

Beyond the Biomedical: Ebola Response and Recovery Through a Psychosocial Lens



Demonstrations of using PPE and role play in New Kru Town.
IMAGE: THERESA JONES

The International Rescue Committee (IRC) based in Monrovia, Liberia, during the 2014–16 Ebola outbreak attempted to look at the emergency health response through three different lenses: medical; infection prevention and control; and psychosocial. The term ‘psychosocial’ means the interrelation of the mind with social factors, all underpinned by the critical influence of culture. Many emergency health interventions integrate different components alongside the provision of medical care, such as infection prevention and control (IPC) and water, sanitation and hygiene (WASH). It is less common, however, to see psychosocial approaches given such equal value within an emergency response. This SSHAP Case Study details how the IRC team in Liberia used a psychosocial lens to gain a different perspective and open ways forward to better respond to the Ebola epidemic.

The challenge: psychosocial impact of Ebola

In March 2014, the Ebola Virus Disease (EVD) began to create a deadly, frightening, and confusing atmosphere throughout Liberia. The initial public health response was predominantly biomedical, centred on isolating suspected cases and quarantining their contacts. Ebola Treatment Units (ETUs) were constructed, often behind high walls and barbed wire. Due to poor initial communication by the responders about their purpose, and civil war being a recent reality, many frightening stories about these 'Ebola camps' spread between neighbours and

communities. Out of fear, people hid sick family members and continued to conduct their own burial ceremonies in secret.

Responders were confused as to why people were not following the biomedical protocol. Liberian people were heard to say 'there are worse things than dying'. Trust had become the most important factor for the implementation of any successful programme, but establishing it was also the biggest challenge. In the middle

of this significant clash of cultures and values, case numbers escalated and it became clear that acknowledging the human aspects of emergency response and recovery was not just about doing the right thing, but that it was a necessary element to ensure that activities worked.

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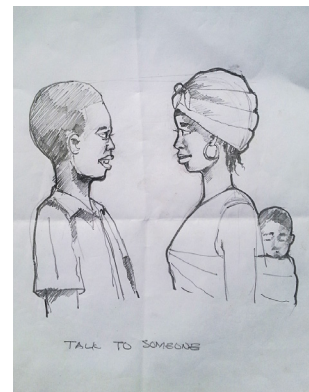
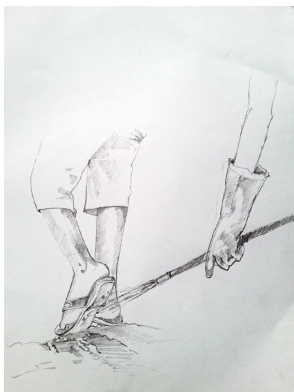
The programme: participatory action research

A key area where the three lens approach was critically needed was around treatment for the disease. In September 2014, the IRC began constructing an ETU in Monrovia. To ensure safe and appropriate care, which is crucial during triage assessment, the team looked critically at each component of the construction and preparation through the three lenses:

- **Medical:** What are the most crucial questions to ask if we suspect this is Ebola?
- **Infection prevention and control:** Are the distances between patient-to-patient and staff-to-patient wide enough to prevent infection spread?
- **Psychosocial:** How can we help people feel safe enough to answer our questions truthfully?

As medical protocols were put in place and WASH systems constructed, the psychosocial team, which was recruited from the surrounding community, gave tours of the soon-to-be-opened ETU and organised meetings to understand and address rumours. This helped to build trust, as the surrounding community felt able to visit the site and ask the team questions about the wider response.

As case numbers began to fall, the good relationships formed with the local communities allowed the team to springboard into undoing some of the damage that perceptions about Ebola had caused regarding social cohesion and wellbeing. The IRC ETU site in Monrovia, despite the fact that ETUs were in general feared and avoided in Liberia,



Information materials designed to aid discussions with community members illustrate the different triage steps at the point of entry to the health facility, together with the facility of being able to 'Talk to Someone'.

IMAGE: THERESA JONES

swiftly evolved into a Community Resource Centre complete with a children's safe recreational area. The Centre also hosted support groups for Ebola-affected individuals.

Health systems strengthening is critical for the continued safe delivery of general health services, and the complexity of this was illustrated at Liberia's largest free government hospital. The temporary closure of Redemption Hospital's inpatient services for six months during the outbreak was decided after 12 staff died of Ebola, and because of violence in the surrounding community (due to both historical tensions and new violence triggered by dissatisfaction with the role of the hospital during the outbreak). The reopening of inpatient services required full disinfection, and an intensive focus on safe services, effective triage, and adequate drugs and supplies. Many of the hospital staff initially refused to work as they were employed elsewhere, too afraid of the surrounding community or too frustrated at the new safety measures to

engage in their tasks as before. Many community members refused to consider using the hospital services ever again.

