Ebola and Accusation
Gender and Stigma in Sierra Leone’s Ebola Response

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ABSTRACT: As Response and Resilience Team Anthropologist for Oxfam GB, my role was to support an inclusive, community-led Ebola response through a better understanding of gender dynamics in the context of the outbreak. This case study identified stigma and blame of affected people as key factors in the ongoing epidemic. Despite social mobilisation efforts to address these attitudes, they remained ingrained in the Ebola response at multiple levels: in Government of Sierra Leone quarantine policies, in community by-laws and in everyday social interactions. Negative attitudes put pressure on the roles of men and women in ways that produced barriers to acting on Ebola prevention and treatment advice or creating an inclusive Ebola response. Our findings prompted several improvements in Ebola response activities that Oxfam Sierra Leone carried forward in their work, demonstrating the key role applied anthropology can play in creating a reflexive process to improve the effectiveness of humanitarian aid.

KEYWORDS: Africa, Ebola, gender, humanitarian, qualitative methods, Sierra Leone, stigma

In March 2015, during the time this study took place, Sierra Leone marked an unhappy anniversary: one year since the first suspected cases of Ebola Virus Disease (EVD) emerged within its borders. As of 30 March, Sierra Leone had reported 8,545 confirmed cases and 3,433 confirmed deaths. In response to the outbreak, the Government of Sierra Leone (GOSL) had implemented a top-down strategy led by the Ministry of Defence. This strategy established a National Ebola Response Centre (NERC), chaired by a Chief Executive Officer who reported directly to the president, and a system of District Ebola Response Centres (DERCs) with district-level Ebola situation rooms and response components, each with a district coordinator. This civil–military coordination deployed Sierra Leonean and foreign military personnel to direct the Ebola response, which GOSL organised into six pillars: (1) case management, (2) surveillance and quarantine, (3) safe burial, (4) logistics, (5) psychosocial support, and (6) social mobilisation (Olu et al. 2016: 3).

Beginning in August 2014, Oxfam worked to curb new EVD infections in Western Area, Port Loko, Bombali and Koinadugu Districts by providing water, sanitation and hygiene (WaSH) in affected communities and via social mobilisation activities. For example, Oxfam supported the formation of Community Health Committees (CHCs) selected by their villages or neighbourhoods; CHCs designed plans to identify and address barriers to EVD prevention and treatment in their areas. Their social mobilisation activities included door-to-door visits to convey EVD transmission and prevention information in hard-to-reach urban enclaves and rural villages. CHCs also participated in Oxfam’s Active Case Search (ACS) strategy, designed to rapidly identify and refer those with EVD symptoms to Ebola Treatment Centres (ETCs) or triage centres, thereby preventing further spread of the virus (Adams et al. 2015).

In early January 2014, the epidemiological trend shifted from a high incidence of new EVD infections in concentrated areas to geographically disparate...
‘hot spots’. By this time, the vast majority of Sierra Leoneans knew that ‘Ebola is real’ (Richards et al. 2015: 3). The majority could list EVD symptoms, modes of transmission and methods to prevent infection (Abramowitz et al. 2014: 1). Early symptoms of EVD include headache, muscle pain and high fever, followed by vomiting, diarrhoea, rash, and in some cases, internal and external bleeding. Once symptoms begin, the virus passes through contact with the sick person’s bodily fluids. Reducing the risk of transmission in the home or community requires regular hand washing, avoiding direct contact with people exhibiting symptoms, and using gloves and other personal protective equipment when caring for ill patients.

Despite this knowledge, affected families and communities did not always follow EVD prevention advice. Most ‘compliance’ issues rested squarely on the ongoing gap between ideal public-health practice and the dearth of ‘staff, stuff, space, and systems’ that Paul Farmer (2014) noted months before, rather than cultural practices or beliefs (38). Nonetheless, a year into Sierra Leone’s epidemic, considerable social and behavioural challenges remained, even as the overall number of reported cases declined countrywide. Conversations with affected communities revealed ongoing fears of ambulances and ETCs, negative perceptions of burial teams and discomfort with government-led quarantine measures. Some individuals and families thus risked further spread of the virus by delaying biomedical treatment; moving across districts in search of alternative treatments; taking steps to avoid quarantine by evading testing for EVD; and burying those who died of EVD without the assistance of protective equipment.

