoE), and on non-negotiable rights, such as the right to life, freedom from torture, and freedom of conscience, among others, which are to be protected during the SoE. It also advised the national authorities on the protection of civilians. UNMIL-HRPS strengthened the capacity of the Independent National Commission on Human Rights and civil society organizations in monitoring and reporting on human rights abuses and violations during the Ebola outbreak.

### 3.2. Human Rights Implications in Responding to the Ebola Emergency

Rights based approaches (RBA) to development and humanitarian aid are critical in ensuring that emergency responses do not violate the rights of vulnerable people. Taking a rights based approach should 'enable those whose lives are affected the most to articulate their priorities and claim genuine accountability from development agencies'; it also should lead agencies to 'become critically self-aware and address inherent power inequalities in their interaction with those people'[15]. Human rights instruments address both the responsibilities of duty bearers and empower rights holders to have meaningful participation in realising their rights, such as those to health or education or livelihood security, including the basic necessities of food and water, and dignity[16]. Clearly, in a situation of a state of emergency, as imposed in Liberia for 90 days from 6 August to November 2014, human rights law continues to apply, although some limitations may be enforced in line with international and regional instruments. Under the International Covenant on Civil and Political Rights (ICCPR), to which Liberia is a party, "States Parties may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin"[17]. Even during a state of emergency, ICCPR lists a series of provisions from which states cannot derogate. The Human Rights Committee, the body in charge of monitoring the implementation of ICCPR, has since clarified the scope of non-derogable rights and identified elements that cannot be subjected to lawful derogation[18]. ICCPR also requests State Parties that have declared a state of emergency to "immediately inform the other States Parties to the present Covenant, through the intermediary of the Secretary-General of the United Nations, of the provisions from which it has derogated and of the reasons by which it was actuated." Liberia has not submitted this notification.

The African Charter on Human and Peoples' Rights, to which Liberia is also a party, does not contain a clause permitting suspension of human rights during a public emergency. The African Commission on Human and Peoples' Rights (ACHPR) has repeatedly held that a declaration of a state of emergency cannot be invoked as a justification for violations or permitting violations of the African Charter. The Ebola crisis in West Africa raises questions for the ACHPR about the terms of a state of emergency as part of a public health response that complies with international law.

**Rights of the Child**

Children experienced marginalisation during the Ebola crisis, with their needs and rights placed as low priority.

Children's rights to education[19], to play[20], to adequate food and nutrition[21], were violated during the Ebola crisis. *My concern is the education; one teacher died during Ebola and presently there is only one teacher managing the school* (Gbegbedu, Lofa). Many children had not returned to school once the Ebola crisis was over and those from Ebola infected

[15] Nyamu-Musembi, C. and Cornwall, A., 2004, 'What is the Rights-based Approach all about? Perspectives from International Development Agencies', IDS Working Paper no. 234, Institute for Development Studies, Brighton

[16] See African Charter on Human and Peoples' Rights Articles 5 re dignity; 9 re expression; 10 re association; 11 re assembly; 12 re movement; 16 re health; 17 reeducation.

[17] ICCPR, article 4(1).

[18] Human Rights Committee, General Comment 29, States of Emergency (article 4), UN Doc. CCPR/C/21/Rev.1/Add.11 (2001).

[19] Article 11 of the African Charter on the Rights and Welfare of the Child; Articles 28 and 29 of the Convention on the Rights of the Child

[20] Article 12 of the African Charter on the Rights and Welfare of the Child ;Article 31 of the Convention on the Rights of the Child. *Children's right to play was also suspended* (UYPETDL: community leadership, Greenhill, Kakata, Margibi).

[21] As included in Article 5 of the African Charter on the Rights and Welfare of the Child and also Article 15 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa; Article 24 of the Convention on the Rights of the Child

families were stigmatised and called "Ebola Kids" and have withdrawn from social interaction with other children (Kpormbu Road Community, Foya Town, Lofa). Some orphans are also out of school. Children are reported to have become more vulnerable as previous mutual community protection mechanisms have been weakened. Some traditional leaders are setting an example of care for orphans and are paying their school fees (Mama Tomah). A child survivor in Monrovia, whose mother died of Ebola, and whose family kept in touch with her in the ETU by phone and met her on discharge to welcome her back and pray with her, praised the support she received from organisations, including Action Aid, MSF and the Ministry of Health, but especially "LIWEN[22], because they paid my last semester tuition" – family and community members and health workers all encouraged her to get involved in the sensitization team (Girl from Paynesville). *When the visitors came they registered the Ebola affected children and orphans. We are not too happy because the registration was not done correctly; most Ebola affected orphans are not getting assistance - we are not happy!* (Gbegbedu, Quardu-Gbondi, Lofa).

Despite widespread complaints that Government should pay for the schooling of Ebola orphans, one community reported that *the Government is doing well catering for orphans – providing free education* (Rock Hill, District 6, Montserrado). It would appear that there is no coherent policy or action on support for Ebola orphans. A need was identified for a survivors' support programme and support for orphan reintegration and education backed by a scholarship programme and support for care-givers. Validation participants considered that Government should increase the priority of its approach to orphans and ETU child survivors, raising awareness and ensuring that a package of measures reaches all equally, ensuring that no survivor is marginalised, and recommended that the Ebola Network at the Ministry of Health be abolished for giving wrong information about survivors.

**Rights of Women and Girls**

In addition to health services around access and delivery of maternal and antenatal care, women rights were not strongly integrated into response. Entrenched cultural practices and traditional beliefs coupled with limited capacity of the security sector to address women protection issues such as sexual and other forms of gender based violence further reinforced gender inequities -particularly putting women and girls at risk of sexual and gender based violence (GBV), compromising their health, dignity, safety and autonomy.[23] GBV services and programming saw a disruption or complete shutdown due to abandonment of one stop centres and health facilities[23]. The incidences of Gender Based Violence (GBV) - sexual violence, exploitation and abuse were reportedly high[24]. There are also reports of increased early marriages and teenage pregnancies during the Ebola crisis likely because girls due to schools' closure[25].

Restrictions on cross-border trade also affected women significantly since 70% of cross-border traders in the Manu River Union are women[23]. An estimated 95%[26] of women who were engaged into small businesses, including the Village Savings and Loans Associations (VSLAs) experienced loss of their livelihood due to slow down and halting of economic activities and repayment post-EVD crisis is further exacerbating economic

[22] Liberian Women Empowerment Network

[23] Ekayu, P., Proposed gender equality programming plan in support of the Ebola response/post-Ebola recovery efforts in Liberia, January 2015

[24] Joint UN Gender Strategy on Response and Management of the Ebola Outbreak in Liberia

[25] *UNDP Assessing the Socio-Economic Impacts of EVD in Guinea, Liberia and Sierra Leone, December 2014*

[26] Food and Livelihood Assessment – FAO Liberia http://reliefweb.int/report/liberia/special-report-faowfp-crop-and-food-security-assessment-liberia-17-december-2014

challenges. Lack of emphasis was also placed on the leadership of women in awareness and prevention despite women role in governance of communities and care of the family[27].

**Right to Health**

The impact on access to basic health services was significant. The closure of many health facilities and failure to set up a universally applied protocol for distinguishing malaria and Ebola without risk of cross infection may have undermined public confidence in reporting fevers and seeking treatment, resulting in increased spread of Ebola at the same time as increasing malaria morbidity. There was a fall in ante-natal consultations to 40.2 per cent in May 2014 from 65 per cent in 2013 and in assisted facility-based deliveries of 24.8 per cent in May-Aug 2014 from 41 per cent in the same period in 2013 (UN Women Gender Concerns April 2015). In one community, pregnant women continued to receive services, being treated at home, but also allowed to go to hospital (Nippy Town, Old Road, Montserrado). Elsewhere, although health workers might be appointed to work with particular communities, *pregnant women were not given the chance to go to hospital* (e.g. People's United Community, District 9, Montserrado). However, in Raymond Field, Montserrado: *Task force allowed pregnant women to go to the hospital.* Pregnant women could access the health facility, *but through a special arrangement* (Rock Hill, District 6, Montserrado). *We lost a little girl who was pregnant during the hot time – no medication was provided and she bled to death. We also had three persons who got sick – we managed to exit one person from the quarantine to get some medicine for them in order to avoid another death* (Zumah Town, Bushrod, Montserrado). Several NGOs continued to provide medication to children and pregnant women following the EVD outbreak (e.g. NEAWHA in Nimba), but elsewhere, pregnant women were reported as dying for failure to access hospital treatment (e.g. Sarbo Sweaken, River Gee), with some hospitals/clinics being closed during the height of the crisis (e.g. in Gibi District, Margibi and in Gbolekhen, Grand Gedeh). *In the beginning many of us did not know Ebola and we did not believe that was killing the people. The clinic was closed. If somebody got sick, the person just died because there were no healthcare workers around in the beginning. There was no medicine, nothing* (Balakpalasu, Voinjama, Lofa). O*ur community clinic was closed and we only survived by God's grace* (elderly in Bolola Road, Benda, Margibi). O*ur hospital was closed* (Darfu Town, Margibi). The Chairlady of Zuma Town in West Point, Monrovia, offered to deliver women at her own home, which was welcomed by women who preferred coming to an individual rather than to a hospital which they saw as not offering due attention (West Point Youth).