The IRC team who supported the reopening of inpatient services considered the importance of trust and good communication between patient and provider as a key part of protecting the facility and patients. Staff were engaged in self-care and peer-support activities and worked on improving their interactions with patients. The hospital

management held meetings with community leaders to ensure their participation in the reopening process. Health workers went into New Kru Town to demonstrate the use of personal protective equipment (PPE) and to allay fears that PPE signalled the presence of Ebola in a health facility. Community member volunteers dressed in PPE and role-played interactions with the health worker, who in turn stood 'in the patient's shoes', as a pathway to building mutual empathy and understanding.

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The hospital regained its ability to provide essential services to the population, and effective communication at the point of triage meant that multiple cases of Ebola were dealt with safely and effectively before entering the hospital.

Such an integrated approach made it difficult to disentangle the added value of the psychosocial lens. Qualitative evaluation with staff highlighted an improved sense of safety at work, increased confidence to deliver quality care, and also an improved sense of pride and value. A quantitative survey verified these findings: the most important motivating factors reported included commitment to the job and smooth working relationship among staff. While monetary incentives were important, findings showed these were the least important (Miller 2016). In a community-wide survey, marked improvements were also reported in the way staff respected patients, in perceived quality of care, and in the overall relationship between facility and community (Jones *et al.* 2018).

Lessons learned: integrating psychosocial response

Psychosocial issues must be considered across all health emergency programming. Activities most likely to transmit Ebola are those which are deeply socially and psychologically meaningful, such as caring for the sick or washing the bodies of loved ones before burial. If responders ignore the 'human factors' of such a crisis, programmes simply will not work – people will not necessarily engage as intended or as they 'should'. Furthermore, the humanitarian community can actively 'do harm' by creating or contributing to distress and other (unintended) negative psychological and social

outcomes. Yet, every response activity has the potential to actively promote wellbeing through how it is delivered; for example, by ensuring it is also promoting a sense of safety, calm, self- and/or community efficacy, connectedness, and hope in every action (Hobfall *et al.* 2007).

The sociocultural aspects of mental health, psychosocial wellbeing, and care must be carefully considered. Understandings of distress and disorder differ across contexts, usually spanning spiritual, social, psychological and/or biomedical frameworks, and this can govern which interventions are acceptable and effective. This needs to be carefully understood by those wishing to intervene. Local structures form the fabric of community-based psychosocial support and must not be overlooked or undermined by 'new' response

activities, but rather engaged as potential contextually appropriate channels of care.

More generally, humanitarian responders must look beyond the biomedical lens in order to minimise the damage caused by disaster and to ensure successful interventions across global health programmes. There is a need to understand the values and cultural customs of others, as well as to understand our own. Specifically, we should consider how biomedicine is, in itself, a 'culture' and not infallible. As shown by the Ebola outbreak, values and cultural customs are deeply held, even when they do not seem to 'make sense'; yet at the same time, humans are inherently flexible and will adapt their actions with new information. Working with, and not against, such dynamics is fruitful and will create stronger health systems.

Further reading

Hobfall, S.E. *et al.* (2007) '[Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence](#)'. *Psychiatry* 70.4: 285–315

IASC (2015) '[Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks. A Guide for Public Health Programme Planners](#)', Geneva: Inter-Agency Standing Committee

Jones, T.E. *et al.* (2018) '[Rebuilding People-Centred Maternal Health Services in Post-Ebola Liberia Through Participatory Action Research](#)', *Global Public Health* 13.11: 1650–69

Miller, L. (2016) 'Whenever Light Enters Darkness, the Places Becomes Bright', Evaluation of IRC support of the restoration of health services at Redemption Hospital, Monrovia: International Rescue Committee

About

The Social Science in Humanitarian Action Platform (SSHAP) aims to establish networks of social scientists with regional and subject expertise to rapidly provide insight, analysis and advice, tailored to demand and in accessible forms, to better design and implement emergency responses. SSHAP is a partnership between the Institute of Development Studies (IDS), the London School of Hygiene and Tropical Medicine (LSHTM), Anthrologica and UNICEF Communication for Development (C4D).



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Credits

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