A Call to Impact and Solidarity in the Wake of Ebola

Accompanying Catholic Health Networks and Supporting Resiliency in West Africa

October 2015

A FADICA Report

EXECUTIVE SUMMARY

This report, ***A Call to Impact and Solidarity in the Wake of Ebola,*** was commissioned by FADICA's International Affinity Group and is intended as a resource for FADICA members, philanthropists, and leaders interested in accompanying the Catholic Church in West Africa as it recovers and rebuilds its health networks in the devastating wake of the Ebola crisis. The report provides an overview of the Ebola crisis and the international response in the three countries hardest hit by Ebola, and describes a Catholic approach to resiliency. It argues that Catholic health networks — as part of the faith-based health systems comprising up to a third of health care delivery in these West African nations — are uniquely equipped to contribute to the ongoing response and rebuilding effort, and critical to community resiliency. Most importantly, it identifies three key gaps and opportunities for action in alignment with the Holy See's Ebola response and rebuilding initiative. This report calls for solidarity with this Vatican special initiative to: **support Catholic health networks as they rebuild; strengthen psychosocial and pastoral care; and encourage collaboration and partnerships**.

The report is the result of four months of research and literature review from scholarly and grassroots sources, as well as daily media updates. It has been enriched, foremost, by the unique voices of leading experts with unparalleled experiences and insight into the Ebola Virus Disease (EVD) crisis, the countries it has affected, and the Catholic response in the midst of the tragedy.

A. KEY THEMES AND LESSONS

It began quietly in December 2013, unidentified until the following March. But in early 2014, Ebola spread in ways never witnessed before, mercilessly killing hundreds — soon thousands — and bringing overwhelming chaos and despair to West Africa. Then, on August 7, 2014, the World Health Organization (WHO) caught worldwide attention when its emergency committee voted unanimously to categorize the 2014 Ebola epidemic as a public health emergency of international concern.

This report identifies several key themes or lessons learned:

The devastation of the Ebola crisis is shocking and unprecedented, and is mostly the product of preexisting, systemic vulnerabilities. The toll of the Ebola crisis is far-reaching and long-lasting. WHO reports indicate that, as of September 9, 2015, the virus infected 28,183 people and was responsible for 11,306 deaths.[1] Beyond its immediate toll on these individuals, the crisis has had a clear and notable impact on nearly every corner of the three most affected countries. It not only jeopardized health systems, but also caused various, destructive sociocultural and socioeconomic consequences. The crisis exacerbated, and was also fanned by, preexisting vulnerabilities, including high levels of income poverty, low access and quality of essential services and infrastructure, and health facilities that lacked sufficient staff, physical resources and effective Infection, Prevention and Control (IPC) mechanisms. The consumption of 'bush meat' was also a significant vector for Ebola. Sociocultural factors, including unmonitored and

[1] http://apps.who.int/ebola/current-situation/ebola-situation-report-9-september-2015

open borders and unsafe burial practices, enabled rapid and widespread transmission of the virus, and local distrust of governments made the outbreaks harder to contain.

International actors responded to the Ebola crisis with significant delays and for most of the crisis had to focus on urgent short-term priorities, rather than long-term, systemic vulnerabilities. Although international actors have responded to the crisis with nearly eight billion dollars in relief, the slow international response did not significantly reduce the intensity and speed of the Ebola epidemic until several months after it began. Even though the Ebola crisis is now receding, international funding was prioritized toward response to immediate challenges, including through Ebola Treatment Units (ETUs), burial teams and emergency supplies. While the majority of the ETU's have been decommissioned and US Government funding has now shifted to health system strengthening, systemic weaknesses and lack of capacity will be a long-term challenge across health systems.

Health system strengthening is essential, and Catholic health networks have room to further leverage their unique position and value in Ebola-affected communities to address gaps, opportunities and needs. Catholic stakeholders on the ground in Liberia, Sierra Leone and Guinea have an undeniably distinct position in the three countries primarily affected by Ebola. Catholic institutions serve as indelible centers of hope for local people, since they have a demonstrable presence before, during and after various crises, provide health and pastoral care, and support community engagement. As a result, the Catholic Church enjoys unique integration with and the trust of local communities. During the crisis, Catholic institutions and actors put these strengths to good use within formal health facilities and by conducting awareness-raising campaigns, engaging rural areas, and accompanying affected individuals and families.

B. KEY RECOMMENDATIONS

This report makes several recommendations for ways in which Catholic stakeholders can further strengthen Catholic health networks and support future resiliency:

1. Catholic health facilities need rebuilding and increased capacity. Catholic hospitals and clinics faced several pre-existing challenges, which the Ebola crisis only complicated. Critical capacity gaps include the need for more long-term health workers, including community health workers, especially from within local communities, as well as training systems and materials that prepare both new and existing personnel for health needs and precautions. Catholic hospitals and clinics often still lack running water and electrical systems, in addition to stable supply chains for medicines and health equipment. Mechanisms for monitoring, evaluation, and quality assurance are also needed in order to ensure Catholic facilities have adequate and effective personnel, physical resources and high quality care outcomes in the future. These quality assurance checks could help prevent replication and repeated investment in unsuccessful and unsustainable health programs of limited duration and scope.

2. Psychosocial and pastoral care demand further attention and action. Tens of thousands of people have been left mentally and socially vulnerable by the Ebola crisis, including those orphaned by the crisis and surviving family members. The Ebola outbreak demonstrated the critical need for a social work infrastructure, particularly as the system strained to meet the needs

of newly orphaned children as well as children who had to undergo quarantines and eventual family tracing, reunification and reintegration. The Catholic Church's holistic approach to healthcare makes it uniquely positioned to provide trauma support and combat the effects of stigmatization and marginalization. While some Catholic organizations and other international actors have already created psychosocial counseling and pastoral care training programs, more programs are needed to reach more people. Additionally, some training manuals of existing programs could benefit from revisions that include greater consideration of the emotional and spiritual concerns of local communities. The Church also has been essential in reaching out to remote and isolated communities, as well as orphans and other children made vulnerable by Ebola. Catholic actors need support to expand psychosocial and pastoral services, trainings, and general capacity, and to further expand their critical outreach in these areas.

3. Collaboration and partnerships both within and outside of the Church can enhance the sustainability and impact of Catholic health networks. Catholic stakeholders often provided overlapping and duplicate services during the Church's Ebola response, typically due to a lack of communication and collaboration between dioceses and parishes. Additionally, while corruption and slow pace of some local governments are admittedly causes for concern, greater collaboration between Catholic health networks and local governments eventually might offer more sustainable opportunities for funding than external donors and patient fees currently provide. Finally, Catholic health networks have an opportunity to demonstrate their utility to international governmental, multi-lateral, and non-governmental donors and technical assistance providers through evidence-based advocacy. Currently, Catholic actors are frequently overlooked by international partners, who instead tend to fund national and local governments and secular NGOs operating at national and/or local levels. Demonstrating and proving Catholics' unique role in West African health systems could lead to increased monetary support and heightened potential for partnerships.

C. OPPORTUNITY FOR IMPACT

This report emphasizes that *now* is the necessary and appropriate time to take measures to effectively and efficiently cultivate long-term resiliency. Until health systems, including Catholic health networks and pastoral systems, are supported to be fully resilient, these three countries and our global community remain as vulnerable as ever to future health crises, including large scale traumatic outbreaks. The crisis and its aftermath are far from over, and the involvement of Catholic philanthropists is needed now more than ever, especially as the media focus and public interest moves elsewhere. It is the authors' hope that Catholic philanthropists and other stakeholders are inspired to action by this report.

In response to this report's findings, an associated impact plan proposes a special FADICA initiative in solidarity and alignment with the Holy See's response to Ebola, focused directly on the report's three recommended areas. FADICA's International Philanthropy Member Affinity Group Anchor, Dr. Maria Robinson, will be a lead facilitator of this project, along with another representative of the Affinity Group. [Interested FADICA members and others interested in this initiative can contact Alexia Kelley, FADICA President, at 202/223-3550 or akelley@fadica.org.]

INTRODUCTION

A. OVERVIEW

It began quietly in December 2013, unidentified until the following March. But in early 2014, Ebola spread in ways never witnessed before, mercilessly killing hundreds — soon thousands — and bringing overwhelming chaos and despair to West Africa. Then, on August 7, 2014, the World Health Organization (WHO) caught worldwide attention when its emergency committee voted unanimously to categorize the 2014 Ebola epidemic as a public health emergency of international concern.

By then, over 1,600 people, primarily in Liberia, Sierra Leone and Guinea, had been infected with Ebola. More than half of the documented cases had proven fatal, but the crisis had not yet hit its peak. Just four months later, by official WHO counts, the virus was responsible for the deaths of more than 7,800 of the 20,000 infected.

Although nearly 11,300[2] people have died during this epidemic, the number of confirmed Ebola cases in West Africa has dropped significantly, remaining below one hundred since early January 2015. In May 2015, in one of the clearest displays of the epidemic's decline, Liberia became Ebola-free after 42 consecutive days without a new infection. Its streak broke in late June 2015 with six new cases, including two deaths, but it was again officially declared Ebola-free on September 3, 2015, after two consecutive incubation periods passed with no new identified cases[3]. While Sierra Leone and Guinea have not yet been able to achieve the same benchmark — as of September 9, 2015, there were two new confirmed cases of infection, one in each country[4] — controlling the Ebola crisis no longer seems impossible.

At the same time, experts warn of the "risk of unrealistic expectations"[5] that Ebola can be completely eradicated, particularly in the face of prevailing and pervasive challenges in the region. Moreover, in the aftermath of the epidemic, it became increasingly evident that rebuilding efforts would face enormous challenges, with unforeseen implications for years to come.

Besides the estimated 27,000 people who have experienced the virus firsthand through infection, millions of others, living in different corners of West Africa, have felt the brunt of the disaster in multiple ways. Unemployment has spiked, poverty has worsened, and many schools have only recently reopened — adversely impacting socioeconomic conditions.