Limited access to other sexual and reproductive health services were also reported by women girls and other key populations, outside of antenatal care and delivery. The Ebola outbreak affected the access to anti-retroviral drugs and treatment for HIV patients including women and girls living with HIV. Prior to the outbreak, more than 6,500 people living with HIV were on treatment; however, with the shortage of health workers and fear about Ebola transmission, more than 60 percent of these facilities were closed[28]. Given that most often access to Anti-Retroviral Treatment (ART) and sexual and reproductive health commodities are facility based, these closure affected adherence and access to life saving drugs. The lack of a coherent policy towards access to routine medical care unnecessarily undermined basic rights to health. There are likely to have been increased deaths from malaria and many more untreated cases of malaria than usual, due to fear in accessing and providing treatment[29]. A 2014 Ministry of Gender GBV assessment found

[27] Lessons learned –ActionAid Response (February 2015)

[28] *UNAIDS, National AIDS Control Programme Liberia 2014 http://www.irinnews.org/report/100869/ebola-hampers-hiv-aids-care-in-liberia*

[29] In Guinea: Nationwide, the Ebola-virus-disease epidemic was estimated to have resulted in 74 000 (71 000–77 000) fewer malaria cases seen at health facilities in 2014. The reduction in the delivery of malaria care because of the Ebola-virus-disease epidemic threatens malaria control in Guinea. Untreated and inappropriately treated malaria cases lead to excess malaria mortality and more fever cases in the community, impeding the

that more than 80 per cent of rape and other GBV survivors in Liberia were denied access to health services due to the fear of health workers contracting Ebola[30]. From the perspective of health workers, who initially were not provided with adequate protection, many left their work places for their own safety. Validation participants felt that Government made a mistake by sending health students to replace health workers on strike, which then caused a higher death rate.

Communities were clear about their priorities for health system strengthening through primary health clinics with assured supply of critical drugs, improved water and sanitation, and access to secondary health care, including transport. Validation participants proposed that each district should have a holistic health response team with communications capability, which should work with community structures, particularly those developed during the Ebola crisis, and clear means of communication with remote communities. These district teams should include survivors in order to draw on their first-hand experience. In crises, first responders should be supported by psychosocial counselling.

*Human rights would be improved in our community by establishing a health centre and a school in the community and strengthening existing structures such as Task Force and Psychosocial team; toilet facilities; We need to improve sanitation and hygiene practices and stop some of the traditional practices that contributed to Ebola transmission* (Mixed group with community leaders in Crab Hole, St Paul Bridge, Montserrado). Joseph Town, Bomi, requested *City Cooperation to establish garbage collection in community*. Crab Hole noted that *improved roads and ambulance service would help respond to public health emergencies in the future*. Kanweaken, River Gee, suggested that *local clinics could be upgraded to rural hospitals with greater capacity; drug supply must be improved as most of the clinics are without basic drugs*. Women in Moses Brown quarter, Kakata, Margibi noted that *the ETU will be a help to respond to public health emergency in the future in our community*. The important role of more community primary health clinics supplied with key drugs was emphasised.

**Right to Water and Sanitation**

Water, Sanitation and Hygiene services were quite inadequate before the Ebola crisis, which contributed to the spread of Ebola, and need to be strengthened as a priority having impact on the right to health. *Improve the water and sanitation condition in the community by building public latrines, hand pumps, economic empowerment through skill training, and entrepreneurships through the provision of small micro-loan scheme* (Joseph Town, Bomi). The validation participants also stressed the fact that communities did not have sufficient access to water and sanitation facilities before the outbreak. Discriminatory exclusion of quarantined households from water supplies was not handled consistently and robustly by Government.

As part of the post-Ebola recovery, the sanitation hardware response could be linked to skill training and entrepreneurship support, especially in such a peri-urban environment of informal sector activity and unemployed ex-combatants. Communities have been convinced by the need for good hygiene, but there is now a clear unmet need for improved WASH facilities – *before we used the bush for toilet and open wells for drinking* (e.g.

Ebola-virus-disease response. Plucinski, M.M. et al, Effect of the Ebola-virus-disease epidemic on malaria case management in Guinea, 2014: a cross-sectional survey of health facilities, The Lancet June 2015

See: http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2815%2900061-4/abstract.

In announcing the state of emergency on 6th August 2014, President Ellen Johnson-Sirleaf stated 'the Ebola epidemic is having a chilling effect on the overall health care delivery … Out of fear of being infected with the disease, health care practitioners are afraid to accept new patients, especially in community clinics all across the country. Consequently, many common diseases which are especially prevalent during the rainy season, such as malaria, typhoid and common cold, are going untreated and may lead to unnecessary and preventable deaths'
http://www.emansion.gov.lr/2press.php?news_id=3053&related=7&pg=sp#sthash.p4lVQjQ9.dpuf

[30] See http://www.frontpageafricaonline.com/index.php/news/3816-stop-all-forms-of-violence-against-women-gender-

Margibi – Benda). *Government should take WASH very seriously as this will help us save lives* (Buzzey Quarter Youth, Margibi). Although Liberia has a very weak WASH sector, the lessons learned through the Ebola crisis offer a real opportunity for Government to make this a priority, preventing many other diseases and risks of epidemics such as cholera. This was recognised by the Government in its support for the WASH in Schools programme in March 2015, even as schools were re-opened[31]. The Ebola crisis has highlighted the need for strengthening the overall national WASH programme and for reinvigorating the Compact of partnership between Government, the Private Sector, Civil Society, Development Partners and the Media, approved by the President in 2012.

**Right to Freedom of Movement and Impact on Other Rights**

Livelihoods were severely constrained as a result of Government restrictions on movement and markets, as well as by community and household decisions to remain in the confines of their homes. Loss of trade and food production means that many are dependent on food aid and need seeds for planting for the coming season. The Food Security Cluster has summarized the preliminary findings of the 2015 Liberia Food Security Assessment that showed that 35 per cent of households with access to farming land did not harvest last season and over 50 per cent of households in Grand Kru, Grand Cape Mount, and Bomi reported monthly income losses compared to the pre-crisis period last year. *Nobody went on the farm; the rice spoiled; no food; nothing to eat for now, only the food that ADRA/WFP is distributing to us. All the materials were burned in the sick person's houses, when they took the patient to Foya. All our household materials were burned; we are all suffering. This is farming time, but we have no seeds and tools. The children are not eating properly - some of mine are still getting sick because the food is not enough* (various women in Gbegbedu, Lofa).

Nyella in Bomi, as a community of traders and migrant workers, reported that *access to food was also another issue that affected us because everyone was stuck in one place*. As a result of markets being closed, many trading businesses have not recovered, nearly a year after quarantines, and many, from day labourers to professionals, lost their jobs and have not been re-hired (various ACF FGDs regarding quarantines, July-Oct 2015). However, significantly, one community noted receiving excellent briefing from a specialist psychosocial worker and, as a result, reported that most of the community had been called back to their previous jobs (Matadi, Montserrado).

**Right to Freedom of Expression**

FGDs noted the lack of freedom of expression during the heat of the crisis, including several citizens being beaten by the security forces, where Government failed to use local community structures and security (West Point Young Men and Women). *Neighbors called police for affected people to be taken from the community - the MSF team mediated and it was resolved* (Clara Town, Monrovia). A more detailed analysis of exactly what happened in West Point and its causes would be required for Government to learn lessons that could be applied in future emergencies.

**Right to Information**

[31] For example: "the dire lack of clean water and sanitation in educational facilities is a major concern for the Government of Liberia. The current outbreak of Ebola has triggered a massive increase in hand washing throughout Liberia by bringing preventative health issues to the forefront for communities. This has translated into a significant increase in citizens' understanding of water-washed and water- borne diseases and the adoption of good hygiene practices. Building on this momentum and recognizing the proven health and economic benefits of water, sanitation and hygiene (WASH) interventions, makes a powerful case for putting investment in WASH in schools at the heart of Liberia's recovery process". Government of Liberia & WASH Liberia Partners, WASH in Schools – Liberia's first step to recovery from Ebola, Government of Liberia Technical Report, March 2015

The weak culture of public access to information, rather than the formal implementation of public right to information in Liberia under the 2010 Freedom of Information Act, became apparent as inadequate information flows fuelled rumour. Lack of accurate, early and transparent communication challenged early stages of containing the crisis. Public health education messages and dissemination were aligned to Liberia's development challenges related to access to the media, high levels of illiteracy and lack of effective health services across the country (ActionAid, Lessons Learned, February 2015). One validation participant stated that the government did not provide clear information to parents about the reopening of schools. Strengthening the process of transparent information flows could help Government to address future crises with greater collaboration from the media and communities. As Government organized its response to the crisis, The Incident Management Team at the Ministry of Health and Social Welfare shared information on a daily basis in group meetings. Although this seemed to be a time consuming procedure, it turned out that this face-to-face meeting served multiple purposes: officials avoided duplications, double-checked with more senior staff and ultimately created the needed trust among health professionals and members of the public (ActionAid, Lessons Learned, February 2015).

### 3.3. Stigma and Discrimination

**Ebola Survivors**

Stigma and discrimination were widely reported, including many examples of workers losing their jobs. Discrimination involved both Government and communities. Many survivors did not receive their formal certificate as survivors and were not even helped with transport to return home. A survivor on Bushrod Island, Monrovia, as a single mother with 6 children, is no longer able to do petty trading. She received initial support from NGOs such as ActionAid and EQUIP, but now only survives on handouts from people in her community.

Besides discrimination relating to employment, survivors and front-line responders found themselves excluded from community facilities. A woman, whose husband died from Ebola while she survived, found that she was prevented from using the communal bathroom – surviving the post-Ebola 21-day quarantine "by the grace of God and support from three people in the community". Several requested that there should be a *designed program for survivors' integration* (Matadi, Montserrado), possibly not dissimilar from reintegration of ex-combatants. *Government should design programs for orphans, reintegrate survivors and affected families* (Peace Island, Monrovia). *Government should design programs to help widows and widowers … and to meet the needs of affected families* (Zumah Town, Bushrod, Montserrado). *Government should provide free education for victims* (Matadi, Montserrado). Validation participants felt that families of survivors and other affected families needed special consideration in terms of the impact of Ebola.