This study set out to identify barriers and enablers to the participation of men and women in epidemic control at the local level through a better understanding of gender dynamics in the context of the outbreak. Although the early stages of the Ebola response overlooked gender relations as a factor in ongoing Ebola virus transmission (Harman 2016), several studies later found that gender roles played a central part in producing vulnerabilities to EVD morbidity and mortality (Ministry of Social Welfare et al. 2014). This study aimed to support a more inclusive, community-led response to the EVD epidemic through a gender-sensitive analysis of the impact of the Ebola response in the areas in which Oxfam Sierra Leone operated.

Conversations with affected communities quickly revealed that community-level factors leading to ongoing Ebola virus transmission could not be separated from factors related to the broader response or to structural issues. Over the course of the research process, this study identified stigma and blame as key factors in the ongoing outbreak. Stigma and blame operated at multiple levels of the Ebola response – from government quarantine policies to community by-laws, to everyday social interactions – and were directed at affected individuals, families and communities. This case study argues that these attitudes put pressure on both men’s and women’s roles in ways that hindered epidemic control, and ultimately protracted Sierra Leone’s Ebola epidemic.

**Methods**

This article presents data collected in Western Area, Bombali and Koinadugu districts, from 3 March to 1 April 2015. Western Area communities included John Thorpe, Robis, Mayenkineh, Rokel and Konto-loh. In Bombali, these communities included Rosanda, Kapeteh Yaluba, Masongbo, Kayassie, Masuba, Kolisokoh, Romano, and Small Bumbuna. Koinadugu communities included Kumala, Farekoro, Yoria and Yiffin. The selection of these areas offered comparisons among a range of urban, peri-urban and rural settings; both within and without Oxfam Sierra Leone’s areas of operation; and among ‘silent’, ‘inactive’ and ‘active’ areas. ‘Active’ chiefdoms had reported EVD cases in the previous 21 days (the maximum incubation period for EVD), while ‘inactive’ chiefdoms had not reported EVD cases in the previous 21 days. ‘Silent’ chiefdoms had never reported EVD cases.

The research team consisted of Oxfam’s Resilience and Response Team Anthropologist and a research assistant recruited from Oxfam Sierra Leone’s WaSH team. We used multiple qualitative methods to triangulate data. Data collection involved focus-group discussions (FGDs), in-depth interviews, participant observation and site visits to Peripheral Health Units (PHUs). Interviews probed the perceptions, experiences and roles of community leaders, health-care providers, religious leaders, EVD survivors and quarantined families in the Ebola response. FGDs with CHC members, youth groups, women’s groups and men’s groups (organised by their village or neighbourhood) concentrated on local understandings of EVD and its causes; key challenges facing these groups in the epidemic and their respective roles in addressing these challenges. Participant observation included informal interviews, direct observation, participation in group activities, and collective discussions and analyses of documents produced by stakeholders. Finally, site visits to PHUs and triage
centres assessed the quality and accessibility of facilities in the communities that they served. Daily field notes recorded detailed observations. Log notes and audio recordings of interviews and FGDs were transcribed and coded by hand.

Community Level

Study questionnaires began by exploring local terms for EVD in order to prompt discussions of community perceptions of Ebola and its effects. Focus groups identified and defined the following terms:

- **Fitina** (Temne): trauma, stress, God judges you
- **Bola Neh** (Temne): suffering without the aid of the community
- **Bola-Bola** (Limba): rolling in pain by yourself without the help of any person
- **Elbola** (Kuranko): the sickness is in your hand; if you touch another person you will pass the sickness
- **Killbola** (slang): it has no cure
- **Tawonah** (Arabic): destruction
- **Boda Wuteh** (Mende): a monster that kills the whole family
- **Sweh** (Krio): fever that kills the whole family