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[2] As of October 3, 2015 per CDC Ebola Case Counts: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html
[3] http://wwwnc.cdc.gov/travel/notices/watch/ebola-liberia
[4] http://apps.who.int/ebola/current-situation/ebola-situation-report-9-september-2015
[5] http://uk.reuters.com/article/2015/08/04/us-health-ebola-who-idUKKCN0Q91JM20150804

Ebola has also had a profound impact on social structures in Liberia, Sierra Leone or Guinea. Survivors and their families frequently face marginalization and severe discrimination, even months after being found free of infection. Families have been broken and displaced, and an estimated 16,600 children across the region have lost at least one parent as a result of the disease. Entire communities have been traumatized and broken, with many people psychologically, socially, emotionally and spiritually scarred from their own infection or the deaths of loved ones. Already vulnerable before Ebola struck, health systems in these nations are now even more of a pressing concern, far less equipped to handle day-to-day health needs, much less future health crises. Numerous and grave before the epidemic, gaps in health infrastructure within the three countries have widened substantially. The virus taxed these systems of their already limited resources, shuttering hospitals and claiming the lives of many health workers, thereby adding to the long list of the deceased. Patients seeking medical care for commonly treatable causes died due to inattention as government health facilities closed for months.

The notable health system vulnerabilities in which the Ebola crisis spread have thus led experts to evaluate the Ebola outbreak as a "window" to the real health crisis. The toll from the lethal virus has been fanned by pervasive and systemic weaknesses in the three most affected countries' health systems, heightening attention toward efforts to rebuild and strengthen them. Moreover, the international community now has both an acute awareness of the global risks from such epidemics and an understanding that the stakes are shared by all.

This report stems from the awareness that Catholic health networks, to date, have not received the attention they warrant as vital players in West African health systems. The importance of strengthening Catholic health care institutions, which — together with other trusted faith-based health institutions — comprise up to one third of health care delivery in the three countries, cannot be overstated. Catholic hospitals, clinics and health centers, as well as pastoral health programs play a critical role in the region and in the management and prevention of future crises. This report argues that Catholic health networks are uniquely equipped to address overarching gaps and needs in several, dynamic ways.

In order to identify how Catholic agencies are best positioned to strengthen health system resiliency, this report identifies key gaps, opportunities and needs in Catholic health networks and strategies, including in psychosocial and pastoral care. The potential of Catholic health systems is analyzed here in the context of the impact of faith-based health infrastructures – both local and transnational. A July 2015 edition of *The Lancet*[6] focused precisely on the value of faith-based healthcare, exploring the solutions these systems can provide when engaged as full partners in strengthening health and community systems.

Observations in this report are presented in consideration of the different international actors operating in the region and the investments and contributions already made. Over the past year, international and humanitarian aid sources have allocated significant resources and leadership to rebuild damaged health systems and communities in the wake of the Ebola crisis. The response of the Catholic community has included the important leadership of the Pontifical Council for Justice and Peace, which developed a comprehensive Church response, and that of Caritas Internationalis, Catholic Relief Services (one of the two USA-based members of Caritas

[6] http://www.thelancet.com/series/faith-based-health-care

Internationalis), and many other international and local entities that committed resources and led specific efforts as part of the overall global response to the Ebola Epidemic in West Africa.

These organizations have had tremendous impact in responding to the crisis — for example, by aiding the creation of safe and dignified burial guidelines adopted by the WHO. However, great needs remain. It is critically important to emphasize that many Catholic health institutions and pastoral care programs remain severely compromised due to health worker deaths and resource shortages caused by the crisis. In addition, Catholic health systems are not reliably supported by government resources, which tend to be distributed through the national health ministries and other government departments.

B. DEFINITION OF TERMS

For the purposes of this report, **health system resiliency** refers to the capability of health systems to (1) effectively prevent or respond to unforeseen health crises and (2) consistently address day-to-day health needs, even during these unforeseen crises. “Building health system resiliency” and “health system strengthening” have been frequently characterized as empty buzz phrases because their use often assumes that health systems were wholly intact preceding the Ebola crisis. Most of the gaps, opportunities and needs overwhelmingly present in Liberian, Sierra Leonean and Guinean health systems, existed in some form before the Ebola crisis began. To inspire future resiliency, actors must be willing to acknowledge both past and present situations and solve vulnerabilities that existed before the crisis.

This report frequently makes reference to the contributions and unique potential of **Catholic health networks** in the context of building health system resiliency in West Africa. The term “Catholic health networks” includes, not only Catholic organizations, institutions and infrastructures that provide health services and care, but also less recognized Catholic entities and leaders. These include Catholic facilities, local lay and religious groups, the Catholic Church hierarchy, clergy, and religious congregations, and grassroots health efforts led by parishes and dioceses.

We reference gaps, opportunities and needs in psychosocial and pastoral care, as well as achievements in community engagement. **Psychosocial care** includes measures designed to treat mental, spiritual and emotional trauma and the effects of stigmatization and marginalization that occur following infection. Psychosocial care refers to support administered both in informal or pastoral settings, such as churches, and in professional settings, such as hospitals and clinics. This report acknowledges that psychosocial care in each context is both productive and necessary to regional wellbeing.

Additionally, although pastoral care and community engagement both involve interactions with people on the ground, the terms, as used in the report, refer to two distinct concepts. **Pastoral care** refers to the direct provision of emotional and spiritual support, especially by religious leaders, within a community. Meanwhile, **community engagement** includes strategies and movements that provide timely and necessary information to local communities in an attempt to promote changes in behavior. The latter term primarily refers to information and awareness

campaigns about the Ebola virus to educate people about the existence, symptoms, and prevention of the disease.

Although we have tried to define these terms separately, they sometimes overlap due to shared characteristics. For example, the design and implementation of safe and dignified burial practices involves psychosocial and pastoral care, as well as community engagement.

C. SCOPE AND LIMITATIONS

The research for this report, focused specifically on the three countries most affected by the Ebola crisis, acknowledges some of the most pressing needs in these nations. The international response has varied, ranging from region-wide concerns to financial contributions on a specific, country-by-country basis. For instance, Liberia has received significantly more resources from the United States government, the primary emergency relief donor in the Ebola crisis, while the government of the United Kingdom has concentrated much of its support on the Ebola response in Sierra Leone.

This report highlights the similarities and interconnectedness of Liberia, Sierra Leone and Guinea by often talking about them collectively, as a region. Their porous borders and similarly weak economies, vulnerable health systems and high poverty levels connect their stories. However, there are significant differences and distinct qualities of each nation in the region, with respect to their individual history, languages, religions, culture, geography, government and organizational structure, and capacity. While we acknowledge the considerable national distinctions, due to limitations in space and time we have utilized a regional approach to this report.

The different characteristics of each country must be properly identified and considered at each step of strategic health system strengthening, including planning, implementation and re-evaluation. However, the three countries share one very important reality: their post-Ebola needs are vast and significant.

While this report seeks to offer a comprehensive look at the gaps, opportunities and needs within West African health systems that Catholic actors are uniquely positioned to address, the conclusions reached here are not exhaustive or absolute. In an effort to produce a timely and useful report, researchers spent several months consulting experts and literary resources that describe the situations in Liberia, Sierra Leone and Guinea and the current and future potential of Catholic health networks. However, given the time constraints of this report and the complexity of the conditions on the ground, we recommend further, continuous examination and consideration of both the status of West African health systems and the ways in which Catholic actors can make unique, lasting contributions in order to strengthen them.

D. METHODOLOGY

To produce this report, researchers primarily interviewed key stakeholders familiar with existing health conditions in each of the three countries, especially within the context of Catholic systems. The list of consulted sources includes scholars familiar with global health and development, representatives of key national governmental and international entities, lead Catholic actors and investors, Catholic relief and health practitioners, and FADICA affinity group members who are active in or familiar with the region. Frequently, sources graciously provided documents that better informed the research for this report.

Interviews were complemented by several months of research and review of existing literature. These sources covered subjects related to Liberia, Sierra Leone and Guinea, especially their health systems, the general international response to the Ebola crisis, the unique value of Catholic and other faith-based organizations' responses, and the countless needs in the aftermath of the outbreak. Daily news reports informed the research considerably.

Research for this report concluded on August 31, 2015.

CONTEXT AND OVERVIEW OF THE EBOLA CRISIS

A. PREEXISTING VULNERABILITIES

Vulnerabilities in the health system infrastructures of Liberia, Sierra Leone and Guinea existed prior to the 2014 Ebola epidemic. The systemic weaknesses allowed the disease to engulf the three countries just a few months after the outbreak's initial spark.

Even before the crisis, health facilities in all three countries had substantial difficulties securing both adequate staff and available supply chains to get necessary resources. Hospitals and clinics, especially free, public ones, lacked sufficient medical personnel on hand. Liberia had 0.01 physicians per 1,000 people in 2008; Sierra Leone had 0.02 physicians per 1,000 people in 2010; and Guinea had 0.1 physicians per 1,000 people in 2005.[7] Comparatively, Nigeria has 0.4 physicians per 1,000 inhabitants, Morocco has 0.6.[8] In the U.S., a higher income country, the number increases to 2.4 physicians per 1,000 people.[9] When the Ebola crisis broke, especially in Liberia and Sierra Leone where cases of infection grew exponentially in the fall of 2014, staffing and bed shortages became an issue of grave consequence. During the peak of the crisis, sick people waited for days to get into hospitals and clinics. Consequently, many either saw their symptoms worsen or died while waiting for treatment they never received.

Hospitals and clinics also lacked consistent access to resources essential for their operation. These resources included not only medications, but also water and electricity, taken for granted

[7] https://www.cia.gov/library/publications/the-world-factbook/fields/2226.html
[8] http://data.worldbank.org/indicator/SH.MED.PHYS.ZS
[9] Ibid.

in many developed health systems. By the time the crisis hit, medical facilities — including those operated by Catholics — still did not have stable supply chains to receive equipment, medicines and Personal Protective Equipment (PPE). As soon as doctors began treating cases of Ebola, PPE became necessary for preventing the spread of Ebola from patients to medical personnel. Sister Barbara Brillant, the National Catholic Health Council (NCHC) coordinator for Liberia, said that in the absence of PPE in the early days of the crisis, medical staff were forced to wear raincoats — an ineffective barrier against the disease.