By contrast, a 15-year-old girl survivor from Paynesville, Monrovia, on recovering, joined the community's sensitization team going round the community spreading messages on preventive measures and finding that people listened to her as a survivor more than to health workers. She felt that God had kept her alive with the care of health workers so that she could spread the messages.

As a result of the October 2014 Gbarnga conference, traditional leaders told people not to stigmatise survivors and that they should eat together, but that partners should avoid sexual relations for six months – and this advice has been widely followed (Mama Tomah). *Public messages, such as 'survivors are not as contagious as communities think', are being used to encourage communities to accept survivors. Messages are also about*

*condom use. Communities, however, are especially sceptical about survivors. It will take time to overcome this scepticism* (Health Worker KII).

**Ebola Responders**

Ebola responders face varying degrees of discrimination, particularly from the community, and lack of adequate compensation from Government. The crisis has left many Ebola responders feeling resentful of the way they feel that they have been treated.

In their own words: *For the most part, families did not reject health workers. But communities did. One health worker contracted Ebola, recovered, and was denied employment from a former employer. … Health workers were afraid of contracting Ebola and became demotivated because they were not protected on the job (they lacked protective gear). As a result, health workers did not go to work. Health workers were also stigmatized. The impact on health workers included: stigmatization, lack of trust in health workers because communities knew they lacked personal protection equipment (PPE). Some health workers were evicted from their homes. Once health workers were evicted, they faced another challenge of finding a new home because once a prospective landlord found out you were a health worker, he or she would not rent to you. … The worst thing people did was to attack health workers. People also stigmatized health workers and destroyed ambulances* (Health Workers FGD).

Health workers felt that Government did not support them appropriately and provided a list of examples: *Another bad thing that Government did related to the compensation of health workers and community mobilizers. Health workers (both those receiving salary and those hired on a contractual basis) were not satisfactorily compensated for their work. … The Government told the public that it would pay health workers involved in the Ebola response $500USD ($300 salary and $200 incentives). However, the Government ended up paying 1700 Liberian dollars* [about $20], *which is not equivalent to $300.00 USD and gave $80USD as an incentive. … The Government also did not hire professionals to respond to the Ebola outbreak even after they had received funding. The Government did not observe the merit system. It put the wrong people in place. For example, regarding the vaccine trials, the Government did not invite laboratory practitioners to make informed decisions about the trials. Nurses and doctors were invited instead. The Laboratory Technician Association wasn't invited to the workshop on the vaccine trial by the Government. … The Government did not protect or train health workers. It forced health workers to go to work without PPEs, which increased the death rate* (Health Worker KII). There has also been a lack of post-traumatic stress disorder counselling for health staff, first responders and orphans, survivors and their families.

**Burial and Contact Tracing Teams**

The 20,000 or so front-line responders in the fight against Ebola, such as members of burial and contact-tracing teams, have experienced stigma and employment discrimination since Liberia achieved Ebola-free status. The UN's IRIN reported on interviews with a number of these as follows: "They don't want to employ us because they feel we have some sort of disease and could infect them. But this is far from the fact", says a 44-year-old [man], who worked as a contact tracer[32]. Before the outbreak, [he] had been working for many years as a waiter in a local restaurant. But when he tried to pick up again from where he'd left off, he was knocked back. "The manager bluntly told me that my services were not needed because he heard that I was working with the burial teams," [he] told IRIN. "The manager said that if he takes me back, most of his customers might not come back to the restaurant." [He] has since applied for a number of jobs, but hasn't had any

[32] "Stigma Leaves Liberia's Ebola workers high and dry", IRIN 11 June 2015 http://www.irinnews.org/report/101623/stigma-leaves-liberia-s-ebola-workers-high-and-dry accessed 29 Jan 2016

luck. A teacher who helped collect blood samples from suspected Ebola victims was refused her job back once someone found out that she had been working with the Ebola team. A [33-year-old man] used to drive taxis in Monrovia[33]. During the outbreak, he offered his services as an ambulance driver, as well as a part-time burial team member. After the outbreak ended, he tried to resume his work as a chauffeur, but was turned away by several potential employers. "I submitted all my documents, including my driver's license… but then was denied access to the interview room," he said. "I didn't know what happened, but a few days later, a source at the office hinted that I was denied the job because the human resource manager heard I used to work for the Ebola team. So I lost that job." [He] now advocates for the Government to help former Ebola workers and make people understand they are not sick and not infectious. "Every day we go from place to place looking for a job, but no luck. This is terrible," he told IRIN. "At the very least the Government could help us find a job after the sacrifice we made for this country. "All the money I got from the Ebola work is finished and life is difficult for me now… My children are out of school because I don't have any money to pay their school fees. I worry about this."

Many local business owners continued to say they were not yet ready to employ Ebola responders. A supermarket manager in Margibi county, for example – who wished to remain anonymous – told IRIN he was still not convinced it was safe to have contact with people who had worked on Ebola response or were Ebola survivors[34]. He still believed they might be infectious. "To be frank with you, I have personally turned some of them down," he told IRIN. "Looking at the history of Ebola, it is something that can come and go and return again… My action might not be good, but I'm still afraid." On the other hand, there are examples of positive discrimination. Some international organisations, such as Save the Children, and local authorities have also made an effort to recruit Ebola responders, who now have valuable health and social mobilisation skills. Ebola responders are in a strong position to use the skills they have acquired to improve the responsiveness of health and education services.

Those experiencing the most stigmas are the few who fulfilled the hated role of cremating bodies[35]. Members of Cremation Teams, vilified as "corpse burners", experience rejection by the community who *feel that they were part of the crematorium and refused to accept them after EVD. … They are being stigmatized to the extent that they cannot get jobs while their individual family is broken apart* (Members of Cremation Team, Margibi). Examples given included refusing to use a taxi run by a former cremation team member and a fiancée abandoning another. Burial teams experienced possibly less general stigma as their role was better understood and valued and the process explained to the community.

**People with Disabilities**

Rights of people with disabilities were not fulfilled (e.g. Youth Group in VOA 1 community in St Paul). People with disabilities were affected in terms of livelihood security, not good for them at the best of times, and discrimination in access to services. It was not clear if one group of disabled people in Kakata were marginalised due to a case of Ebola or due to their disability. *The Group of 77[36] was greatly affected by the EVD, the virus made us to be*

33 Ibid

34 Ibid

35 The New York Times published a report of interviews with some former Cremation Team members in Dec 9, 2015: http://www.nytimes.com/2015/12/10/world/africa/they-helped-erase-ebola-in-liberia-now-liberia-is-erasing-them.html?_r=0

36 The "Group of 77" was established in 1977 with the intention to cater to the needs of the less fortunate citizens of Liberia. The organisation is administered by the Office of the Vice President of Liberia, and its executive director is the spouse of the vice-president. The objectives include assisting disabled children to attend school and ensuring that disabled people become self-supported. Due to the war, however, there are very many disabled persons in Liberia. Many former combatants have lost a limb. The majority of them now roam Monrovia and other towns as beggars. The

*disowned by the community. We could not get any one to come to our office and say a word of encouragement because of fear. We were informed about the first case in September 2014 … People were scared of us and told us to stop all our activities at our office. … There was no clinic to take care of us as persons with disabilities; only by God's grace we survived … The community should also consider persons with disabilities in all activities. … We stopped begging on the street, this is the main source of our income … (Government could improve the situation post-Ebola) by working with all citizens including persons living with disabilities to improve their living condition* (UYPETDL: Group of 77 – young men with disabilities – Kakata, Margibi). Ebola may simply have exacerbated an already endemic problem of discrimination and marginalisation experienced widely by persons with disabilities in Liberia[37].

**Addressing Stigma and Discrimination**

Government has a clear responsibility to address discrimination through legislation and regulation to prevent flagrant abuses in employment. Changing public attitudes that relate to stigmatisation can be helped by leadership from Government in working openly with Ebola survivors and responders and using them in Government promoted awareness programmes, as well as using their skills to continue as health promoters and providers. Drawing on the wide acceptance of changes hygiene behaviour, this can include involvement of community structures in promoting hygiene and preventative practices and the WASH Compact.

## 4. Lessons Learned

### 4.1. Lessons Learned about Public Health Messages on Hygiene; Burials; Quarantines

In the early days, rumours were in danger of subverting key messages about Ebola. These were confronted effectively by Internews, particularly through its DeySay SMS project[38] and through facilitating journalists and the international and local humanitarian response to connect with affected communities in a two-way communication approach, ensuring that affected populations' voices are heard. Rumours were not helped by the attitudes of some medical staff in the early period. A health worker raised a number of Government failures in the early days: *People who didn't have knowledge on virus transmission were recruited to build community awareness, which may have led to an increase in the death rate. The Government also made the mistake of sending health students to rural areas to work when the health workers were on strike. The Government did not craft the right public health messages. It made Ebola a fearful thing, so no one wanted to be associated with Ebola* (Health Worker KII). *The way the County Health Officer spoke to us - When he first came he told us that we had to brush a large area where we could bury the deaths, because plenty of us were going to die. He said; "You are dying because of denial, sick people hide in the bush"; he did not sensitize us, didn't make us understand the danger in Ebola". Instead he created fear in us that's why sick people ran away from the community* (Parluken, Grand Kru). On the other hand, there were examples of more sensitive workers. *Our people really listened to the advice of these groups [the burial team and the health team] as they used the local language* (Yankoitahun, Kolahun, Lofa).

