Liberia was highly vulnerable to a health crisis even before the Ebola outbreak of 2014–2016. It had a weak health system, a lack of healthcare infrastructure, few drugs or trained personnel, and very poor water, sanitation and hygiene. Ignorance of the disease and deeply entrenched cultural practices around care for the sick and burials helped Ebola to spread rapidly, and thousands of people died. It soon became a complex emergency as businesses and borders closed, food production floundered and livelihoods deteriorated.

We had been working in Liberia since 1996 through two partners: The Association of Evangelicals of Liberia (AEL), an interdenominational fellowship, and a Christian NGO called EQUIP. Their experience and reach meant they were able to start emergency work very quickly, even before large-scale funding started coming through our Liberia emergency appeal.

After an initial response focusing on meeting immediate needs and reducing people's pain and suffering, AEL and EQUIP started work on spreading information about Ebola through radio, TV shows, village meetings and house-to-house visits. They recognised that faith leaders were key to behaviour change – not least because they were sometimes part of the problem.

At this point, several churches were suggesting Ebola was a punishment from God, fuelling fatalism and trauma; some leaders were contributing to the spread of the disease, unwittingly, by laying hands on people for healing.

Tearfund worked with Christian and Muslim leaders in Liberia to change harmful beliefs and practices to help control the Ebola crisis.

WORKING WITH FAITH LEADERS TO HALT AN EPIDEMIC

CHANGING ATTITUDES AND BEHAVIOURS IN LIBERIA
Many believed that if the dead were not buried or mourned properly, they would not pass peacefully to the next life.

AEL and EQUIP decided to give training to 200 religious leaders on the causes of Ebola and how it was spread, encouraging them to pass on this information from the pulpit. This proved hugely effective: whereas people were often sceptical of official government information, they were trusting of faith leaders, who delivered messages in a culturally appropriate way. As one government worker in Bo district in Sierra Leone acknowledged during the same Ebola outbreak, ‘Faith leaders have reach into every part of the country and they are highly trusted by community members.’

When faith leaders spoke, people listened and changed their behaviour. This was a significant factor in bringing Ebola under control. Faith leaders also used their sermons to tackle stigma around Ebola-affected families, which also proved an important bolster to people’s emotional well-being.

An evaluation team heard how people valued regular visits from these trained faith leaders, who they felt showed compassion and restored their hope.

AEL and EQUIP paid salaries and training allowances to religious leaders to carry out health education, trauma counselling and psycho-social support during the crisis. If they continue this work without payment and see it as part of their wider service to their congregations and communities, the sustainability of this approach will be substantial.