Additionally, Liberia, Sierra Leone and Guinea had negligible mental health infrastructures. Even though people within all three countries faced serious psychosocial problems, especially those resulting from the trauma of infection or the loss of loved ones, few trained mental health specialists were available to assist them. A 2012 WHO analysis of mental health in Sierra Leone found that although 715,000 people in the country suffered from mental health disorders, only 2,000 had received treatment.[10] Sierra Leone and Liberia each have only one practicing psychiatrist, a handful of mental health nurses, and a mere hundred trained "paraprofessionals" to assist a population of 6 million and 4.69 million, respectively.[11] The relative absence of psychosocial health systems further compounded the effects of the crisis, leaving tens of thousands of mental health and trauma patients untreated (from orphans to health workers) with few initiatives in place to modify this trend.

Health systems in the three primarily affected countries were also missing quality control mechanisms to ensure medical facilities and the services they provided were both adequate and effective. Facilities often lacked appropriate Infection, Prevention and Control (IPC) systems, exacerbating vulnerabilities facing health workers. Moreover, in the early days, IPC measures were ineffective due to poor or absent case tracing mechanisms. Widespread distrust of local governments and governing structures, fueled by violent civil wars and human rights abuses further complicated contact tracing, as individuals misreported to authorities about their exposure to Ebola. Lack of confidence in public institutions also convinced people to believe myths and spread misinformation about the virus, and as many avoided seeking potentially life-saving care, IPC structures were severely threatened.

Further, experts have noted various sociocultural factors, external to health systems but further debilitating them, which created a regional environment that was highly susceptible to a quickly moving, multinational epidemic. First, the open, typically unmonitored borders between the neighboring countries of Liberia, Sierra Leone and Guinea enabled individuals to unintentionally carry the disease country to country, thereby widening the area that required a response. Additionally, traditional funeral practices across the region involve close and unmitigated physical contact with the body of the deceased, which includes washing, dressing and sometimes kissing. Because Ebola spreads through physical contact, these cultural practices made containment of the disease especially difficult.

[10] http://www.who.int/mental_health/policy/country/sierra_leone_country_summary_2012.pdf (p. 3)
[11] http://jama.jamanetwork.com/article.aspx?articleid=2086725

B. OVERVIEW OF THE CRISIS

Experts now widely believe that the 2014 Ebola crisis began in a small, rural village in Guinea in December 2013. The early days of the epidemic are largely undocumented and unclear because cases of Ebola were not officially recognized until March 2014. By the time the three governments began recognizing and reporting cases of Ebola to the WHO in March 2014, Ebola had crossed regional borders and spread widely.

Although the Ebola crisis went unidentified for several months and the total number of reported cases did not exceed 500 until early June 2014,[12] the situation soon became widespread and reached emergency levels in Liberia, Sierra Leone and Guinea. By mid-July, the total number of reported cases had climbed to over 1,000.[13] In late October, the crisis escalated to an unprecedented rate of acceleration. In only four days between October 25 and 29, the total reported cases of infection jumped from 1,553 to 1,906 in Guinea; from 3,896 to 5,235 in Sierra Leone; and from 4,665 to 6,535 in Liberia.[14] Concerns were raised about the epidemic becoming global, and many countries began to prepare Ebola response mechanisms.

Overall, the World Health Organization reports that Ebola has infected 28,183 people and caused the deaths of 11,306 across Liberia, Sierra Leone and Guinea to date.[15] Although experts estimate that 17 percent of cases went unreported, the figure could be as high as 70 percent. The affected nations have felt the toll from the Ebola crisis to different extents. Of the three countries, Sierra Leone had the highest numbers of Ebola infection cases, totaling 13,683, as of September 9, 2015.[16] Though Liberia has been declared Ebola-free since September 3, 2015, the World Health Organization reports that 4,808 people died of Ebola in Liberia,[17] making this the largest number of recorded Ebola-caused deaths in any country. And while Guinea has had significantly lower rates of Ebola-related cases compared to those of Liberia and Sierra Leone, the country has experienced the longest lasting outbreak by several months, since the crisis originated there, and is still ongoing.

Each Ebola outbreak in the three countries stands on its own as unprecedented, particularly when compared to previous Ebola outbreaks, which involved, at most, a few hundred cases of infection. The largest Ebola outbreak before the current crisis had just 525 cases,[18] a fraction compared to the tens of thousands of cases witnessed over the last two years. The striking fragility and lack of capacity of health systems in the affected countries, and increased mobility at frontiers and migration into densely populated urban areas are attributed for the enormously difference between previous outbreaks and the most recent Ebola epidemic.

Yet, the World Health Organization's figures documenting the number of infections and deaths fail to represent the true extent of the toll of this crisis. In fact, experts have cast doubt on the accuracy of the numbers, as noted above. Experts primarily have pointed to problems with

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[12] http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html
[13] Ibid.
[14] Ibid.
[15] http://apps.who.int/ebola/current-situation/ebola-situation-report-9-september-2015
[16] Ibid.
[17] Ibid.
[18] http://www.who.int/mediacentre/multimedia/survivor-meeting-vpc.pdf?ua=1 (p.4)

monitoring and contact tracing systems, especially in hard-to-access rural areas without developed road systems. Additionally, during the first several months of the crisis, cases of Ebola were misreported as malaria, due to the symptomatic similarity. Third, numerous challenges arose both from local populations' preexisting suspicion of governing institutions and from widespread myths that health professionals were euthanizing those seeking medical attention at facilities. Due to pervasive fear, many people did not seek medical attention or alert anyone of their sickness or that of a family member. Similarly, the WHO acknowledges that unsafe burials often took place in secret, in effect masking the true extent of infection and death. Lastly, because the Ebola crisis strained already limited health facilities and their resources, many people died from common and easily treatable health problems, such as HIV/AIDS, malaria, tuberculosis and even physical injuries. Official death counts do not take into consideration victims who never contracted Ebola, but died from Ebola's impact. The true extent of the 2014 Ebola crisis is hard to estimate, but it is certainly higher than WHO reports indicate.

The number of active, reported cases in West Africa now hovers near zero. However, the virus has not completely disappeared. Experts from various international health organizations have warned that, until all three affected countries each have 42 consecutive days without a single case of Ebola, the crisis still has potential to flare up. This potential still exists in countries previously declared as Ebola-free — a point proven by a second outbreak in Liberia that began at the end of June 2015 without warning or explanation, despite the country being "free" of the disease just a few months earlier. In Sierra Leone also, the hope of an emerging Ebola-free period was crushed with a new death to Ebola announced on July 31st and 700 people were quarantined due to an Ebola death in September. And in Guinea, four new lab-confirmed cases were announced on July 29th. Since the Ebola Virus Disease (EVD) is endemic and it is not completely eradicable, the key priority is to strengthen health systems in order to better respond to Ebola and other emergent infectious diseases and to promote overall community health.

The extent to which health systems can be strengthened will depend on increased support from multiple sectors, as even now, it is difficult to know what the long-term effect of the epidemic will be beyond the immediate consequences. The economic impact of Ebola will affect, not only Liberia, Sierra Leone and Guinea, but potentially the entire region. Domestic income and employment were significantly lowered. According to a United Nations Development Group (UNDG) report, Guinea could face a decrease of 3.4% in its average GDP growth between 2014 and 2017, but Liberia and Sierra Leone could, respectively, see a reduction of up to 8% and 5% of the average GDP growth in the same period[19]. West Africa as a whole could lose, on average, $3.6 billion annually, as food insecurity and poverty worsen due to losses in agricultural production (abandoned farms, closed borders) and thwarted trade routes.

[19] https://undg.org/wp-content/uploads/2015/07/ebola-west-africa.pdf

THE EBOLA RESPONSE: ACTORS & ACTIONS

A. OVERVIEW OF THE INTERNATIONAL RESPONSE

Health experts and world leaders have routinely characterized the international response to the Ebola crisis as insufficient and slow. The bulk of the widespread criticism fell on organizations responsible for coordinating monitoring and health responses — namely the World Health Organization — for not demanding the world's attention earlier. The delay of the international response largely has been attributed to the lack of well-developed monitoring systems in each country, which failed to detect the virus for several months. WHO Director-General Dr. Margaret Chan responded to criticisms, saying her organization underestimated Ebola's complexity and, as a result, the scale of the international response did not match that of the outbreaks.[20]

Once mobilized, the international response to the Ebola crisis was substantial and essential to containing the virus and many of its immediate effects. According to the World Bank, international donors have provided a total of $7.797 billion in response to the crisis.[21] Generally, actors financing the response have focused their funding on initiatives controlled by national and local governments and locally operating, non-governmental organizations (NGOs). Funding has generally gone toward meeting short-term demands, rather than to fixing long-term vulnerabilities. Because existing facilities were overwhelmed by mid- and late-2014 influxes of Ebola infections, governments focused much of their financial support on the provision of Ebola Treatment Units (ETUs) — temporary facilities and labs for Ebola treatment and testing — and on employing safe and dignified burial teams. As part of the international response, international donors provided personnel working on the front lines with necessary personal protective equipment (PPE) and other emergency supplies.

Multiple international governments, organizations and other entities have contributed to the international response to Ebola. While the list below cannot possibly highlight every actor or initiative in just a few pages, it attempts to discuss some of the most apparent and significant contributors to the response.

B. KEY ACTORS & ACTIONS

THE WORLD HEALTH ORGANIZATION & WORLD BANK

Respected worldwide as the leading expert in international health, the WHO has provided an important forum for actors to collaborate and coordinate with each other in response to the Ebola crisis. Despite the fact that the WHO waited until August 7, 2014 to label the Ebola crisis as a public health emergency of international concern, the organization began monitoring, employing contact tracing, and offering information and strategic coordination when governments first began reporting cases. Additionally, in October 2014, with the assistance and insight of faith-

[20] http://time.com/3548096/ebola-world-health-organization-margaret-chan/
[21] http://www.worldbank.org/en/topic/ebola/brief/global-ebola-response-resource-tracking

based partners, the WHO published a manual for teams to conduct culturally-sensitive, safe and dignified burials that avoided physical contact with bodies of Ebola victims, while honoring proper grieving. The WHO also produced a booklet on administering psychological first aid to people traumatized by the crisis, among numerous other best practices guides and strategic resources.