"Group of 77" is unable to meet their needs. Source: http://www.dandc.eu/en/article/liberia-many-old-people-have-not-enough-live-especially-disabled-civil-war-veterans

37 The validation workshop raised the issue of discrimination in the Educational Reform Act (August 2011) where Article 4.4.1, C), iv, states that "A school may exempt a child entirely, partially or conditionally from free and compulsory school attendance if it is in the best interest of the child, especially those with disabilities", which undermines the principle of inclusive education.

38 See Internews website http://www.internews.org/our-stories/project-updates/combatting-rumors-about-ebola-sms-done-right. UNICEF-Liberia (2012) *Communication Strategy on Water, Sanitation a& Hygiene for Diarrhoea & Cholera Prevention* recommends that 'During an outbreak, it would be crucial to set up a rumor tracking system to identify, investigate and address misperceptions or misunderstandings through community workers, and the media'.

Behaviour change must involve both health staff and communities. Generally, there was respect for most of the Ebola preventive measures, but "*it was difficult to respect the restriction on the eating of bush meat – youth still ate*" although not openly (Kanweaken & Sarbo in River Gee and some places in Nimba, Rivercess and Sinoe) and many communities reported similar failure of this measure; people avoided crowded places and preferred in-doors activities; they avoided and reported strangers in the community and avoided receiving guests in their homes. Others reported failure to observe the advice against sexual intercourse between partners (e.g. in Nimba, River Gee and Rivercess), including for 6 months after being otherwise free of the virus. Although these medium risk activities may have continued, the highest risk activities, relating to handling the dead and hand-washing and protection, received better compliance, once Government had an appropriate approach and advice. Shaking of hands stopped widely, although some reports from Rivercess and Sinoe suggested this was not fully complied with. *Behavioral change messages were okay. The messages did not change over time even though the context changed. For example, the message "Ebola is here, Ebola is real" was appropriate when people were in denial; however, the message should have switched quickly to address stigma against Ebola survivors. The Government was too slow in manufacturing messages* (Health Worker KII).

**Forming the Messages**

All successful public health messaging must involve a two-way process of technical experts communicating with communities and understanding their perspectives[39]. In the early stages of the Ebola crisis, messaging regarding containing the outbreak and avoiding transmission came from the Ministry of Health, supported by CDC, UNICEF and WHO. The Social Mobilization Cluster, coordinated by UNICEF, worked with the John Hopkins University Center for Communication Programs, to carry out an SMS-based mobile survey of 1,000 respondents across all counties in order to sustain a national public awareness campaign, utilizing radio, television, and other media, in collaboration with the Ministry of Health.

During the first six months of the crisis, traditional and religious leaders seem to have been seen as additional conduits for pubic health messages, rather than as key partners in developing the messages and representing the views of communities.

Some who were interviewed felt that the traditional doctor-patient relationship needed to be replaced in the crisis by a public-health community protection focus – a shift of priorities from private goods to public goods. *Medical doctors should not have been at the forefront of the Ebola response. Public health specialists should have taken the leadership role instead. Because public health specialists have skills in public health ethics and law; they understand the epidemiology of disease; how it occurs, exposure factors. Ebola is a priority public health concern since it cannot be cured. It has to be prevented. Also there are things that public health specialists see as ethical that medical doctors do not see; for example, medical doctors would protect the confidentiality of the patient first and not think of the threat to the public. Public health, however, surpasses private health. Public health is not about enforcing a militarized approach; it is about educating people about reality* (Health Worker KII).

[39] Such a position has already been partially made in Liberia in UNICEF-Liberia (2012) *Communication Strategy on Water, Sanitation a& Hygiene for Diarrhoea & Cholera Prevention* e.g. page 24: '*Communities need to be involved and engaged in identifying their problems as well as solutions for them. Rarely do solutions given from outside sustain as there is no ownership towards them. … This is important as communities understand their issues best and only solutions identified by the community ultimately sustain as they are need-based and owned by the community*'; and page 29: '*However on-going assessment, monitoring and listening to communities will also be vital during the outbreak*'.

There were mixed views on who was involved in public health messaging on Ebola and how messages were to be agreed. *The best thing Government did was to accept that it could not fight Ebola alone and requested assistance from the international community. Also, the Government did a good thing by tasking Tolbert Nyeswah, who has a public health background, to lead the national Ebola response. … Ministry of Health did not accept National Health Workers Association of Liberia's (NAHWAL) public health statements. The ministry wanted to clear everything first, so NAHWAL contributed to public health messages through press statements. … Health authorities were not responsive. It they were, they would have included NAHWAL representatives in their initiatives. For example, NAHWAL did a press statement on no internal border closures. The health authorities did not want to meet and talk with NAHWAL. They just took NAHWAL's ideas* (Health Worker KII).

There was also a feeling that national front-line responders were initially undervalued. *Government demotivated us by reducing our salary, did not treat us fairly*. *We worked for 21 days without preventative materials including foods, PPEs and etc., until MSF intervention and there was no capacity building activity such as training on the entire process. Later began to pay them with salary as well as food including oil and rice* (Members of a Cremation Team, Margibi). *Before the Ebola crisis, health workers used their bare hands to handle a patient. Now they use precautionary measures* (Health Workers' KII).

Women's Campaign International (WCI) spread the warning message that women were in particular danger. As is culturally endorsed, women continued to care for the sick even when Ebola was suspected. At an early stage in the crisis, more women than men were thought to have contracted Ebola (Mama Tomah), potentially as a result of their being the principal care givers for the sick. This was not borne out by the evidence across the whole period of the crisis[40]. Generally, messages on keeping safe from Ebola were the same for women as for men (Mama Tomah), without recognition of the different gendered roles and expectations. *The messaging was not gender sensitive; it was general* (Health Worker KII). As part of failing to meet audience diversity, some noted that the messaging was not adequately framed for the local context or in local idiom or local languages, nor did it evolve adequately over time as core issues to be addressed changed from early denial to post-Ebola stigma. In future health epidemics, women and their organisations and leaders should be listened to and their gendered roles and practical and strategic needs considered more carefully. Health professionals should be trained to recognise that disease impact and response do not affect men and women in the same way.

### Hygiene

Basic hygiene precautions and hand-washing were widely accepted by communities, who often had their own responses to ensure their own protection. *Communities should organise a hygiene team and all communities should be kept clean* (Zumah Town, Bushrod, Montserrado).

[40] This may only have been true in the early stages of the crisis. 'Julia Duncan-Cassell, Liberia's minister for gender and development, said health teams at task force meeting in Liberia found three-quarters of those who were infected or died from Ebola were female' according to a report in The Independent:
http://www.independent.co.uk/news/world/africa/ebola-virus-outbreak-this-is-why-75-of-victims-are-women-9681442.html
However, an article in the New England Journal of Medicine of 7 Jan 2016 reported that, by August 2015, complete records showed that the proportion of patients with Ebola who were male was 50.2% in Liberia. 'Female patients were significantly less likely to die than were male patients (case fatality rate, 63.0% vs. 67.1%; odds ratio, 0.83; 95% confidence interval, 0.77 to 0.91)'. 'In addition, although a higher proportion of female patients than male patients reported an exposure to a sick person, the number of exposures reported by female and male patients did not differ significantly' – See Ebola Virus Disease among Male and Female Persons in West Africa N Engl J Med 2016; 374:96-98; DOI: 10.1056/NEJMc1510305; http://www.nejm.org/doi/full/10.1056/NEJMc1510305 accessed 29 Jan 2016

### Burials

Cremation appeared to technical staff as the "safest" form of disposal of bodies, but in effect it was not, since it could increase fear and avoidance of seeking treatment or assistance in burial of the dead, resulting in lower compliance. The WHO guidance for safe burials provided a much safer way of handling the dead as a result of increased compliance, without increased risk of infection. Safe burial practice towards the end of the crisis was a welcome relief in Liberia from the unacceptable practice of cremations, possibly ultimately contributing to greater final compliance than in neighbouring countries.

### Quarantines

Quarantines and restrictions on movement of people and goods lacked a coherent strategy. With no assured food and water and hygiene supplies pre-positioned at county or district headquarters and a system for their delivery to affected communities and households, Government was in danger of imposing conditions on people who lacked the means to sustain them.[41] Government needs to work more closely with communities who have their own traditional quarantine approaches, such as *Boka* that can be enforced through traditional sanctions, provided these already comply with or can be reformed to align with human rights standards.

## 4.2. Lessons Learned about Broadening Participation

Religious and Traditional Leaders were vital communicators between Government's health experts and communities. Government failed to work effectively with traditional leaders until the Gbarnga October meeting. However, earlier in the crisis, as traditional leaders came to understand the danger of Ebola and that touching should be avoided, UNICEF and WCI provided training on hand-washing and the use of faucet buckets, which they in turn shared with local leaders. The Carter Center, supported by the Swedish Embassy, took a team involving their Country Director, Pewee Flomoku, Chief Zanzan and Mama Tomah as heads of the men's Poro and women's Sande societies, the Special Assistant to the Minister of Internal Affairs and Liberia's Cultural Ambassador, Julie Endee, from County to County to train others in a cascading process.