*Fitina, bola neh,* and *bola-bola* highlight the trauma of EVD, the isolation it inflicts and the stigmatisation of the sick. *Killbola, tawonah, boda wuteh* and *sweh* emphasise the virulence of the disease. *Boda wuteh* and *sweh* also point to local conceptions of EVD as a group illness – one that affects the whole family rather than merely the individual body. This resonates with local terms reported from Liberia such as *Ju’pa* (Kpelle), which means ‘to kill the whole family’, and the darkly witty term ‘family visa’ to the other side (Modarres et al. 2015). In contrast, the international community’s response to the outbreak tended to be grounded in public-health approaches, such as the 2014 Centers for Disease Control and Prevention (CDC) interim guidance, that focus on individual rather than merely the individual body. This reso-

Unlike local terms for EVD, these discussions of Ebola causation pointed to the stigmatisation of affected individuals or groups (see also Berghs et al. 2014), as well as the centrality of family relationships in the transmission of the virus. Rather than focusing on individuals as vectors of disease, this view recognises Ebola as a crisis that devastates entire families. Like local terms for EVD, this view highlighted the importance of keeping the families of sick persons informed and involved in the management of potential Ebola infections. In the final instance, notes Richards et al., families are the most reliable source of assistance and care in a crisis, those to whom a sick person will turn for help (2015: 6). This suggests the ‘need to understand Ebola risks from the perspective of family, and its notions of social obligations’ (ibid.: 7). It also carried implications for the targeting of select individuals (such as survivors and orphans) for assistance. These interventions may have increased pressure on individuals to support other family members. At the same time, sharing material support may have contributed to reintegrating individuals into important family and community relationships.

Local conceptions of Ebola also had profound implications for gender relations. In most communities, respondents described a division between male/female and public/domestic roles. Men were held responsible for security, but women were held responsible for family health. Women were generally obligated to maintain the bodily and environmental hygiene of the family, particularly in relation to children. Women’s caregiving role placed them in...
regular contact with the bodily fluids of children and other dependents, leaving them little room to follow Ebola prevention advice to ‘avoid body contact’. In survivor focus groups, one female survivor after another described having fallen sick – not because of denial, resistance or hostility towards EVD prevention advice – but because of the critical social weight of women’s ‘sympathy’ in caring for the sick and the dead. ‘This issue of denial is relating to emotional affection’, reported a female CHC member in Robis, Western Rural District. ‘We believe in collective responsibility. When you are sick I will visit you, see you, and talk to you; you will say I love you. If I don’t visit you, you will see me as an enemy.’ Refusing to attend to the sick or dead represented an extreme moral failing, one that may invite accusations of witchcraft (Hunleth 2011: 210).

Ironically, women’s caregiving role may have prevented them from seeking health care outside the home. Anthropologist Almuneda Saez found that, in Koinadugu District, ‘leaving the family home, even to give birth in a hospital, is viewed as a sign of failure to fulfil their domestic responsibilities. Men do not carry out these chores in the absence of their wives and subsequently pressure them to remain at home’ rather than seek medical assistance (Saüz 2013: 10). In some cases, husbands may respond to these perceived failures with insults and violence (ibid.). During the Ebola epidemic, the burden of caregiving fell even more heavily on women due to ongoing distrust of Sierra Leone’s weak health care system, in which PHUs struggled to provide essential care and basic medicines. Particularly in times of crisis, women’s unpaid care work underpins health-care systems, and ‘women absorb the burden of care through self-exploitation’, which leads to both direct and indirect damage to their health (Harman 2016: 525).

Yet women’s caregiving role also meant that they faced stigma and blame in the event of a family illness or death. In focus groups, female survivors in particular described accusations that they were ‘wicked’ or ‘careless’ in the wake of their own and others’ illnesses. Women may also encounter accusations of witchcraft under these circumstances. The consequences of such accusations can be severe: expulsion from the community, economic and social marginalisation, and acts of violence. In this study, while male survivors reported negative attitudes specifically related to fears that they could transmit EVD through sex, female survivors more frequently reported broader issues such as eviction, family rejection, loss of livelihoods, and loss of former leadership roles due to stigma.

This placed women in difficult binds as they attempted to manage not only illness but relationships and identities as well. Women undertook these negotiations in a context of structural violence and poverty, in which community and family relationships remain key to survival (Richards et al. 2015). The EVD outbreak undermined critical family survival strategies: according to youth in Bombali District, restrictions on movement cut ties to relatives in Freetown or other areas, on whom family members in the village relied for access to cash and commodities.