The World Bank Group has contributed $1.62 billion as of August 12, 2015, [22] making it the second largest financial contributor in the global Ebola response, just behind the United States. The group has focused primarily on stabilizing socioeconomic conditions within Liberia, Sierra Leone and Guinea, by alleviating poverty and addressing food shortages. To address the loss of an estimated $1.6 billion in foregone economic growth in 2015,[23] the World Bank now has separate frameworks for funding in Sierra Leone through fiscal year 2016 and in Liberia and Guinea through fiscal year 2017.

THE UNITED NATIONS AND RELATED BODIES

Meanwhile, the United Nations (UN) has functioned as a hub for collaboration and fundraising for the international response. To illustrate this function, in July 2015, international governments gathered for a meeting at the UN to pledge $3.4 billion in future support to the governments of Liberia, Sierra Leone and Guinea, surpassing the $3.2 billion requested for long-term development. Additionally, UN members created the UN Mission for Ebola Emergency Response (UNMEER) specifically in order to coordinate the Ebola response in the absence of swift, substantial action by the WHO. Established on September 2014, UNMEER was formally dissolved on July 31, 2015 after providing case management, contact tracing, safe and dignified burials and social mobilization, and achieving its goal of mobilizing response on the ground.

Other UN bodies have also provided services as part of the Ebola response. The United Nations Children's Fund (UNICEF) has provided essential care for children. It has monitored and cared for children orphaned by Ebola or otherwise left vulnerable, and has worked to integrate children who lost both parents into new households. Among its numerous achievements during the crisis, UNICEF worked with partners to find, by February 2015, new homes for all 773 children in Guinea who had lost both of their parents to Ebola.[24]

The UN World Food Programme (WFP) has provided substantial food supplies in areas where the Ebola crisis otherwise jeopardized access to food. By July 2015, the WFP received $329 million for its Ebola response and distributed food to three million people affected by Ebola, especially 800,000 people living in Ebola hotspots.[25] In addition, the WFP has aided 15,000 orphans and their foster families and housed critical medical supplies used in the on-the-ground medical response.

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[22] Ibid.
[23] http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet
[24] http://www.unicef.org/media/media_79742.html
[25] https://www.wfp.org/emergencies/ebola

WORLD GOVERNMENTS

As the single largest international contributor to the Ebola response, the United States government, as of August 14, 2015,[26] has spent over $1.9 billion, on the Ebola response through its Agency for International Development (USAID), the Department of Defense (DOD) and the Center for Disease Control and Prevention (CDC).[27] According to the World Bank, over $1 billion of U.S. government funding has now gone to Liberia.[28] This focus on Liberia is likely due to the close historical and sociopolitical ties between the two countries, including the U.S.'s critical role in Liberia's colonial and post-colonial development. Across affected West African countries, the U.S. government has committed funds to nearly every aspect of the Ebola health response through various — but selectively chosen — international organizations, NGOs and faith-based organizations operating on the ground. Of note, USAID, through the Office of Foreign Disaster Assistance, also granted $5,550,687 to Catholic Relief Services (CRS), as part of its humanitarian assistance to the three most affected nations, with a special concentration in Guinea.[29]

The British government has also contributed a substantial amount of money to the international response, especially within Sierra Leone, where, even before the Ebola crisis, it influenced colonial and post-colonial development. Of the more than $687 million the United Kingdom has committed to the Ebola response, $324 million has gone to Sierra Leone, while $362 million has been in the form of non-country-specific pledges.[30] Like the U.S., the U.K. has contributed money toward a wide array of immediate needs.

NON-GOVERNMENTAL AND FAITH-BASED ORGANIZATIONS

NGOs, operating on a local level, have also played a central role in the international Ebola response. Doctors Without Borders/Médecins Sans Frontières (MSF) is credited as being one of the first responders to the crisis, with MSF personnel opening and operating some of the earliest facilities specifically constructed to treat Ebola patients across the three affected countries. However, this contribution also resulted in a toll on personnel. As of early 2015, 28 MSF personnel had been infected with the virus and 14 had passed away.[31]

Among other NGOs, member organizations of the International Federation of Red Cross and Crescent Societies (IFRC) — including the American Red Cross — have provided essential services in the three most affected countries. The IFRC has primarily helped conduct safe and dignified burials, deliver community education campaigns and monitor cases. It has also provided psychosocial support using the psychological first aid manual published by the WHO.

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[26] https://www.usaid.gov/sites/default/files/documents/1864/08.14.15%20-%20USG%20West%20Africa%20Ebola%20Outbreak%20Fact%20Sheet%20%2343%20%281%29.pdf
[27] Ibid.
[28] http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/8/511531439474123847/World-Banks-Global-Ebola-Response-Resource-Tracking-as-of-08-12-15.pdf
[29] https://www.usaid.gov/sites/default/files/documents/1864/08.14.15%20-%20USG%20West%20Africa%20Ebola%20Outbreak%20Fact%20Sheet%20%2343%20%281%29.pdf
[30] http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/8/511531439474123847/World-Banks-Global-Ebola-Response-Resource-Tracking-as-of-08-12-15.pdf
[31] http://www.msf.org.uk/sites/uk/files/ebola_-_pushed_to_the_limit_and_beyond.pdf

Finally, faith-based organizations (FBOs), including Catholic entities, have provided essential services in the wake of the crisis. Although Catholic Relief Services is the only Catholic organization responding to Ebola that has received financial support from the U.S. government, many other Catholic actors have also responded. The individual efforts and contributions of Catholic organizations and the overall Catholic response to the Ebola crisis are specifically discussed in the next section, *The Catholic Approach to Building Resiliency*. Other FBOs — including Christian organizations like Medical Teams International, Samaritan's Purse, Christian Aid, Medair and World Vision — have also provided Ebola-related assistance in the region and have each received funding for their initiatives from the U.S. government.[32]

THE CATHOLIC APPROACH TO BUILDING RESILIENCY

A. OVERVIEW

Catholic and other faith-based actors add distinct value to health systems and infrastructure in two key ways: first, the construction of local systems and networks, and, second, the mobilization of these networks, which include not only health providers but the Church, its parishes and orders. The construction of local networks makes healthcare services available within communities; and network mobilization activates the power of the relationships forged through that presence. Embedded in these two critical activities is the unique commitment of Catholic organizations and other faith-based actors to a holistic, integral approach to healthcare, which places as much emphasis on attending to physical needs as it does to alleviating emotional and spiritual suffering.

Of particular importance to Catholic health delivery is the Church's rich tradition of accompanying the sick and vulnerable, especially in times of trial. Although there are many shared convictions and principles of spiritual healing and care amongst multiple religious health actors on the ground, this report specifically examines the Catholic approach to building resiliency, within the larger framework of faith-based health systems. Though it is by no means exclusive to Catholic healthcare, this section provides evidence-based arguments for why — and how — Catholic networks and facilities have proven their pivotal role not only in offering emergency and humanitarian relief to Ebola victims and their families, but also in strengthening health systems and building resiliency in Ebola-affected nations.

Yet, Catholic healthcare, as part of the broader health systems, remains an underutilized asset in the international effort to rebuild and strengthen. As the role of faith-based health networks becomes increasingly recognized for its critical importance within local communities, both during and beyond times of crisis, Catholic organizations are faced with significant new

[32] http://repository.berkleycenter.georgetown.edu/141008BCWFDDResponseEbolaMappingReligiousNetworksFIOs.pdf

opportunities to leverage their presence and mobilize human and other resources as unique and critical actors in the field.

The list of Catholic contributors in this section, though not exhaustive, reflects the multifaceted, tireless mission of the universal Church on the ground, through various dioceses, archdioceses, parishes and congregations of religious sisters and brothers, as well as local, national, and international Catholic organizations. The examples presented reflect the strategy laid out in the Special Initiative of the Holy See — providing emergency and humanitarian relief through established networks, offering psychosocial support and pastoral care, and mobilizing a community through existing and trusted health and social networks.

B. THE CATHOLIC RESPONSE

PRESENCE, ACCESS AND DELIVERY OF HEALTH FACILITIES AND SERVICES

The principle of compassion, inseparable from faith organizations, has been widely recognized as a powerful force in planting strong roots for quality relationships in communities. Here, the Church serves as a force of hope that maintains a consistent presence, even in challenging circumstances. Besides providing health care at low cost, motivated as they are by faith and mercy rather than profit and business, Catholic organizations have traditionally provided vital financial resources that many local institutions lack. In this sense, faith-based health networks are present in communities before, during and after environmental, man-made and health crises. They also make up very significant portions of the health sectors in developing countries. Conservative estimates indicate that, in the three Ebola-affected nations, Catholic programs provide up to 30 percent of health services. The reach of their infrastructure extends beyond hospitals and clinics, with community and volunteer health workers comprising a significant part of their health workforce. This component of Catholic healthcare is particularly relevant, since it establishes a presence in marginalized communities that are often remote and hard to access, where government institutions and others do not reach.

The Catholic Church’s response to the Ebola crisis added to the efforts of the international community by providing emergency and humanitarian relief. Its active involvement in the provision of services included supporting the work of previously established Ebola Treatment Units (ETUs) by providing supplies and contributing with mutual referrals to and from ETUs. The Church became a crucial partner in supply chain management by ensuring critical emergency medical supplies, including rehydration solution, and delivering these transparently and efficiently. It was fundamental in equipping Catholic hospitals and clinics with capable staff, Personal Protective Equipment (PPE) and essential medicines. Additionally, the Church supplied facilities with Infection, Protection and Control (IPC) tools, proper diagnosis training, medical volunteers and means of financial and technical support, as well as providing residential accommodations for international volunteers working in the ETUs. Local Catholic institutions, including dioceses, archdioceses, religious congregations and task forces, made essential contributions to the emergency response. National and international organizations — such as Catholic Relief Services (CRS), CAFOD, CORDAID, and other national member organizations

of Caritas Internationalis; as well as Misereor, Healey International Relief Fund (HIRF), Catholic Medical Mission Board (CMMB) — all helped to mobilize material and human resources during the crisis. Members of the Catholic Health Association of the USA (CHA-USA) also shipped materials through partners, provided technical resources and mobilized Catholic networks and health systems abroad and on the ground to inform people and bring them to action.