Community chairmen and chairwomen were particularly important, although no community mentioned higher-level elected officials as having any role. In contrast to the norm, in one community, the community chairman was afraid and absented himself, so the community held a re-election (LBS Community, District 3, Montserrado). Generally, paramount and clan chiefs and the zoes were arguably the main leaders listened to by communities, but *all leaders worked together as a team* (Mama Tomah). *At the inception of the Ebola crisis, the town chief with the leadership structures - women, youth and council of elders in the town - held meetings, having realized the danger of the Ebola disease, and urged all family heads in the town to keep their individual family members at home to avoid contraction or infection and spread. In addition, they began using hygiene promotion ahead of the Ministry of Health prevention campaign* (Gayah Hill, Bomi). *The elders prescribe preventive measures and impose a fine on anyone that does not comply – similar to the emergency measures imposed by the Government* (Totoquelle, Gbarpolu). Traditional and religious leaders worked together to create community awareness teams to educate communities on preventive measures and what to do when a person fell sick or died. In communicating public health messages, the trusted community Town Crier could contribute credibility and add value to the communication (e.g. Gobah, No 1 Todee, Montserrado).

[41] UNMIL-HRPS, through the Protection Cluster, monitored quarantined communities and through its coordination and advocacy with other Clusters, such as the WASH, Health, and Food Security Clusters, was able to ensure that the basic necessities of quarantined communities were met by humanitarian organizations and human rights of quarantined persons and communities improved..

Imams and Christian ministers were valuable messengers in informing their congregations of what needed to be done to protect themselves and their communities. Religious leaders, Muslim and Christian, also collaborated through the Inter-Religious Council of Liberia to reach people with shared messages on how to respond to Ebola and protect themselves from the virus. They found Biblical and Koranic support for changed behaviour to cope with such a contagious disease and communicated this through their networks. Many examples of the influence of religious leaders were provided. *Churches and Mosques should continue to educate people on the prevention of EVD* (elderly in Kakata). *The National Muslim Council of Liberia, the Inter Religious Council of Liberia and the Liberia Council of Churches collaborated and did work separately as well* (Mohammed M. Sherriff, Head of Council of the Muslim Community in Liberia 17 Sept 2015). Muslim leaders noted that they acted as facilitators between health workers regarding prevention and the communities and their experiences, which they recorded and reported to donors. In meetings at community level, religious leaders invited the County Health Team to be present in the meeting in order to respond to feedback. When church members told a previously quarantined member to stay away from church for three months, the pastor stood by the member until the matter was resolved (Flamah Community, Monrovia).

A key to influence, apart from pre-existing relationships of trust and leadership, lay in providing services that people needed. NGOs were well placed to do this and were often trusted partners already in the communities where they worked, using their capacity on the ground and leverage internationally to facilitate international humanitarian assistance. *Local and international NGOs gave communities the most support such as training on hygiene promotion and delivering hygiene materials such as chlorine and buckets. Communities also helped themselves and the private sector got involved in community initiatives. Health workers were supported by local and international NGOs, which brought in hygiene supplies and provided training. For example, the Liberia Laboratory Association was aided by the Centers for Disease Control and the World Health Organization trained 100 laboratory practitioners throughout the 15 counties. … NAHWAL had a partnership with community-based organizations, such as CASE Liberia, to disseminate messages and deliver hygiene packages. CASE Liberia included students and CBOs* (Health Worker KII). NGOs were often the only source of supplies to quarantined communities as well as supplying chlorine and faucet buckets for washing – e.g. Samaritans Purse (Big Belleh Junction, Montserrado) or CHESS, SAMFU or CARITAS in Nimba as well as German Agro in River Gee. Other civil society organizations such as YMCA and local organizations (e.g GAGOTO in Bain-Garr, Nimba), as well as UN organisations, sensitized communities on EVD measures. *MSF; Samaritan Purse; Liberian National Red Cross; UNICEF; Peace Link; ADRA all came to assist us - There was door to door sensitisation* (Gbegbedu, Quardu-Gbondi, Lofa). Other NGOs have been mentioned elsewhere in this report. Where communities felt neglected by Government, some considered that Government should pass its responsibility over to NGOs to work with communities and strengthen them to do this.

Health workers had influence, but international partners had the most influence and added value in terms of logistics and helping people to adhere to the public health messages (Health Worker). For some: *health workers were perceived as carriers of Ebola. Initially, there was hostility from communities. For example, health workers were attacked in rural areas. But gradually, because of health promotion and the increasing number of deaths, communities began to see the truth in what health workers were saying. People had been eating primates for many years and they never had Ebola. So people thought Ebola was a myth. Once they saw the death rate increasing, they began to consider health workers messages on health promotion i.e. avoid primates, safe burials, taking the sick to the hospital for advice and laboratory results* (Health Worker KII).

Given systemic distrust of formal Government institutions[42], rooted in the past marginalisation of rural communities, failure to deliver services and years of civil conflict, it was hard for Government messages, messengers and institutions to be believed. Informal community based institutions were more trusted, particularly women's organisations. *People listened more to women than men – they need to be considered more as they are very good messengers* (Mama Tomah). Many communities formed community Task Force teams, comprised of active young men and women from the community, who worked with outside bodies to provide information and support within the community, particularly providing food to quarantined households. Communities valued these and in many cases gave them fulsome praise. These new community structures, often formed by the community leaders, may prove the greatest positive legacy from the Ebola crisis. *The task force was very effective and created some changes in the community* (Smythe Road, Old Road, District 10, Montserrado) and many continue to function. However, by February 2016, validation participants noted that the community-based initiatives and health volunteer committees/task forces were no longer effective. Government may already have missed a significant opportunity.

Youth associations were engaged in addressing Ebola at the community level, but could have been more involved on preventive measures and maintaining a clean environment (Kanweaken, River Gee). The motorcyclist union can help with responses to public health emergencies in the future (Kanweaken, River Gee). Indeed, the potential of the motorcyclist unions to be major partners in addressing a public health crisis has been underestimated, given their mobility, national and local networks, discipline and structure – both for transmitting messages and data on infection, medicines and both the sick and health workers in both directions.

Where they combined training and sensitivity, both community and Government responders became trusted influencers towards behaviour change. Formation of various community structures of an Ebola Task Force, contact tracing team, case finders and a psychosocial team helped empower communities to become proactive with increased agency for containing EVD. Psychosocial workers from MoH were particularly praised by a number of communities around Monrovia (various ACF FGDs). *The Government should train social workers and employ them in the communities* (Shoe Factory, District 12, Montserrado). Communities identified a need for strong youth organisations, women's organisations and community leadership to work together on public health issues. *The youth got involved when NGOs started provided training and engaging communities* (Health Worker KII). In Totoquelle, Gbarpolu, where no Ebola occurred "*an EVD Task Force comprising community youths was organised to monitor the preventive regulations*". These new task forces in most communities proved most effective. Some communities introduced a WASH team (e.g. Low Cost Village and Freeman Reserve, Careysburg; Lynch Street, Monrovia).

### 4.3. Lessons Learned about Emergency Preparedness and Support

To enable future quarantines to work, Government should ensure that there are sufficient water-points and electric power supplies within any quarantine area and that there is a method of providing food and materials to sustain households during the 21-day

[42] e.g. See Platform for Dialogue and Peace in Liberia: *Peace in Liberia – challenges to consolidation of peace in the eyes of the communities*, Interpeace 2010, page 6: '*The overall perception is one of pervasive mistrust. The notion that authorities do not serve the common interest and are corrupt and inefficient in fulfilling their duties is the source of considerable tension and conflict …'*; and page 45: '*The local population demands state institutions that are effective in addressing their needs and concerns and state institutions require the local population to rally and support their efforts to address these needs, thus validating and legitimizing their authority. The local interface between state authority and local population is therefore critical; for it is around it that a bond can be established. However, mistrust resulting from perceptions of bad performance of local government representatives prevents such convergence and dilutes the link between national authorities and population in the county'*.

quarantine. Government should enable Task Forces to provide awareness and for health workers to continue to provide services to people within quarantined areas. As quarantine is about protecting others from the spread of a disease there is a human rights obligation by Government to provide the necessary inputs and to meet the rights to food and water and health for those affected in order to ensure that the quarantine can work and the right to health of surrounding communities can be assured.

More needs to be done in preparing for post-emergency recovery in future. *Health worker training should include how to deal with emergencies* (Students at Capitol Hill). The Government needs to strengthen the legislative basis for employee protection to ensure that the right to work is not affected for those who are quarantined. There should be a clear policy for support to orphans as a result of an emergency. One community complained that the registration of Ebola affected children and orphans had not been done well and the Social Welfare Office had not verified the registration and, until this was done, no assistance could be given (Gbegbedu, Lofa). Many in rural communities complain of the lack of assistance, hearing radio reports of Government ministries receiving significant Ebola funds, but seeing no food aid or other support to the community.

Disease surveillance monitoring and reporting is weak and fragmented, unable to respond uniformly across the country in a crisis. Mobile phones were used to communicate information on suspected Ebola cases, but areas of poor connectivity were excluded from such communication. For example: *in Bokojelee between Sinoe, Grand Gedeh, River Gee and Grand Kru - Remote communities had no knowledge of an Ebola case from Bomi that travelled to Bokojelee* (Health Workers' KII). Monitoring of quarantines was poor, reflecting the lack of capacity in handling such an approach. In other areas, mobile phone communication made a positive contribution: *We learned to report sick cases through 4455 or 1313* (Whipa, Nimba).

Dependent on Government preparedness, there could be positive collaboration with communities, who have shown their willingness in being proactive in a situation of Government weakness. Some communities formed a psychosocial team to support those affected. As knowledge of EVD increased, communities felt more "*confident and courageous*" to give support to quarantined people and ensure transport of sick people to the ETU, helped by the ambulance service (Crab Hole, St Paul Bridge, Montserrado FGD), which in turn reduced risks of transmission. *During the outbreak of the Ebola, in our community, one survivor, who lost six of her family members, was given support by the community before the Government and NGOs could come in to help. Each member of our community contributed in cash and kind to support (her) while quarantined at home* (Bomi – Harmon Hill). However, by February 2016, validation participants reported that the Government's disaster management and links with community structures were not being sustained.