This produced further vulnerability for women and girls, highlighted by the apparent rise in teen pregnancies during the epidemic (Rissa-Gill and Finnegan 2015). According to a UNDP report, teen pregnancy increased by up to 65 per cent in some communities during the epidemic (UNDP and Irish Aid 2015). Public commentary on this trend often directed blame towards girls: when schools closed, some argued, boredom led girls to engage in unprotected sex (Margai 2014). ‘In Koinadugu’, a young male respondent remarked, ‘the nights are long’. Women’s rights organisations, on the other hand, held men responsible as perpetrators, pointing to a rise in sexual violence against teen girls as the cause (Ministry of Social Welfare et al. 2014). Yet conversations with women and girls also suggested a third factor: as hopes for schooling faded, girls looked to romantic relationships with men to provide financial assistance. Bearing children created new relationships that might provide a small measure of support in an unstable environment. According to young women in Kumala, Koinadugu District, a local by-law mandated that if a man impregnated a schoolgirl, he must pay her school fees after she gave birth.

The burdens of caregiving, stigma and vulnerability limited public roles for women and girls in some areas, particularly visible roles in the Ebola response. Female Community Health Workers (CHWs) and CHC members, in particular, faced community suspicions that they had brought EVD into the community. In Kolisokoh, Bombali, neighbours shouted insults and threw stones at the health clinic and home of a nurse, after she provided medical treatment to an elderly Traditional Birth Attendant (TBA) who subsequently died of EVD. According to the nurse, the TBA had unknowingly contracted the virus in a neighbouring village after helping an EVD-positive woman give birth. Family members blamed the nurse for causing the dozens of deaths that followed the TBA by calling the burial team. Relatives believed that the burial team, rather than the TBA, brought the Ebola virus into their community. This narrative highlights
a chain of women’s caregiving that exposed them to infection and blame for carrying out their expected roles.

These limitations compounded gendered hierarchies that, in some areas, already restricted women’s participation in public roles. In Masuba, Bombali District, CHC members stated that women are expected to stay at home; in community meetings, they sit behind the men and might be ‘chased away’ if male relatives objected to their presence (see also Carter et al. forthcoming). In Romano, Bombali District, a women’s group complained that men excluded them from decision-making and did not inform them about community meetings and trainings, particularly if the meeting involved stipend or per diem payments. In Kumala, Koinadugu District, a councilwoman noted that, traditionally, women were not supposed to speak in front of men, and could not act as chiefs or council members: ‘We are not supported in other [community] decisions – only if we have a programme on “women’s issues”. In the traditional court women are not encouraged at all to talk. You will only see the woman who has her case. By law we are supposed to have elderly women who are supposed to represent us as women.’ Women’s ability to participate in community decision-making depended heavily on local factors, including the influence of local women leaders (such as female chiefs, known as Mami Queens) and the acceptance of individual male chiefs.

Limitations on women’s public roles resulted in an epidemic response composed, in some areas, of all-male teams of surveillance officers, contact tracers, social mobilisers and burial workers – often recruited from outside the communities in which they worked. An all-male surveillance team in Koinadugu District suggested that local women did not participate in these activities because women are ‘shy’ and find the work ‘too hard’. Yet further probing revealed that restrictions on women’s mobility hindered their ability to participate in social mobilisation activities: a woman seen moving from village to village, sometimes on motorbikes with men after dark, might risk accusations of bad behaviour or promiscuity.

Yet qualitative research in EVD-affected countries has repeatedly shown that community members often do not trust outsiders with sensitive personal information (Minor 2014; Richards et al. 2015). Effective community engagement in the Ebola response required direct engagement with women who worked as trusted envoys in community sensitisation (Minor 2014; Niang 2015). Without women’s direct involvement, men in some areas did not convey critical information on Ebola prevention and treatment to women, thereby reinforcing cycles of infection, stigma and blame (Minor 2014).