Catholic and other faith-based health networks had a particularly significant impact in ensuring that basic health systems were in place to address local needs, including by equipping maternity and pediatric wards and by attending to other non-Ebola related emergencies and diseases. Ultimately, the Catholic Church had tremendous influence in alleviating the pressure Ebola exerted on health facilities. In Liberia, for example, the National Catholic Health Council (NCHC), as part of the Catholic Church Ebola response, committed to keeping 14 of 18 Catholic health units open throughout the entire epidemic. This commitment came at a time when the majority of public clinics and hospitals were closing at alarming rates. In Sierra Leone, HIRF committed to supporting the local bishops' initiative to rebuild 40 clinics especially through funding and other technical and medical support, over time. Besides dedicating enormous resources in order to staff overrun and closed health facilities, Catholic organizations, with significant contributions and leadership from CRS national and local offices, also responded by rebuilding decimated health facilities, such as St. Joseph's Hospital in Liberia, which was forced to close for several months after the deaths of 9 of its senior health staff. The Catholic Church was also active in establishing numerous hand washing and body temperature monitoring stations, to ensure proper hygiene measures were in place. Furthermore, efforts were directed towards better equipping Catholic clinics with running water and reliable electricity. Food distribution to infected persons and families was also part of its emergency response.

The fundamental role of the Catholic Church in the wider strategy of strengthening health systems moved beyond emergency response towards a sustainable, long-term strategy. For example, CRS' plan for strengthening health systems in Liberia is built on two main pillars. The first focuses on building up and supporting human resources, by developing and thus strengthening the health workforce. It commits to increasing medical staff, providing appropriate training, ensuring the necessary equipment is present and functioning and strengthening overall financial and operational capacities. The second pillar focuses on reinforcing supply chain management systems, ensuring widespread coverage and offering innovative health programming, such as Information and Communication Technologies (ICTs) for data collection.

The critical presence of Catholic organizations and facilities in these nations, and the powerful relationships of trust and respect that arose in response to decades of development, have allowed for quick mobilization of Catholic health networks. In turn, Catholics were well positioned to serve among the first responders to the Ebola epidemic. In effect, this unique presence also lent itself to the capacity to efficiently conduct essential community outreach on prevention and other related issues, and to address psychosocial needs going forward. Its role in accompanying people through the chaos of Ebola complemented public and international organizations, who faced great challenges with accelerated staff turnovers, cultural barriers, and short-term solutions to a large-scale problem. Not only was the Church an effective mediator between health workers and patients, and a provider of essential health services; it was also an agent of change that triggered much of the behavior that helped to reverse the course of Ebola.

COMMUNITY LEADERSHIP, ENGAGEMENT, AND SOCIAL MOBILIZATION

Filling the gaps left by public and international institutions, Catholic organizations are well-positioned to engage and integrate with grassroots and local communities, leveraging the often higher levels of trust and acceptance that their longtime presence has earned. These strong and sustained community links have allowed the Church to become more culturally competent over time, as Catholics have acknowledged, understood, and familiarized themselves with local practices and beliefs. Ultimately, this cultural integration was crucial in changing the course of the Ebola crisis, when the faith-based, multisector initiative of safe and dignified burial practices was introduced into communities. The implementation of these guidelines came in the midst of widespread anguish and sorrow, both at the loss of loved ones and at the inability to demonstrate the close human contact to which they had been accustomed. For example, in July 2014, Caritas Internationalis, in collaboration with experts at the World Health Organization, produced a Guidance Note on Response to the Ebola Epidemic, focusing on health-related, socio-cultural, development, and pastoral measures to be taken; this resource was shared with its 165 national member organizations in all regions of the world as well as with other Catholic and faith-based organizations. Caritas Internationalis also was among the leading religious partners that provided expert consultation to the World Health Organization as the latter revised its Manual for conducting safe and dignified burials. The manual has been widely considered a "game-changer" in the Ebola crisis.

With compassion and mercy — but also firm professionalism and caution — religious and secular actors trained and were trained by local faith leaders in how to better reach communities with scriptural and spiritual evidence for modifying burial practices in order to prevent Ebola from spreading further. This process required accompaniment of victims and families, and was complemented by the Church's unique approach to psychosocial support and pastoral care, as well as its focus on addressing the trauma that affected everyone from health workers to orphans. One such example was the work of CAFOD (the Caritas member from England and Wales) which joined other faith-based organizations in the UK to survey the attitudes and perceptions of religious leaders in Sierra Leone and to engage them in promoting and observing the WHO Safe Burial Guidelines.

Also in this regard, the Church was active in providing capacity training for pastoral and community outreach and mobilization, particularly in the more inexperienced generations, as well as in mental health expertise through professional formation and mentoring. Caritas, CRS, local archdioceses and dioceses, and other Catholic organizations on the ground provided training manuals and counseling programs to counter trauma and other mental health impacts caused by Ebola.

For example, the Camillian Task Force (CTF) was, and continues to be, actively involved in institutionalizing a psychosocial counseling program in the Diocese of Makeni in Sierra Leone to respond to local needs. The CTF has provided training and cultural competence to future counselors to address mental health issues. After attending multiple workshops set up under this initiative, community support facilitators provide counseling, facilitation and other psychosocial support to approximately 20 families at one time. To further incentivize attendance at counseling

sessions, counselors also currently offer money to families to provide for their health and education needs.

The Church's expertise, credibility, and pastoral sensitivity also were indispensable in diminishing the effects of stigmatization and marginalization. Drawing from lessons learned with the HIV/AIDS crisis, the Church became a catalyst of behavior and attitude changes within communities, where prevailing fears about contagion had a devastating effect on survivors of Ebola. Recovered patients and other affected persons experienced "shunning" from their own communities and families, as well as discrimination in the workforce. Of particular concern is the stigma and marginalization affecting children made vulnerable by Ebola, especially those who have been orphaned — many of whom have relatives who are skeptical about reintegrating them within extended family structures. The orphan crisis has been another point of focus where the Church has leveraged its structures and credibility by offering protection and temporary care until such children could be returned to their families and/or local communities. Though massive challenges remain in this area, UNICEF estimates that 90% of children who lost both parents have now been reintegrated into new homes.[33]

Besides spiritually accompanying Ebola-infected persons, survivors and their families, as well as the general population, Catholic networks have proven effective at social mobilization by spreading timely and truthful information to dispel myths, misconceptions and rumors regarding contagion. Heightened awareness about the Ebola virus helped to reduce risky behaviors and curb the dangerous trajectory of the epidemic. Mobilized volunteer corps and community health workers became essential human resources, disseminating critical information on prevention, care and treatment. These volunteers were critical in serving at the frontlines and providing stable services to affected families, especially those in remote areas, as well as in motivating an altruistic concern for others. Catholic health networks were effective vehicles for culturally appropriate messages, which ultimately contributed to a boost in hope and morale at the community level. Many communities had previously been consumed by fear, chaos, mistrust, anger, and resentment. In areas where public and international organizations were seen with suspicion and even contempt, the Church was often better positioned to maintain and win the support of local communities for effective mobilization of community health workers.

Integrating the physical and spiritual needs of infected persons, families, survivors, health workers and many others affected by Ebola, the Catholic Church's response to the crisis in Liberia, Sierra Leone and Guinea holistically addressed both the emergency needs in health facilities and the psychosocial toll on communities. Medical treatment was supported by prayer, spiritual counseling and accompaniment, and through the administration of the sacraments, particularly the blessing of and prayer for the sick and the burying of the dead. Thus, the universal church, the most globalized institution, was deeply involved in local communities and able to alleviate suffering and despair. With a deep commitment to and tradition of family support, the Church worked to strengthen families, which in turn supports for stronger social cohesion.

Ultimately, the Church's universal call to compassion and care mobilized worldwide emergency appeals coordinated by the Vatican's Special Initiative, Caritas Internationalis, CRS and other

[33] http://www.unicef.org/media/media_79742.html

Church-based organizations. It enabled solidarity aid to those engaged in direct service of patients and their families. This distinct Catholic response made a difference locally, particularly in cementing cornerstones of long-term resilience in affected health systems. Of special consideration was the Catholic focus on psychosocial health and pastoral care. These aspects are critical but often forgotten dimensions of health care, and urgently demanded within every unit of the social fabric, from schools and homes to churches and community integrated institutions. The lack of adequate attention paid to this basic component is an area of considerable opportunity for Catholic networks to explore on the ground. This area, framed in the larger context of health systems strengthening and resilience-building, is the topic of the next section, *Looking Forward: Remaining Gaps, Opportunities & Needs for the Future*.

A final point of consideration in this section: although the critical role of the Catholic response in the Ebola epidemic and its aftermath is acknowledged and presented here in broad terms, it is by no means complete. Many more organizations and actors were and still are actively committed to planting the seeds for long-term health system resiliency. Most importantly, though, huge gaps, opportunities and needs remain.

LOOKING FORWARD: REMAINING GAPS, OPPORTUNITIES & NEEDS FOR THE FUTURE

A. OVERVIEW OF GAPS, NEEDS & OPPORTUNITIES

While extensive resources have been committed to the Ebola response, and though efforts have begun to rebuild health systems for the long-term, massive gaps remain. We argue that Catholic health systems have a unique capacity and critical role to play in ensuring resilient communities, and therefore need direct support, inclusion and integration in broader health system strengthening efforts.

Serious sociocultural and socioeconomic difficulties have resulted from the crisis, and serious deterioration of health systems is evident. The vast scale of the crisis' impact and associated suffering complicates the task of prioritizing the urgent and complex challenges ahead. However, precisely because the needs are so numerous and large, so too are the opportunities to fill gaps and create resiliency. Catholic organizations face an important, extraordinary moment to act on these opportunities by leveraging their unique strengths and potential to address some of the most pressing needs. Hence, the opportunities for action highlighted in this section are made considering Catholic health networks' special advantages and unique value in the region.