The Government should engage with community leaders in developing an emergency preparedness strategy that addresses issues raised in this report. Further to preparedness for managing quarantines, there should be a prepared response of provision of essential materials (hygiene, water, food) in place at County level that can enable effective quarantines to be imposed, together with setting up monitoring teams. Women, through their organisations and leaders, should be involved directly in emergency preparedness in order to ensure that their perspectives and strategic and practical needs are appropriately addressed in future. Validation participants recommended that all health facilities across the country must be equipped to effectively respond to community needs (testing machine, equipment, triage, etc).

### 4.4. Lessons Learned about Addressing Human Rights

Addressing human rights while containing a public health crisis requires a balance between enforcing necessary public heath discipline in the interest of the public good while respecting the rights of individuals. State of Emergency powers must be tailored to the necessity for particular actions to maintain public health, such as water purification, treatment of waste, public and private hygiene, restriction of movement of persons or goods, on the one hand, and the rights of individuals and communities to security of livelihood, access to health and education. The Government decided to impose a 90-day State of Emergency in August 2014 and not to continue it from November 2014, once a coherent response had been developed. Such a decision is in line with international human rights standards (article 4 of ICCPR), as long as the Government considers carefully which rights are temporarily suspended and limits those derogations to the extent strictly required by the exigencies of the situation. This condition requires that States parties provide careful justification not only for their decision to proclaim a state of emergency but also for any specific measures based on such a proclamation. All actions must be governed by the principle of proportionality. In this respect, some derogation might be justified, as they have a direct impact on spread of infection, such as closure of schools, and restrictions on movement of people and goods, while making arrangements for the movement of goods that are vital to sustain access to water and basic food. While the introduction of cremation appeared to have a public health justification, this report has shown that this was far from the case, reflecting Government's excessive reliance on international technical partners, who lacked local knowledge.

Access to health services requires a nuanced approach to ensure that services that could safely be separated from the infection risk, such as maternal services, could be accessed, while treatment of less clearly distinguishable symptoms, potentially malaria or cholera or respiratory tract infections, should be treated with the same caution as the disease itself, but without risk of cross infection. Global concern focused on the risk of spread of Ebola to other countries and consequently shifted resources away from endemic diseases, such as malaria, pneumonia and diarrhoea, the principal causes of death of infants in particular[43]. The health care system strengthening must ensure the continuity of care for reproductive health services in the non-Ebola affected areas as well as affected areas[44]. There is a danger that the Ebola response, given the weak health infrastructure in Liberia, may have reversed the progress made in reducing child mortality, where under-five mortality rate declined from 220 per 1000 live births in 1986 to 75 per 1000 live births in 2012[45].

The levels of discrimination that occurred through and after the Ebola crisis show that Government needs an urgent agenda to introduce legislation and regulation that ensure that various forms of discrimination are prevented. It also needs to develop a communications programme to confront stigmatisation. This could also address long-standing discrimination and stigmatisation of people with disabilities. Such programmes should be designed with those affected, not simply for them. Validation participants recommended that Government should issue a letter of clearance for all survivors of epidemics and provide professional support to ensure that they are reintegrated into work and their communities.

Health system strengthening should focus on increasing the number of primary health clinics, stocked with reliable supplies of key drugs. The Ebola response has highlighted the grave inadequacies of the WASH sector, particularly safe water and good hygiene, and their critical role in any emergency response that may involve quarantines. Crisis response

[43] E.g. see WHO: http://www.afro.who.int/en/clusters-a-programmes/frh/child-and-adolescent-health/programme-components/child-health.html.

[44] Ekayu, P., Proposed gender equality programming plan in support of the Ebola response/post-Ebola recovery efforts in Liberia, January 2015

[45] WHO Country Cooperation Strategy for Liberia 2013-17 http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_lbr_en.pdf

needs to ensure that services for endemic high morbidity and mortality diseases continue to be accessed. Technical strengthening will be unsustainable if not accompanied by strengthening the governance of the system by allowing greater participation of communities and increased accountability and responsiveness to community priorities.

In addition to economic, social and cultural rights, the EVD outbreak had an impact on civil and political rights. The use of excessive force by security forces to implement the state of emergency and curfew, as demonstrated during the West Point incident, raised its own challenge that required urgent protection attention and response. An assessment called for a need to strengthen the capacity of security institutions to respond appropriately and proportionately within the mandate to enforce law and protect civilians. The EVD crisis amplified underlying human rights challenges, especially during the state of emergency, and required a rapid, targeted and coordinated human rights and protection support to the Government and particularly to the national security entities, with the Liberian National Police (LNP) as the prime target.

Overall, the Ebola crisis has highlighted the need for creating the institutions and framework for providing accountability for human rights violations. The Independent National Human Rights Commission (INHCR) has a clear role to ensure that such violations do not recur and to highlight and bring to account any that continue.

### 4.5. Sustaining Response Capability

Increasing participation in health service delivery and public health is vital. *There is a need to provide more training in the rural areas to do more, but there is a problem of transport in reaching rural people* (Mama Tomah). *Communities must be regularly engaged in health matters. Community-based health workers are needed to mentor the community on hygiene practices not only when there is an outbreak. Instead it should be done regularly* (Health Workers' KII). A child survivor emphasised that personal hygiene and hand washing must continue in order to protect against future outbreaks of Ebola or another virus, including "diarrhoea and malaria". Such a statement supports the need for public health messaging to cover protection from the other major killers, such as malaria.

Behaviour change of health professionals' willingness to listen to communities must be sustained. Health system strengthening should include increased participation by community-based structures. New partnerships need to be formed with traditional and religious leaders and with key potential players in emergencies, such as the motorcyclist unions. Rebuilding health institutions must include the building of accountability and responsiveness of health service providers to local communities, which in turn will lead to communities' increased trust in and collaboration with the health system. Technical strengthening without such governance strengthening will leave the health system at risk of future collapse. Already there are clear signs that Government has not applied the lessons from Ebola in terms of sustaining emergency preparedness.

With regard to accountability, Liberia has a history of social exclusion and unaccountable elites profiting for themselves through concession extraction of primary products at the expense of local communities, which has fuelled conflict and undermined local development. Solutions for this are certainly not simply technical, involving only investment in service provision without accountability. As the former SRSG noted in her farewell remarks in a City Hall address on 30th June 2015: *With more attention, engagement and support to communities, I have every reason to believe that the Liberian project will prosper. Accountability and transparency are about societal norms - about expecting integrity, and making integrity not only a habit, but a habit that pays*.

Had the health system been more responsive to community needs, partnerships for addressing Ebola would have emerged quickly. Health services and NGOs should *engage with our community leaders and our traditional council on best practices, empower youths and women groups through training on risk management and put a risk management team in each community* (Harmon Hill, Bomi); *Communities need to have health committees that will work directly with clinics. There is a need for primary health care. There is a need to monitor health supplies and ensure accountability to communities* (Health Workers' KII). Community Task Forces, which were set up to help respond to Ebola and spread hygiene messages and manage quarantines proved effective. Matadi, Montserrado, which was the community that affirmed the good briefing by a psychosocial worker when imposing the quarantine, reported that its Community Task Force was *very active in contact tracing and constant monitoring of affected homes*. Good communication from trained workers in MoH when imposing quarantines and promoting their self-protection, would increase the level of compliance and community involvement in managing their own response. In Matadi, the community task force and a volunteer group were effective in helping provide water and food and received NGO backing with a box of preventive materials and spray cans.

Even health workers felt that Government was not responsive to their needs. Some health workers felt that Government did not listen to them adequately and that it was NAHWAL that *advised that there is a need to build many ETUs throughout the country. In a radio interview NAHWAL also called for training of health workers; the American Government responded to this need. NAHWAL also called for hazard pay and ambulances* (Health Workers' KII). There were failures in delivery of required resources. *For example, when the Chinese government brought in many PPEs, the Government kept the PPEs in stock for a month and did not deliver them to health workers in rural areas. This is an example of a lack of political will because the Government wanted cash not PPEs* (Health Workers' KII).

Accountability was raised in a number of communities. One suggestion was that NGOs could help the community to *set up a monitoring team to assess the funds to Government and projects within the community* (Crab Hole, St Paul Bridge, Montserrado), although others felt that *the international community should monitor the funds they send to Government* (e.g. Neezoe Community, District 3; Kamaso, District 17, Montserrado)). Several communities felt that both NGOs and the international community should provide funding direct to communities, not through Government (e.g. LPRC, District 12, Montserrado).

There is a danger that the international community, concerned at the potential spread of an outbreak such as Ebola far beyond Liberia's borders, will undermine new opportunities to develop a common agenda of social inclusion and of accountable and responsive service provision, by investing solely in the infrastructure of health services, confirming the status quo ante that contains the seeds of conflict.

### 4.6. Overall Lessons

**Parallels with conflict management**

There are clear parallels with post-conflict management, particularly related to the need for trauma counselling and handling post-traumatic stress disorder (PTSD) affecting whole communities, as well as those directly involved in the fight against Ebola; also the need for PTS Counselling, Re-training, Re-deploying and Reintegrating those involved in the front-line as contact tracers and in the burial teams and in rewarding them for their contribution as volunteers taking some of the greatest risks to protect their communities. Without a clear reintegration programme, survivors and former workers will become disillusioned

unemployed and will risk destabilising recovery efforts. As with post-conflict DDR programmes, these should take as long as the trauma period and not be seen as a short option of a couple of months. As with "peace dividends", there is a real opportunity for a "post-Ebola dividend" of using Ebola survivors and workers as health extension workers and community mobilisers.