Response Level

Yet stigma and blame did not operate only within community-level social interactions. Organisations involved in the Ebola response inadvertently contributed to misconceptions about gender roles in Sierra Leone, placing blame on EVD-affected communities for their perceived lack of women’s leadership or involvement. Although communities generally divided male/female and public/domestic roles into men’s responsibility for community surveillance (such as task forces and checkpoints) and women’s responsibility for domestic surveillance and caretaking, these were micro-social efforts at disease containment in the absence of adequate health, infrastructural and material support. As anthropologists observed in Liberia, community members saw these efforts as ‘necessary but less desirable than well-supported health systems-based response […] involving considerable individual, social, and public health costs, including heightened vulnerability to infection’ (Abramowitz et al. 2015). Such community-led epidemic control efforts did not necessarily demonstrate empowerment from the ground up but rather a response to abandonment (ibid.).

These observations resonate with field experience in Sierra Leone. In every single interview and focus group, participants pointed out the desperate lack of health clinics and schools. Many also discussed the need for water, transportation and communication networks. They called attention to the lack of first aid and hygiene equipment, such as soap, disinfectant, gloves, buckets, protective clothing and oral rehydration salts (Richards et al. 2015: 13). While most participants readily answered questions about gender roles in disease containment, their final message was clear: community members – and women in particular – only have meaningful choices for participation in epidemic response in a context of functioning systems: of schools, health care, water, roads and communication.

Identifying only household- or community-level barriers and enablers to female participation in epidemic response risked engaging in discourses that development scholars label ‘gender scapegoating’, in which ‘the suffering endured by women in the world’s poorest communities is blamed on local patriarchal values rather than fully acknowledging the extent to which women’s vulnerabilities (like those
of men) are driven by broader global structures of impoverishment and inequality’ (Diggins and Mills 2015: 2). Discourses that blame ‘non-modern’ gender relations as a root cause of EVD deaths in Sierra Leone, noted several anthropologists, are ‘difficult to correlate with our experience of communities in which members of both sexes have held positions of religious and political authority, and have been active participants in public economic life, for as long as anyone can remember’ (ibid.).

Although women in some areas reported exclusion from community power structures, these responses varied significantly among communities, depending on individual chiefs and women leaders. In Kontoloh, Western Area District, a female chief noted that, ‘When the outbreak started, [women leaders] held a meeting in our community and we suggested the idea of not washing bodies, frequent hand-washing, and we should call 117 to come and collect the deceased – and the men supported us in it. We came up with the idea before the organisations came to our aid.’ A councilwoman in Kumala, Koinadugu District, observed that respect for women’s leadership had grown significantly over the past ten years, due to previous Oxfam Sierra Leone programmes focused on increasing women’s political participation.

In Sierra Leone, gender scapegoating accompanied the stigmatisation of ‘traditional’ social structures. Early in the EVD epidemic, the government of Sierra Leone banned traditional healers and herbalists from practising traditional medicine, placing blame on local healers for fuelling the outbreak. Organisations engaged in the Sierra Leone response belatedly began dialogue with traditional healers to facilitate their participation in epidemic control, rather than marginalising or blaming them for driving infections. Organisations in the response also tended to regard gendered initiation societies as problems to be overcome, rather than potential partners, by focusing narrowly on the role of ‘secret societies’ in female circumcision. While Bondo societies play a role in regulating gender and sexuality, they also provide a critical vehicle of women’s influence as a broader collective in which they wield power. Women’s ‘secret societies’ provide opportunities to control their time and movement, as men generally cannot question women’s involvement in Bondo activities (Saez 2013: 45). A limitation of this study is that, although respondents cited the suspension of cultural activities as a major consequence of the epidemic, a full exploration of its impact on communities lay beyond our scope. However, as community-based structures responsible for relaying health information and organising responses to illness and death, Bondo societies could have provided critical support in epidemic response and recovery.

‘Cultural’ explanations for vulnerability can harm the vulnerable when they drive approaches to empowerment that overlook the lack of material resources. In identifying barriers to women’s and men’s participation in the Ebola response, unpaid labour emerged as a basic but key issue. For both sexes, the reduction of cash incentives for volunteers during the transition from emergency response to recovery meant that NGOs and the government relied on the donated labour of already impoverished people to carry out recovery programmes (Maes 2014). This compounded the time constraints on the many women who already shouldered the double burden of domestic and farm labour. This ‘free, supposedly elastic work of women that underpins health systems’ has been conspicuously ignored in policy and programme decision-making in the Ebola response and recovery (Harman 2016: 536). For men, volunteer work does not address the pressures they face to provide cash and commodities within conditions of mass unemployment. From this vantage point, volunteering for the Ebola response may look more exploitative than empowering. Non-participation in epidemic response may therefore reflect both men’s and women’s need to triage labour in a context of poverty and volunteer burnout. In the words of a female volunteer in Rokel, Western District, ‘An empty bag cannot stand.’