As potential donors, funders, and other actors seeking to make an impact on the ground will notice, areas of concern are vast and varied, but can be categorized into two main areas of possible action: (1) Repairing and strengthening Catholic health networks; and (2) Supporting psychosocial and pastoral care. In some cases, resources and technical support to strengthen or reinforce already existing services and programs will be necessary. In others, there will be a need to start almost from scratch. Capitalizing on the Catholic Church's rich and diverse charisms,

multiple issues can be addressed on different levels, making the Catholic response vital to the future of health systems in the Ebola-affected nations.

B. REPAIRING AND STRENGTHENING CATHOLIC HEALTH NETWORKS

REBUILDING MEDICAL FACILITIES

GAPS AND NEEDS: The intensity of the Ebola crisis devastated health networks, facilities, personnel and their general capacity to provide health services to patients. Numerous public hospitals and clinics closed their doors after being overwhelmed with people infected with Ebola. Health facility shutdowns were by no means isolated to public care centers. Some Catholic hospitals and clinics — though focused mostly on providing care for non-Ebola health problems that would not have been available otherwise — were also forced to shut down temporarily at the height of the crisis. For example, the St. John of God Brothers, operating several Catholic health facilities in Sierra Leone, had to temporarily close their hospital in Lunsar from the public in September and October 2014 after the deaths of its director, a doctor and a surgeon.[34] A similar situation occurred at St. Joseph's Hospital, operated by the same religious congregation in Monrovia, Liberia.

The lack of the Protective Personal Equipment requisite to avoid direct contact with infectious body fluids of patients, as well as inadequate training and adherence to Infection, Prevention and Control (IPC) instruction, put hundreds of health workers and their patients at risk of infection. The resulting loss of personnel was significant. An early 2015 report by Doctors Without Borders/Médecins Sans Frontières (MSF) found that approximately 500 health workers died from Ebola during the 2014-2015 epidemic.[35]

While most of the health facilities that closed during the crisis have since reopened, they face serious challenges in maintaining their existing staff. Both regular personnel and volunteers, who either survived infection or never became sick, still suffered serious problems of exhaustion and decline in their morale. The aforementioned MSF study found high turnover rates for staff members, with personnel lasting a maximum of a few weeks, rather than months.[36] Additionally, in Sierra Leone, many doctors, nurses, hospital cleaners, lab technicians and burial workers who worked in public facilities were not paid for months during the crisis. An investigative *Newsweek* report, published in May 2015, found that hundreds, if not thousands, of medical personnel had yet to receive paychecks.[37] Most felt they now had little hope of ever receiving them. Improving the situation of health workers is therefore a critical need.

To recover from personnel losses, health facilities need additional, qualified health workers. Dr. Liese, Director of the Global Health MS at Georgetown University, explained there was not enough long-term health personnel on the ground, identifying a clear problem with health networks' investment in human capital. Sarah Ju, Health System Strengthening Program

[34] http://sierraleonehsjdbcn.org/2014/10/28/ebola-virus-outbreak-in-sierra-leone/
[35] http://www.msf.org.uk/sites/uk/files/ebola_-_pushed_to_the_limit_and_beyond.pdf (p. 2)
[36] Idem, p 19.
[37] http://europe.newsweek.com/frontline-health-workers-were-sidelined-3-3bn-fight-against-ebola-327485

Manager for CRS Liberia, emphasized that local colleges graduate just 40-60 medically trained professionals each year. This number of qualified professionals is not enough for hospitals and clinics, including Catholic facilities, to simultaneously manage both future crises and prevalent health needs.

Finally, many Catholic — and public — facilities were taxed in their medical resources and saw a dramatic decrease in their capacity to provide general health services. Catholic health facilities often need more effective supply chain management to ensure they have necessary resources and medical equipment. In particular, medical resources for addressing maternal and child health, HIV/AIDS, malaria and other diseases are still constrained. Ben Parra, Executive Director of Healey International Relief Foundation (HIRF), said many Catholic hospitals and clinics in Sierra Leone do not have consistent access to electrical or waste management systems and have limited access to clean water and sanitation facilities. A CRS representative in Liberia also said that medical equipment in many Catholic hospitals was damaged during the Ebola crisis and still has not been replaced. He added that, since this is a chronic problem in Liberia, rebuilding efforts present an opportunity to replace obsolete or damaged equipment with machines that are easier to repair, and to provide training to local technicians in repair and maintenance.

For the sake of this report and related impact plan, we identify areas of focused impact to directly support Catholic health systems as they rebuild. Of course, it is critical to note that strengthening overall health systems will require a multi-faceted approach, incorporating technical assistance, training, equipment and supplies, capital infrastructure, and a plan for ensuring sustainable resources.

OPPORTUNITIES FOR ACTION: Catholic health networks have several opportunities to improve their health facilities in Liberia, Sierra Leone and Guinea, beginning with an emphasis on local medical personnel and training. Given the exhaustion, trauma and deaths of health staff from Ebola, Catholic health facilities need partners to support them in identifying and investing in additional *community health workers*. Dr. Liese argued that addressing the gap in personnel must involve elevating the local perception of the service industry, including health services. He also said health providers should hire people that will remain in these communities in the long run. Much of the volunteer staff that flocked to Liberia, Sierra Leone and Guinea came only to handle the short-term demands of the Ebola crisis. Therefore, Catholic networks have room to further invest in committed, sustainable, community health worker programs. Catholic health networks could also benefit local communities by strengthening and expanding training programs on IPC and other medical skills for both new and existing staff, integrating both medical and cultural competence skills.

Catholic health systems need support to institute mechanisms for quality assurance to guarantee the effectiveness of their personnel and training in medical facilities. A central aspect to fostering health network resiliency is enabling these systems to make changes over time if the services they provide are not working. St. Louis University Professor Beth Embry emphasized that organizations must be willing and prepared to report cases where strategies have not worked well or have failed outright. Reporting weak spots will allow Catholic networks to avoid replicating and investing in unsuccessful strategies. Georgetown University Professor Katherine Marshall likewise stated that information is the best tool FBOs have, adding that self-criticism is

necessary. Addressing any gaps or deficiencies in personnel or training must also include implementation of quality assurance systems.

ENHANCING EFFECTIVENESS AND SUSTAINABILITY

FOSTERING COOPERATION BETWEEN CATHOLIC ACTORS:

GAPS AND NEEDS: Catholic health networks faced several administrative challenges during the Ebola crisis. The epidemic highlighted the need for stronger communication in order to reduce overlap between health services provided by Catholic networks. Raskob Foundation and Catholic Medical Mission Board (CMMB) Board Member Dr. Maria Robinson noted that it is difficult to talk about a singular or unified Catholic response to the challenges created by the Ebola crisis, since needs and responses have varied. Numerous other sources reinforced Dr. Robinson's assertion about the lack of a unified response by Catholic networks. Fr. Aris Miranda, MI, of the Camillian Task Force, explained that not all parishes in the Sierra Leonean Diocese of Makeni, where he works, were mobilized during the Ebola response. Even the parishes in the diocese that responded, he added, did not do so as a unified front. By the time the Ebola crisis had plunged the community into chaos, Fr. Aris said, the diocese, which makes up more than a third of Sierra Leone, had not had a bishop for five years. As a result, the services provided by different Catholic health facilities in the area had significant overlap.

An expert focused on Sierra Leone spoke further about the challenges caused by the tensions between bishops in Sierra Leone, explaining bishops can be very protective and territorial with regard to hospitals in their dioceses. By no means has this problem been confined to Sierra Leone. Another Sierra Leone in-country Catholic health leader said the response by Catholic networks in Liberia often followed the principle that "a bishop's territory is a bishop's territory." In turn, these tensions made cooperation within Catholic health networks harder and prevented a more coordinated response.

OPPORTUNITIES FOR ACTION: More consistent communication and coordination between different entities involved in Catholic health networks, especially local dioceses and parishes, is urgently needed. If Catholic health networks hope to provide patients in their dioceses with the services they need in the future, tensions between bishops need to be reduced and communication between different moving parts of dioceses must be enhanced

One particularly interesting area of cooperation to explore between multiple partners, both on the ground as well as abroad, is the use of telemedicine for joint learning and capacity building. For Dr. Maria Robinson, the unexplored potential of this collaboration mechanism could be highly impactful and cost-efficient, and would contribute to overall efforts to provide appropriate training and avoid an overlap in resource delivery. Furthermore, telemedicine would prove a sustainable and clever method to engage local and national actors, involving parishes, universities, and health networks. Empowering locals with advanced tools and knowledge that incorporates know-how from experts globally can then foster stronger health systems on the ground, and contribute to the overall goal of cultivating resiliency.

CREATING PARTNERSHIPS WITH LOCAL AND INTERNATIONAL GOVERNMENTS:

GAPS AND NEEDS: Despite close integration with local communities and a complex understanding of local values, Catholic health networks in Liberia, Sierra Leone and Guinea have not formally integrated with local government structures and initiatives. According to Katherine Marshall, of the three countries primarily affected by Ebola, Guinea has had the least integration between Catholic health networks and public, government-backed health networks. As a result, Catholic health networks have so far received little funding from national or local governments to operate medical services and facilities. International governments have generally neglected to set aside additional funding for Catholic or other faith-based health networks. Illustrating this point, as the only Catholic organization that has received money from the U.S. government's Ebola response thus far, CRS received $7.8 million from USAID, or just 0.42% of the total $1.873 billion distributed by the U.S.[38]

Numerous experts have voiced concerns about the sustainability of locally operating Catholic health facilities and services. An article concerning the intersection between faith and health, published in the *Lancet* medical journal, notes that faith-based health care has several disadvantages, "such as inadequate or unpredictable financing, variable governance, or priorities and strategies that differ from national health systems."[39] One notable deficiency, raised by Sr. Barbara Brillant, is that Catholic health facilities often have to charge patients for care, whereas government-operated health facilities and their services are free for patients to access. In turn, Catholic health networks may be less accessible for poor people seeking care than public health facilities that provide free health services. Also, during the crisis, she noted, workers in Liberian public facilities generally received larger paychecks than did staff members in Catholic health facilities, making it harder for Catholic hospitals and clinics to maintain their personnel. During the crisis, local governments received substantial international financial support, while Catholic health facilities mostly relied on outside funding.