## 5. Recommendations emerging from Lessons Learned

There is a real opportunity now to generate an "Ebola Dividend", particularly in changing governance of, and partnerships for, service provision. Liberia's weakness in addressing the Ebola crisis was as much a crisis of governance as a crisis of weak health infrastructure. It inevitably led to the violation of a wide range of human rights and amplified existing human rights challenges. New informal institutions and partnerships must be built on in order to construct a better future. All actions of the Government should be guided through human rights based approach in compliance with national law and international obligations to which Liberia has adhered. Government actions should ensure respect for the inherent dignity of the human person and be guided by the principle of non-discrimination.

### 5.1. Strengthening the Governance of Health Systems:

(i) Trust is essential for building any sustainable delivery systems. This must be part of a wider governance agenda, but a **focus on building trust** can speed up risk identification and response in a health emergency.

(ii) Health professionals should be trained to identify gendered roles and needs in responding to a health emergency.

(iii) **Disease surveillance** monitoring and reporting should be strengthened and **include new community structures** as institutional partners.

(iv) All health facilities across the country must be equipped to effectively respond to community needs relating to maternal health and key disease risks, such as malaria, cholera and Ebola (testing machine, equipment, triage, etc).

(v) There is a need for **Integrated and inclusive** systems – horizontal and vertical – rather than a fragmented silo provision of services. There should be strong links between Health, WASH, Education, Local Government and Internal Affairs working together with a **national emergency response unit** (ERU) at the centre. The ERU should work with the current Incident Management System and the National Disaster Relief Commission and be tasked simply to ensure development of emergency planning and capacity building.

(vi) The formal institutions, especially technical ones such as MoH, must give recognition to informal influence and decision-making spaces; also for the role of community entrepreneurs as social innovators or service providers. In addition, it is critical to **involve at the local level women and children** in awareness and task force activities.

(vii) Improved WASH facilities could be linked to linked to skill training and entrepreneurship support for **micro-enterprises that produce sanitation hardware**, especially in peri-urban environments of informal sector activity, together with use of community structures to promote good hygiene practices.

### 5.2. Government-Community Partnerships:

(i) Technical service provision without responsive/accountable governance cannot deliver in itself. **Participation is critical for effective service**

**delivery** with limited resources. Technical medical approaches without the counterbalance of community perspectives cannot generate effective public health messaging and behaviour change of the public and of health workers.

(ii) Government should **broaden and strengthen partnerships with civil society** and vulnerable groups, providing leadership in working with Ebola survivors and responders.

(iii) Both the accountability and the responsiveness of (health) services should be improved through **institutionalising community-based monitoring**.

(iv) Government should **institutionalise real-time monitoring and feedback mechanisms from communities** to service managers and policy-makers, institutionalising role of community task forces and providing training for these.

### 5.3. Emergency Preparedness:

(i) Government **preparedness initiatives for emergencies** including for contagious diseases **should involve women**, through their organisations and leaders, and include:

a. a community-based early warning system;
b. inclusion of NGOs and skills available in each District;
c. strong communication by trained psychosocial workers through community leaders and their selected community task forces;
d. training of health staff in managing health emergencies;
e. support for community-level Disaster Management Committees;
f. training of Community Health Worker volunteers, possibly using an experienced NGO such as EQUIPT;
g. the indicators for imposing quarantines;
h. consideration of border closures;
i. emergency food and non-food reserves and protective materials pre-positioned at County and District level for immediate distribution at the same time as imposing quarantines;
j. mobile community treatment clinics;
k. health worker allocation to affected quarantined households;
l. protected access to basic health services such as malaria treatment and maternity services;
m. provision of free drugs for epidemic treatment and critical diseases that cannot be treated in hospital during the emergency;
n. livelihood support during and, for a period, after quarantine, including introducing penalties for discriminatory termination of employment despite health clearance certification;
o. strong public messaging to ensure inclusion in communities of all who may experience stigma and discrimination following an emergency;
p. a coherent national policy for support to orphan victims of health emergencies, including free education that is urgently needed now. This should cover, among other things, cash transfers, access to school textbooks and support for orphans in completing education;
q. design for a framework Post-Crisis Programme, covering a period as long as the crisis period and involving Post-Traumatic Stress Disorder (PTSD) Counselling; and Re-training, Re-deploying and Reintegrating those involved as front-line responders.

(ii) **Strengthen programmes for safe water and sanitation** across all communities, especially in poor urban areas, and **use community structures to promote hygiene practices**, together with increased provision of clinics and assured drug supplies.

(iii) Provide public health measures for public goods, such as use of rat poison and spraying against mosquitoes through the city of Monrovia.

(iv) Whenever introducing a State of Emergency to address a particular crisis, Government must look in detail at (a) which rights will be directly or indirectly affected and expressly notify the relevant organisations about such derogations, (b) the mitigation measures that will be deployed with due attention to accountability through adequate complaint procedures and mechanisms and effective remedy, and (c) regularly assess the situation to see which derogations can be lifted and whether the conditions for maintaining a state of emergency continue to be met.

### 5.4. Addressing Human Rights

Alongside the need to strengthen health systems, governance structures and institutions, as well as emergency preparedness, the Ebola crisis has highlighted the centrality of human rights and the need for strengthening national human rights promotion and protection mechanism. In this regard, the government must:

(i) **Strengthen the institutions and framework for promoting and sustaining accountability for human rights violations including sexual and other forms gender based violence. This can be** effective in ensuring, development of basic health infrastructures, training of health workers and equitable access to health care for the people.

(ii) Ensure security institutions including law enforcement agencies and personnel are trained to perform, in situation of crisis, their protection duties with due respect to human rights and according to international norms and standards applicable.

(iii) Support the Independent National Human Rights Commission (INHCR) in fulfilling its human rights oversight obligations in line with the Paris Principles.

(iv) Urgently **review** employment, labour and other pertinent legislations to provide a protective framework for combatting all forms of discriminations and especially those affecting Ebola- survivors, their families and communities.

(v) In situations of unavoidable declaration of a state of emergency, take all required steps under ICCPR to immediately inform the other States Parties to ICCPR, through the intermediary of the Secretary-General of the United Nations, of the provisions from which it has derogated and of the reasons by which it was actuated.

(vi) Ensure that a gender and human rights-based approach guide all recovery programs to allow for the meaningful participation of women, men, girls and boys and marginalized groups.

(vii) Take special measures to protect women, survivors of Ebola, orphans and health workers from stigmatization and discrimination as acknowledged in the Economic Stabilization and Recovery Plan.

## 6. Annex: Ebola - WHO Guidance on Safe and Dignified Burials

10 November 2014

Excerpts from the 17-page document, which can be downloaded from http://www.who.int/csr/resources/publications/ebola/safe-burial-protocol/en/

Page 1:

*Twelve steps have been identified describing the different phases Burial Teams have to follow to ensure safe burials, starting from the moment the teams arrive in the village up to their return to the hospital or team headquarters after burial and disinfection procedures. These steps are based on tested experiences from the field.*

*The handling of human remains should be kept to a minimum. Always take into account cultural and religious concerns. Only trained personnel should handle remains during the outbreak.*

*The burial process is very sensitive for the family and the community and can be the source of trouble or even open conflict. Before starting any procedure the family must be fully informed about the dignified burial process and their religious and personal rights to show respect for the deceased. Ensure that the formal agreement of the family has been given before starting the burial.* ***No burial should begin until family agreement has been obtained.***

***Step 1: Prior to departure: Team composition and preparation of disinfectants***
***Step 2: Assemble all necessary equipment***
***Step 3: Arrival at deceased patient home: prepare burial with family and evaluate risks***
***Step 4: Put on all Personal Protective Equipment (PPE)***
***Step 5: Placement of the body in the body bag***
***Step 6: Placement of the body bag in a coffin where culturally appropriate***
***Step 7: Sanitize family's environment***
***Step 8: Remove PPE, manage waste and perform hand hygiene***
***Step 9: Transport the coffin or the body bag to the cemetery***
***Step 10: Burial at the cemetery: place coffin or body bag into the grave.***
***Step 11: Burial at the cemetery: engaging community for prayers as this dissipates tensions and provides a peaceful time.***
***Step 12: Return to the hospital or team headquarters.***

Page 4:

*1. Prior to departure the team leader must brief the burial team about how to conduct a dignified burial in this particular religious and social context.*

*2. Arrival of the burial team from the Red Cross Society, Ministry of Health, WHO or MSF.*

*3. The staff should not be wearing PPE upon arrival.*

*4. Greet the family and offer your condolences before unloading the necessary material from the vehicles. Request respectfully for a family representative.*

*5. The communicator should contact a local faith representative at the request of the family members to arrange to meet at the place of collection for the burial of the deceased. If a local faith representative is not available the team leader can use the list provided of phone contacts, with the agreement of the family.*

*6. The communicator and the faith representative should work together with the family witness (such as a paternal uncle), to make sure that the burial is carried out in a dignified manner.*

*7. Burial team to wait whilst the faith representative and family witness can be called and have completed their discussion with the communicator about the safe and dignified burial.*

*8. The Burial team leader should ensure that the family witness and other family members have understood these procedures.* ***Obtain the formal agreement of the family's representative before proceeding.***

Page 7:

*An information card that uses the steps below, endorsed (signed) by a local Imam or Muslim representative, could be used to perform the dignified burial of a patient who has died from suspected or confirmed Ebola*