National Level

Stigmatisation and blame of affected families and communities was also ingrained in the tone of the Ebola response in Sierra Leone. The government response, organised by the Ministry of Defence, took a military approach to tackling the virus, with most of the weight placed on by-laws, quarantines, and surveillance – what anthropologist Cheikh Niang (2015) termed ‘the logic of war’. Niang noted the emphasis on the more ‘masculine’ approaches to disease containment (such as quarantine and logistics) and the de-prioritising of the softer, more ‘feminine’ aspects (such as psychosocial support and social mobilisation) (Niang 2015). The masculinised spaces of decision-making in the Ebola response tend not only to overlook the differential impact of the Ebola outbreak on men and women but also to reproduce gender hierarchies within the Ebola response (Harman 2016: 535).
National by-laws imposed heavy fines and prison terms on families who ‘hid’ sick relatives, conducted ‘secret’ burials and hosted ‘strangers’. This strategy redirected government and international actors’ responsibility for a belated and messy response, placed blame squarely on affected families and communities, and characterised the sick as ignorant, untrustworthy and transgressive (see also Calain and Poncin 2015: 127). At the international level, respected media outlets attributed ongoing cases to ‘hostile’ communities, ‘confused beliefs’ and ‘traditional rituals’, rather than the lack of communication, inadequate health systems and counter-productive quarantine policies this study observed (New York Times 2015). These narratives worked to justify the degrading treatment of affected families and communities through implicit claims that they brought the virus on themselves.

When anthropologists asked why families and communities ‘resisted’ Ebola prevention and treatment messages, however, a different picture emerged, one that revealed the deprivation of basic rights and dignity driven by the stigmatising tone of the response. ‘Resistant’ community members in this study raised legitimate questions about the confidentiality of personal information recorded by surveillance teams. Others described ambulance teams as ‘ruthless’, treating potential patients ‘like criminals’ (Ministry of Social Welfare et al. 2014: 17). Bereaved families witnessed ‘safe and dignified’ funerals in which burial teams, fearing infection themselves, conducted burials that amounted to ‘little more than sanitary disposal’ of a loved one’s body (Richards et al. 2015; see also James et al. 2015). Security forces imposed months-long quarantines on affected families without ensuring access to water, food or latrines. As a result, some families began to avoid quarantine: concealing illnesses, creating false copies of the certificates given to patients who test negative for Ebola, or fleeing their homes when they became symptomatic. Facing the prospect of quarantine, isolation, social ostracism, suffering and possible death, families understandably reacted with disbelief and opposition (Calain and Poncin 2015: 127).

Respondents in this study also raised questions about the definition of ‘strangers’, which in this context might include a sibling, cousin or parent who stayed in another village for a period of time. In Sierra Leone, households are somewhat fluid, with frequent movement among relatives and villages. Under national by-laws, however, family members met the definition of ‘strangers’ and were banned, while other strangers (such as contact tracers, surveillance teams and aid workers, whose roles may have been unclear and who may have had more direct contact with EVD) moved freely in and out of villages. In other words, outsiders had unfettered access to villages, while the normal movements of family members were literally pathologised (Benton 2014).

The restriction on movement created particular vulnerabilities for women who married outside of their home villages due to patrilocal norms. Women who marry into another village will also be termed a ‘stranger’ (Richards et al. 2015: 7). In cases of conflict or domestic abuse, women in this study said they would normally return to their natal village until relatives helped resolve the conflict. Village-wide quarantines and district-wide restrictions on movement meant that women did not have access to these coping strategies.

Other negative effects on women of the militarised government response have been documented elsewhere: rising rates of gender-based violence and rape; quarantine guards coercing women and girls to exchange sex for access to supplies; pregnant women under quarantine giving birth without medical support; and increased poverty and food insecurity due to the loss of access to farms and trading (Ministry of Social Welfare et al. 2014; UNDP and Irish Aid 2015; Chavez 2015). These policies compounded pressures on women’s caregiving role within the household and contributed to the cycles of infection, illness and blame.