OPPORTUNITIES FOR ACTION: Catholic health networks need support to establish partnerships and foster closer integration with local governments and their health initiatives in order to access additional, sustainable streams of revenue and resources, beyond outside donors. Integration between Catholic health networks and the health initiatives of local governments has, in the past, proven successful. In separate conversations, Katherine Marshall and Dr. Liese each cited successful, practical arrangements between Catholic networks and the government in Ghana as an example in which partnerships have made Catholic health networks more effective. In response to the Ebola crisis, despite opposition from Catholics within the Diocese of Makeni, the Camillian Task Force chose to collaborate with the local government health departments in Sierra Leone to rehabilitate a public health facility. Br. Luca Perletti of the Camillian Task Force noted that the government in Makeni was keen to collaborate, even if it worked at its own pace.

To further bolster their impact, Catholic health networks could also use support to advocate for increased recognition by and funding from international governments and organizations. As noted throughout this report, Catholic health care institutions in West Africa — together with

[38] https://www.usaid.gov/sites/default/files/documents/1864/08.14.15%20-%20USG%20West%20Africa%20Ebola%20Outbreak%20Fact%20Sheet%20%2343%20%281%29.pdf
[39] Azza Karam, Julie Clague, Katherine Marshall, and Jim Olivier, *The Lancet*, p 3.

other trusted faith based health institutions — comprise up to 30% of health care delivery. In addition, a graph published by *The Washington Post* identifies religious leaders as the most trusted figures in Liberia after family and radio talk show hosts.[40] Yet, they have not received substantial international funding that has been accessible to secular NGOs and local governments, leaving Catholic health networks severely constrained and vulnerable.

Catholic organizations now have a unique opportunity to combat negative perceptions about faith based systems through clear-cut, evidence-based advocacy. A USAID advisor explained that, to garner further assistance from government entities, FBOs need to show their 'secular purpose[41]' of providing essential services in the response to Ebola and its aftermath. In short, Catholic networks must prove their efficacy in multiple areas of the health sector. Similarly, Katherine Marshall said FBOs need to present government organizations not only with success stories that show their positive function on the micro level, but also quantitative data to demonstrate their results on the macro level.

An aspect of considerable attention is the importance of including Catholic health networks in an effective system of Ebola surveillance as well as in the monitoring of vaccine availability, particularly for health workers and patients suspected of having Ebola. For Brown's Professor Tim Flanigan, "because the virus is still circulating in natural reservoirs, a surveillance system with the availability of diagnostic tests for clinics and hospitals is most important. It is key that the Catholic healthcare system not be left out of this diagnostic network." This doesn't necessarily imply building laboratories, he explained, but rather advocating for prompt and efficient blood testing in suspect patients. Moreover, Professor Flanigan said "it is critically important that the Catholic healthcare network be well represented and advocacy makes sure that they are not left out or prioritized at the very bottom of the list" when it comes to access to and distribution of Ebola vaccines, as they become available.

A notable instance that highlighted joint work in the health sector between FBOs, NGOs, local governments and intergovernmental organizations was the creation and implementation of the safe and dignified burial guidelines. An article published in the *Lancet* medical journal affirms the tremendous value of this process, stating, "Change of funeral practices was imperative to reversing the epidemic and religious leaders (modern and traditional, Muslim and Christian) had to be involved."[42] The success of these guidelines and their implementation should serve as a testament to the potential for future collaborative efforts.

[40] http://www.washingtonpost.com/blogs/monkey-cage/wp/2015/08/07/ebolas-rapid-spread-terrified-us-a-year-ago-what-did-it-teach-us-about-west-africa/
[41] https://www.usaid.gov/faith-based-and-community-initiatives/usaid-rule-participation
[42] Katherine Marshall, Sally Smith, *The Lancet*, p 5.

C. PROVIDING PSYCHOSOCIAL AND PASTORAL CARE

PSYCHOSOCIAL CARE

GAPS AND NEEDS: Prior to the Ebola crisis, trauma and mental health problems were already widespread in Liberia, Sierra Leone and Guinea due to brutally violent civil wars and severe human rights abuses committed by both governmental and non-State actors. The Ebola crisis has only exacerbated serious psychosocial challenges in the three primarily affected countries.

Ebola survivors have faced some of the most significant psychosocial impacts. They have personally witnessed the devastation caused by the crisis as well as the deaths of many family members and neighbors, and they were treated in medical facilities with countless sick and dying. Those who survived often endured mentally and socially isolating quarantines that lasted weeks, and have been left to cope with the numerous consequences of the disease. Many survivors now face crippling physical after-effects from their experiences with Ebola, including severe limb pain, memory loss and other health issues. About 25 percent of survivors have reported eye problems, such as inflammation, impaired vision and — though rare — even blindness.[43] Learning to live with these new, long-term health challenges is a disorienting and traumatic process on its own.

The overall devastation also left a mark on health personnel and burial teams, who served as firsthand witnesses to sickness and desperation in the region. They now face significant trauma from their work in facilities where patients and colleagues died en masse.

Even people who neither were infected with Ebola nor treated Ebola victims have experienced significant trauma and other psychosocial effects that remain unresolved. Mass grave burials, which occurred prior to the development and implementation of new guidelines for safe and dignified burials, prevented people from mourning their deceased loved ones. While these mass burials were efficient, they lacked necessary cultural and emotional sensitivity and, in effect, created an additional psychosocial toll.

As Georgetown University Professor Katherine Marshall noted, the three countries primarily affected by Ebola are so impoverished that mental health and other psychosocial support often gets little to no attention. Illustrating this point, the number of psychiatrists across Liberia, Sierra Leone and Guinea is in the single digits, making their mental health support infrastructures virtually non-existent.

Local governments have not funded support programs to reduce the psychosocial toll of this crisis. For example, although the Liberian government created a strategic mental health plan to deal with the trauma caused by the Ebola crisis in its borders, the latter was never funded or implemented. International organizations have often discussed programs for long-term counseling and mental health support, but this attention area has routinely fallen at the end of the list of health concerns these governments and organizations have sought to address, despite the need being so great. Michael Myers, Managing Director of the Rockefeller Foundation, noted

[43] http://www.reuters.com/article/2015/08/07/us-health-ebola-survivors-idUSKCN0QC1TF20150807?irpc=932

that, after analyzing past epidemics that afflicted developing countries, he found that mental health has been a consistent but serious blind spot.

OPPORTUNITIES FOR ACTION: If left untreated, these psychosocial challenges can evolve into far more serious, long-term mental health problems. Therefore, psychosocial care is an area of great opportunity for Catholic networks to make substantial, positive and unique improvements to local communities, given their close integration with local communities and deep understanding of their values.

While some local Caritas offices, namely Caritas Freetown, and other Catholic organizations, such as the Camillian Task Force (CTF), have already begun training local people to provide psychosocial counseling to individuals and families, substantial opportunities remain to increase the reach of these programs. These programs could be expanded and actually implemented in entire communities across all three countries, especially in areas where no such initiatives exist. Support for and proper training of local counselors are necessary to make these programs sustainable.

Opportunities also remain for Catholic health networks and others already operating psychosocial counselor training programs to strengthen the materials used for these initiatives. When asked about how best to strengthen psychosocial care, Reverend Monsignor Robert Vitillo, Caritas Internationalis' Head of Delegation to the United Nations in Geneva, articulated the need for a new manual to train psychosocial counselors that includes the Church's holistic approach to healthcare. Namely, Msgr. Vitillo believes a revised manual could better provide for the spiritual needs of traumatized and stigmatized individuals, in addition to the distribution of the sacraments by Catholic chaplains. Improving these materials can be accomplished in the context of the Holy See Initiative and can involve the participation of clergy and others in the religious community who have already delivered psychosocial counseling in response either to the Ebola crisis or to different health emergencies, such as HIV/AIDS.

SUPPORTING ORPHANS AND OTHER VULNERABLE CHILDREN

GAPS AND NEEDS: The Ebola crisis has had a strong impact on children, though not necessarily through direct infection. Though only about one-fifth of the total people who were infected by Ebola in the 2014 crisis were children,[44] tens of thousands of parents or guardians were overwhelmingly affected. In fact, a study conducted by UNICEF in mid-January 2015 found that an estimated 16,600 children had lost at least one of their parents to Ebola, with 3,600 having lost both.[45] The majority of registered orphans counted by UNICEF — 7,968 in mid-January 2015 — live in Sierra Leone.[46] While UNICEF says that less than 3% of orphans needed to be placed outside of family or community care, [47] children who have had to move into homes with new guardians — generally relatives — often experience a substantial decrease in their quality of life. Their new guardians often already have children of their own and taking in new children further stretches already thin resources. Though UNICEF reports that the vast majority

[44] http://www.unicef.org/media/media_81290.html
[45] http://www.unicef.org/media/media_79742.html
[46] http://www.unicef.org/appeals/files/UNICEF_Sierra_Leone_EVD_Weekly_SitRep_14_Jan_2015.pdf
[47] http://www.unicef.org/media/media_79742.html

of these children have been integrated into new homes, in some cases, stigmatization and fear have made reintegration especially difficult.

In Liberia, the Ebola crisis has also disrupted birth registrations, leaving an estimated 70,000 children at risk of exclusion from essential services, including education, and wider marginalization. Between 2013 and 2014, the percentage of birth registrations in Liberia decreased by 39 percent and, between January and May 2015, only 700 Liberian children had their births recorded.[48] Unregistered children do not have access to public health or social services and are put at increased risk of being trafficked or illegally adopted, meaning the high number of at-risk children extends significantly beyond those who have been orphaned.

Extended school closures also have created large gaps in children's education. During multi-month periods of being out of schools, children and youth have been at increased risk for unplanned pregnancies, child labor and trafficking. Ben Parra said that field data from Caritas Sierra Leone suggests there could be more than 12,000 vulnerable children — including those orphaned, separated, pregnant and malnourished — just in Sierra Leone.