- *The team leader will explain the safe and dignified process of burial.*
- *Ask the family if there are any specific requests in regard to the process of a dignified burial, for example, do they want to perform a dry ablution on the body prior to burial?*
- *Deceased Muslims should not be cremated or placed in the body bag naked.*
- *A dry ablution can be performed by a Muslim member of the burial team on the deceased patient before being placed in the body bag. Otherwise a Muslim person/family member can perform this simple procedure once they have been placed in the body bag (see next page information for dry ablution).*
- *The deceased patient is shrouded by wrapping in a plain white cotton sheet before being placed in the body bag. The shroud should be knotted at both ends. The BMT should provide a shroud for the family or they provide one themselves.*
- *If there are female members of the Burial team, they should shroud deceased female patients prior to placing in a body bag (see next page information for shrouding).*
- *Permission can be sought in advance from the Imam that the body bag can be used to represent a shroud. White body bags should be used for Muslim patients.*

Page 8:

**Dry ablution**

(To be only carried out by a Muslim person or Muslim faith representative).
A short Arabic prayer of intention is said over the deceased.
The hand of the Muslim Burial team member carrying out the dry ablution (in PPE), softly strikes their hands on clean sand or stone and then gently passes over the hands and then the face of the deceased. This symbolically represents the ablution that would normally have been done with water.
A short Arabic prayer is said over the deceased.
The body bag is closed if no request for shrouding has been made.
Dry ablution can also be carried out over the deceased in the body bag if a Muslim Burial team member is not available and it was not possible to perform directly on the body.
This process takes about 1-2 minutes only.

**Shrouding**

A plain unstitched white cotton sheet (scented with musk, camphor or perfumed) is placed on top of the opened body bag.
The deceased is lifted by the Burial team and placed on top of the shroud.
The extended side edges of the shroud are pulled over the top of the deceased to cover the head, body, legs and feet.
Three strips cut from the same fabric are used to tie and close up the shroud. One for above the head, one for below the feet and one for around the middle of the body. It is knotted at both ends.
If there are female members of the Burial team, they should shroud the

deceased female patients.
The body bag is closed.

Page 11:
*1. Transport the body bag to the coffin, which should be placed outside the house, by 2 or 4 persons wearing PPE (depending on the weight of the body and the number of persons in PPE)*

*2. Place clothes and/or objects of the deceased patient inside the coffin if the family so wishes*

*3. Allow one of the family members to close the coffin, ensure they are wearing gloves at all times*

*4. Disinfect the coffin*

*5. Respect the grieving time requested by the family*

- ***At the end of this step the coffin is decontaminated and is ready to be transported***
- ***In case no coffin is available, the body bag should be gently placed on the rear of the pickup vehicle by placing the head towards the front. This should be performed by 2 staff wearing PPE.***

Page 14:
***Wear gloves and transport the coffin or the body bag from the house to the cemetery***
*1. For the transport of the coffin, which has not been soiled, protection with household gloves is sufficient*
*2. Distribute household gloves to the family members who will carry the coffin*
*3. The rear of the car can serve as a hearse*
*4. The coffin is placed (delicately) on the platform of the car that will serve as the hearse, usually the head towards the front*
*5. Respect the time of grieving, possibly with a speech about the deceased and religious songs (chants) to aid the departure of the deceased to the cemetery, according to cultural and religious habits*
*6. During the departure of the funeral procession to the cemetery, some family members might be on rear of the car with the coffin*
*7. No family member should sit in the car cabin*
*8. Only the burial management team, without PPE, has the right to sit in the car cabin*
*9. The other participants of the funeral will follow on foot, behind the car at walking pace, with the alarm lights on and possibly dressed with funeral signs (bundles of palm trees on the bumper)*
*10. Conventional expression of pain through shouting, crying/songs of crying should be respected*
***At the end of this step the coffin has departed for the cemetery***

Page 16:
***Engaging community for prayers as this dissipates tensions and provides a peaceful time.***
*1. Respect the time required for prayers and funeral speeches*

*2. Family members and their assistants should be allowed to close the grave*

*3. Special attention should be given to the first shovel of earth; in general this is done carefully around the head area*

*4. Place for an identification on the grave (name of the deceased and the date) and a religious symbol if requested*

*5. Recover all household gloves,*

*6. Place household gloves in an infectious waste bag for disinfection.*

*7. Burial team to attend funeral and offer condolences (sign book) or offer small gifts to support the funeral.*

***8. Family to communally wash hands with disinfectant after the burial (using chlorine solution 0.05% or make an alcohol-based hand-rub solution available for hand hygiene performance) for all members involved in the funeral process.***

*9. Thank the family members.*

## 7. Annex: CEED Districts and Validation Workshop Participants

**Counties & Districts where 202 Community Empowerment and Engagement Dialogues were held:**

| | |
|---|---|
| Bomi | Senjeh |
| Gbarpolu | Bopolu |
| Grand Bassa | District #1; District #3; District #4 |
| Grand Gedeh | Gbarzon; Konobo; Tchien |
| Grand Kru | Forpoh |
| Lofa | Foya; Kolahun; Quardo Bondi; Voinjama |
| Margibi | District #1; District #2; Firestone; Kakata; Mamba Kaba |
| Maryland | Pleebo |
| Montserrado | Statutory Districts of Careysburg and Todee; St Paul River and Greater Monrovia, including townships and communities: #3; #4; #5; #6; #7 - West Point; #8; #9; #10; #12; #13; #14; #17; and #16 - New Kru Town Borough & other on Bushrod Island; |
| Nimba | Bain-Garr; Gbeahlay-Geh; Saclapea; Sanniquelleh-Mahn |
| River Gee | Chedepo; Gbeapo; Sarbo; Tubro |
| Rivercess | Central Rivercess; Noyorwain; Timbo |
| Sinoe | Butaw; Greenville; Kpanyan |

**Participants at validation workshop, 16 February 2016:**

53 Participants from members of PPF, community leaders, traditional and religious leaders, the National Civil Society Council of Liberia, INGOs, the Independent National Commission on Human Rights and the UN and Ministry of Justice met to validate the Draft Report. A number of invited participants from government ministries, UN and civil society were unavailable.

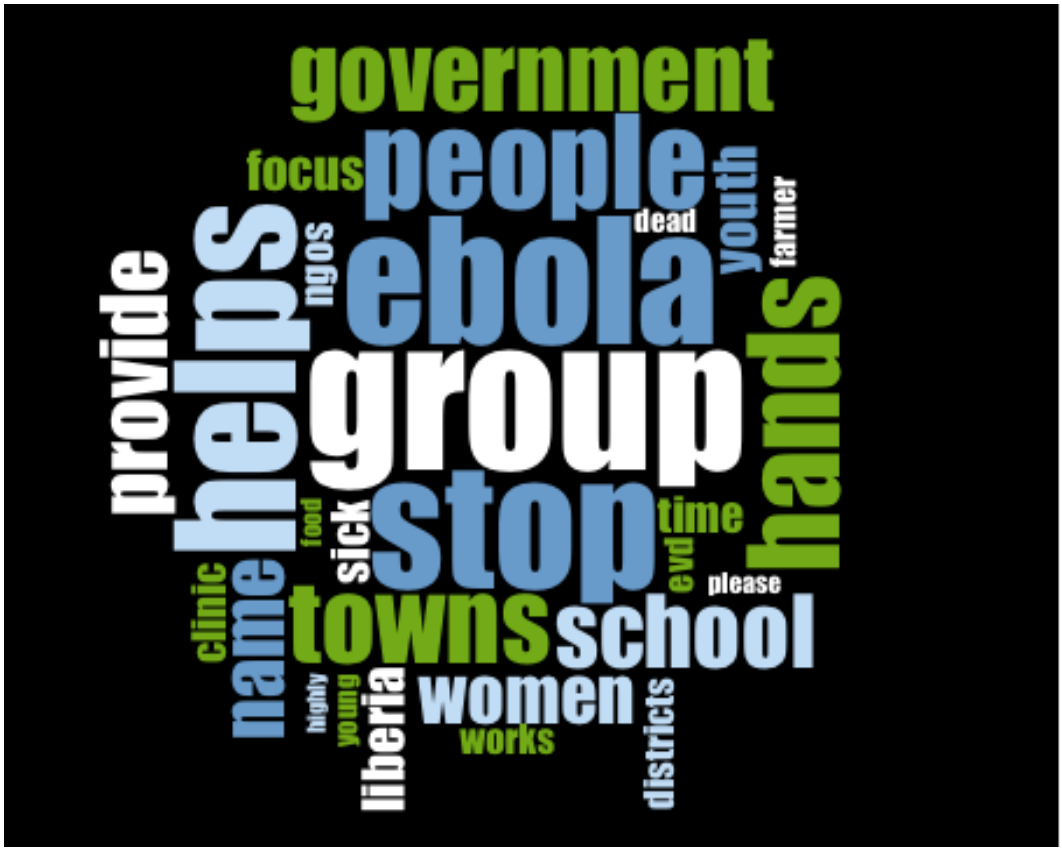
NGOs:
ACF; CAFOL; CIS; CHT; COHADO; DEKAP; DRC; ESAL; Family Rescue LINNK; HRP; IRC-Liberia; LAFSO; LIBNEP; NCSCL; NAHWAL; NUOD; OXFAM; Right Alert International; TWUP; WCI; WCSCL; WIPNET; WOCHIAD; WONGOSOL; YPPD;

INCHR;

Government:
MOJ;

UN:
UNDP/RCO
HRPS/UNMIL

Counties:
Bomi, Bong, Margibi, Lofa, Nimba and Montserrado




Word Frequency of CEED Responses