The effects of these same policies on men received less attention, as most assessments of ‘gender’ focused exclusively on women. Yet men in this study also described experiences of profound loss, lack of freedom, isolation and demoralisation. In the words of a young man in Farekoro, a village in Koinadugu District where EVD took a heavy toll, ‘Everybody is traumatised because their relatives, friends, and loved ones died in the cold arms of Ebola.’ Young men in Bombali District said that men their age felt angry about the consequences of the Ebola epidemic. They perceived the flow of ‘Ebola money’ and power among governments and international institutions, none of which reached them in time to save loved ones. Frustration, fear and distrust drove sporadic violence: a group of young men in Bombali District, for example, threw stones at a burial team for mishandling a body. Police jailed their parents in order to force the young men to come forward, whereupon a court sentenced them each to eighteen months in prison.

Frustration and sporadic violence easily fed into narratives that blamed ‘hostile’ and ‘resistant’ communities for the ongoing outbreak. Yet this ‘resistance’
was a reaction to Niang’s ‘logic of war’, in which it appeared that the fight was against one’s own people rather than the virus. ‘They have come with guns to threaten us, and when you are diagnosed to have Ebola, they arrest you. That alone makes you to be depressed, and not for the disease but of the forces surrounding the patient. The entire family is looked at negatively’ (James et al. 2015: 2). This approach increased pressures on the roles of men and women, and ultimately produced counter-productive responses that contributed to the epidemic.

Yet the international community also cannot place blame on GOSL’s response without fully acknowledging the extent to which broader global structures of impoverishment and inequality fuelled the Ebola epidemic. ‘The three countries most afflicted by Ebola are those with some of the lowest public investment in healthcare and public health in Africa’, noted Paul Farmer (2014: 38). ‘They have been wracked by war, and by extractive industries, which have never failed to turn a profit’ (ibid.). Efforts to contain the epidemic were severely hampered by the lack of ‘staff, stuff, space and systems’ that Farmer observed more than six months earlier (ibid.). Before Ebola emerged, Sierra Leone’s ability to meet basic health care needs had been severely eroded by financial policies promoting disinvestment in public health and other social services; any critique of its response must be considered within this context.

Impact of Anthropology in Oxfam Sierra Leone’s Ebola Response

The findings of this study suggested several improvements in Ebola response activities that Oxfam Sierra Leone carried forward in their work at the community and national level. Throughout the Ebola response, Oxfam Sierra Leone supported social mobilisation activities in neighbourhoods and villages in order to prevent new infections and provide support to affected families. These efforts also aimed to encourage female and youth leadership through CHC member recruitment and training. As CHC members, women and youth played active and visible roles in reducing EVD transmission through house-to-house messaging, active case finding, and public-health promotion.

During the transition from emergency response to recovery, Oxfam Sierra Leone incorporated activities to reduce stigma and blame levelled at survivors and affected families. National staff reviewed plans to provide assistance to affected individuals and families, holding discussions with beneficiaries on how to contribute to community reintegration through participation in existing community structures (such as agricultural, development and women’s groups). Oxfam Sierra Leone also drew lessons from post-civil-war ex-combatant reintegration programmes to address stigmatisation (Berghs et al. 2014). In Koinadugu District, for example, staff worked with the Koinadugu Accountability Action and Development Group (KAADG), a drama club that specialised in post-conflict reconciliation. The KAADG trained local drama groups to write and perform skits aimed at reducing the stigmatisation of survivors and affected families. Finally, Oxfam Sierra Leone facilitated face-to-face dialogues in eleven Koinadugu sub-districts among public-health officials, ambulance and burial teams, health-care providers, local leaders, survivors and community members. During these ‘Community Information Days’, community members could inspect ambulances and ask questions of those involved in the Ebola response. These events provided opportunities to reduce stigma and distrust through dialogue.