The Ebola crisis had tremendous adverse effects for mothers and children. As facilities that provided childcare, maternal care and pediatric support closed, medical attention for women waned. Compounding the problem, health personnel, through contagion, death, or fear, were no longer able to attend to the needs of mothers and children. In many cases, this meant women and children were at an increased risk of death from preventable causes, further exacerbating the vulnerability of minors and undermining what little stability these groups had previously retained during the crisis.

OPPORTUNITIES FOR ACTION: Catholic organizations are assets of trust and presence essential to meeting the needs of orphans and other children who the Ebola crisis has left vulnerable. Catholic health networks can mobilize their existing connections in communities to direct material, monetary and educational support to orphans, vulnerable children and their households. In evaluating the best approach to attending to children's needs, Daniel Lauer, Senior Program Officer for the GHR Foundation, emphasized that Catholic organizations should let communities decide where orphaned children should be placed.

Another way in which Catholic health networks can become involved is by partnering with such organizations as Maestral International regarding the placement and monitoring of Children Without Appropriate Care, an initiative Maestral is already supporting in Liberia. With partners such as Catholic Relief Services, Maestral actively works with local governments and other partners in support of social welfare systems to benefit vulnerable children.

Moreover, as part of a holistic initiative to provide better psychosocial care, detailed above, Catholic networks can include and emphasize orphans in the audience they target for psychosocial counseling. This counseling should be done by community social workers that have received appropriate training.

[48] http://www.unicef.org/media/media_82699.html

For Philip Goldman, Founder and President of Maestral International, Catholics are in a good position to show communities how children are valuable assets for future national progress. In this sense, as advocates of better health and education opportunities, Catholic networks can ensure these systems are able to respond to multiple health problems faced by orphans and vulnerable children. In fact, Catholic health networks can make unique contributions by providing critical health services for mothers and children — at risk of dying from other treatable diseases, such as malaria or tuberculosis, or pregnancy complications — who lack adequate healthcare access. To better protect children, Catholic organizations should continue to emphasize the importance of strengthening health systems to meet basic standards, both during and outside times of crisis.

Speaking to this point, Michael Myers, Managing Director of the Rockefeller Foundation, asserted that focusing on the community level could yield results, since the Church is a trusted resource on family care on the ground. In addition, Catholic hospitals in many areas of Liberia, Sierra Leone and Guinea provide the majority of healthcare services to mothers and children. One such example is the St. Gabriel Catholic hospital in Guinea, which according to Godlove Ntaw, CRS Guinea's Country Representative, routinely receives the highest number of patients in the country — predominantly women and children. Similarly in Liberia, St. Joseph's Catholic Hospital in Monrovia receives and manages all the birth referrals in the capital area, home to half of Liberia's population, for complicated deliveries, according to Jerome Farrell, of CRS.

ACCOMPANIMENT

GAPS AND NEEDS: Medical and burial team personnel, fully cured Ebola survivors and their family members all face significant marginalization and stigmatization from their peers in surrounding communities. People frequently avoid others who they know have been around Ebola victims, refusing to go near them out of fear, thereby increasing victims' sense of separation and isolation from their communities. In a September 2014 study, conducted by CRS, Focus 1000 and UNICEF in Sierra Leone, 96% of people reported some discriminatory attitude towards people suspected of having or having had Ebola. The survey also found a shockingly high percentage of people, 76%, would not welcome a neighbor recovering from Ebola back into their community.[49]

Travel restrictions, police-enforced quarantines against communities and even the countries themselves and numerous other response measures meant to contain the Ebola crisis have inadvertently caused entire communities to feel trapped, isolated and stigmatized. Speaking to this point, an article published in February 2015 by *The Journal of the American Medical Association* says the Ebola crisis has created a "national stigma" in which "outbreak-affected nations have been stigmatized and labeled 'infected countries.' "[50]

OPPORTUNITIES FOR ACTION: Accompaniment is a key component of Catholic pastoral care and one of Catholic health networks' most central activities, yet it has not been fully

[49] http://newswire.crs.org/wp-content/uploads/2014/10/Ebola-Virus-Disease-National-KAP-Study-Final-Report_-final.pdf (p 12)
[50] http://jama.jamanetwork.com/article.aspx?articleid=2086725

explored in the context of West African health systems. Sufficient, appropriate training on best practices for administering pastoral care is not always available. Even when it is, according to Sr. Barbara Brillant, the community may still miss out on fundamental resources for wellbeing and betterment if priests are not receptive.

Past Catholic Church initiatives have actively accompanied victims, families and survivors to help individuals heal, both individually and collectively. Based on Msgr. Vitillo's experience with pastoral care and ministering during the HIV/AIDS crisis, accompaniment implies not only supporting victims in the difficult process of learning to cope with a devastating disease, but also showing solidarity and compassion with those facing significant discrimination and marginalization from society. Accompaniment, including through the safe and dignified burial practices, also provides the necessary space for people to mourn the loss of loved ones and gradually overcome that grief. Moreover, Msgr. Vitillo noted that Church leadership can and should utilize diocesan networks of clinics and communication outlets previously established by Caritas in the HIV/AIDS response to scale up efforts in the post-Ebola scenario.

Beyond HIV/AIDS, lessons of accompaniment can be traced back to biblical times, as Dr. Bernhard Liese noted. The role of the Church in seeking out and comforting those who were shunned, traumatized and devastated due to leprosy can — and should — be replicated in the context of the Ebola crisis. Because accompaniment encompasses a wide array of psychosocial needs, from that of stigmatized orphans to traumatized community health workers, it is a crucial component of pastoral care that the Catholic Church is well positioned to actively address. Its importance should be further underscored by and within parishes and local religious communities to ensure it receives enough attention, especially in the form of training programs for local religious leaders.

STRENGTHENING LOCAL COMMUNITIES, ESPECIALLY FAMILIES

GAPS AND NEEDS: The Ebola crisis has shaken entire communities to their emotional and spiritual cores, as the sense of loss and devastation lingers. Communities have been decimated, having witnessed widespread deaths. Some people have lost a dozen or more family members, friends and beloved community leaders. Distrust, resentment, and fear have broken or reconfigured social ties, leaving the social fabric profoundly vulnerable and social cohesion weakened.

Socioeconomic conditions have also worsened, increasing pressure on already struggling communities and households. Before the crisis, Liberia, Sierra Leone and Guinea were already some of the most impoverished countries in the world. International trade and travel restrictions to and from the three countries severely damaged their economies, though the World Bank and others have tried to have a stabilizing effect. Attempts to prevent the spread of Ebola by temporarily or permanently closing borders and businesses have caused high unemployment, as have stigma and discrimination. A Gallup poll, whose results were published by the World Bank in January 2015, found in Liberia that 40 percent of men and 60 percent of women were out of

work.[51] Meanwhile, in Sierra Leone, 9,000 wage workers and 170,000 self-employed workers outside of agriculture had lost work since the July/August 2014 baseline.[52] Making matters worse, food shortages and trade restrictions complicated already dire socioeconomic conditions.

OPPORTUNITIES FOR ACTION: Catholic networks can play several unique roles in strengthening and empowering local communities, beginning at the family level. The opportunity to create greater resiliency and strengthen community networks through family support must not be ignored, since, as Georgetown Professor Katherine Marshall noted, these are basic, essential ways to effectively engage in community outreach and pastoral care. One way to support families at personal levels in order to ensure collective wellbeing in the longer run is in providing psychosocial support and accompaniment for individuals who have become unemployed due to Ebola. Often, discrimination disqualifies survivors from the workforce; in other instances, breadwinners have either died or are no longer capable of working due to debilitating health consequences. Thus, fostering support mechanisms at this level is critical.

Moreover, by improving communication with families at the micro level, communities at the macro level can cultivate necessary relationships for fostering trust and cooperation, which is essential for swift, effective action in future crises. Ebola's former widespread and rapid infection rates can largely be attributed to mistrust, among local people, of governments, public entities and each other. Had stronger community networks been in place, communication would have been substantially more effective, helping to dispel myths, rumors, and hostilities earlier. Additionally, enhancing the Catholic focus on family and community relationship building allows response efforts to future crises to more effectively promote solidarity and compassion, overcoming the challenges of stigmatization and marginalization that worsened the Ebola crisis.

Additionally, in light of widespread schools closings, the role of Catholic schools in community rebuilding, including in providing social support and dealing with stigma, will be critical. Professor Flanigan, from Brown University, noted that the Catholic Church "runs an incredibly large and well respected network of education that greatly impacts families and communities and reaches into every segment of society." Ensuring stability and resiliency in the Catholic education systems is therefore of the upmost importance to providing community support and empowerment. Indeed, empowering communities to take ownership in creating local resilience remains a critical aspect of Catholic networks' efforts to strengthen communities. As Professor Beth Embry pointed out, the stories of success in curbing the crisis must highlight local action, allowing communities to "feel successful in their own right." Her colleague Dr. Alexander Garza agreed that, in the face of the crisis, inspiring stories of hope and trust in local and community actors, even governmental and public actors, should be privileged over ones that center on international contributions. Similarly, Fr. Aris Miranda underscored the need to *embolden local communities to be proactively involved in shaping their systems and in feeling capable of building the Church themselves.*

The Catholic community's response to Ebola was shaped by the resources, tools, and experience available at the moment, helping to alleviate suffering and pressure immediately after the

[51] http://www.worldbank.org/en/news/press-release/2015/01/12/ebola-hampering-household-economies-liberia-sierra-leone
[52] Ibid.

outbreaks. The work ahead will be long and difficult, but it is vital. The positive impact of the Church's engagement, contributions and presence — and that of its crucial, multisector partners — is an inspiring call to action to Catholics everywhere.

In response to this report's findings, an associated impact plan proposes a special FADICA initiative in solidarity and alignment with the Holy See's response to Ebola, focused directly on the report's three recommended areas. FADICA's International Philanthropy Member Affinity Group Anchor, Dr. Maria Robinson, will be a lead facilitator of this project, along with another representative of the Affinity Group. [Interested FADICA members and others interested in this initiative can contact Alexia Kelley, FADICA President, at 202/223-3550 or akelley@fadica.org.]

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