This study also highlighted the need to engage better with traditional healers, TBAs and other informal health-care providers who serve as frontline sources of care at the local level. In response, national staff in Koinadugu District identified networks of formal and informal health-care providers in eleven sub-districts. Interviews with community leaders also discussed critical health issues and strategies to address them. Koinadugu staff drew up plans to engage with informal health-care providers, with the aim of improving access to health care, reducing distrust in the formal health-care system and including informal health-care providers in community epidemic preparedness plans.

Finally, Oxfam Sierra Leone played an advocacy role in reducing stigma and blame at the national and international level. Throughout the Ebola response, Oxfam Sierra Leone lobbied DERC and NERC leaders to adopt a human rights-based approach to epidemic response. This approach recognises affected individuals’ and families’ right to dignified treatment rather than simply regarding them as vectors of disease (see also Calain and Poncin 2015: 131). Oxfam Sierra Leone’s programme manager lobbied the government to exercise restraint in imposing quarantine, arguing that quarantine should be used as a last resort. ‘There are clear legal principles and every effort must be made to maintain people’s rights. Poorly-
implemented quarantines make life even harder on communities who, in many cases, are already vulnerable. The danger is that people will try and avoid quarantines, and there will be a knock-on effect with people under-reporting infections and deaths, or trying to care for Ebola victims at home’ (Hlaing 2014).

Oxfam Sierra Leone’s responsiveness to anthropological perspectives provides one demonstration of the importance of applied anthropology in the context of humanitarian aid. Anthropologists can offer emergency response teams a deeper understanding of community perceptions, beliefs and practices. This is one of the key contributions of anthropology to humanitarian aid: understanding the categories, frameworks and terms that beneficiaries use to understand their own experiences. In the Ebola response, for example, asking respondents about the local terms they used to describe Ebola revealed critical information about how beneficiaries perceived and experienced the disease as a destructive force that affected families rather than merely the sick individual. This led Oxfam Sierra Leone to much more sensitive consideration and support for the needs of affected families.

However, anthropologists do not just study ‘the community’ or ‘the other’. Reflexivity is a central component of anthropology: an awareness of how the anthropologist’s own cultural background and social position affect the research process and the analysis of data. Likewise, the purpose of anthropology in humanitarian aid is not merely to study the beneficiary community but rather to focus on the relationship between the response and the community. Humanitarian organisations need to understand not only the perceptions and beliefs of beneficiaries; they need to remain reflexive and self-critical about the assumptions, beliefs and categories that inform their perceptions of a crisis, what kind of support communities need and how response teams should be delivered. What frameworks and assumptions inform how a community experiences a crisis and humanitarian aid? What impact does humanitarian aid have on community beliefs and practices? What assumptions and beliefs shape the response? Is there a disconnect between the way responders approach a crisis and the way beneficiaries understand it? If so, how do organisations address these gaps, strengthen links with communities and improve the acceptability and effectiveness of their work? Creating space for this kind of reflection, discussion and analysis is the key contribution of anthropologists in the context of a crisis.

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**Notes**

1. For a comprehensive overview of Oxfam’s Ebola response activities in Sierra Leone, see Adams et al. (2015).
2. Sierra Leone’s health infrastructure is made up of a system of Peripheral Health Units (PHUs) meant to deliver primary health care. Maternal and Child Health posts are often the first point of contact, located in local villages and serving populations of 500 to 2,000 people. Community health posts (CHPs) are meant to serve several villages and have a broader range of services. CHPs refer more complex health problems to Community Health Centres, which serve the entire chieftdom (the level of government below the district). In practice, Sierra Leone’s civil war and the Ebola outbreak devastated the country’s health infrastructure, leaving many PHUs without adequate staff or basic medical supplies needed to address Sierra Leoneans’ health-care needs.
3. The social meanings of blood no doubt run much deeper than the analysis here. ‘Worldwide, blood carries highly differentiated symbolic meanings; at times attributed with supernatural properties, perceived as a therapy, as a mere commodity, or linked to sorcery and witchcraft, which function as social means of understanding inexplicable events such as illness and death […] Preliminary ethnographic observations in Guinea suggest that the first Ebola deaths were believed to have occurred by breaking the taboo of touching the fetish (an object providing supernatural protection) of a diseased member of a secret society. Accordingly, susceptibility to Ebola was initially perceived to be restricted to the ethnic group whose members constitute this secret society’ (Bannister-Tyrrell et al. 2015).
References


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