Community perceptions of Ebola response efforts in Liberia:
Montserrado and Nimba Counties

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Summary

This study aimed to support Oxfam's Public Health Promotion (PHP) strategy through a rapid qualitative assessment of the remaining social barriers to compliance with Ebola prevention and treatment messages. At the time of the study, most Liberians had a high awareness of Ebola prevention and treatment information. However, new infections continued to occur in "hot spots" around the country. A preliminary assessment suggested that negative perceptions and fear of Ebola response efforts contributed to non-compliance and resistance in some areas. Research activities assessed the sources of negative perceptions and fears of Ebola response activities, and looked for suggestions to improve Oxfam's response.

Based on formal and informal interviews, focus group discussions, site visits, and participant observation, this enquiry found that Liberians' early experiences with the belated and often inadequate Ebola response continued to create (1) distrust of government actors; (2) fear of outsiders; (3) disparities in access to information about Ebola between men and women; (4) fear of ambulances and medical facilities; and (5) reliance on self-treatment for illnesses.

This suggests strategies for improving Oxfam's Ebola response activities, including (1) reinforcing trainings for community health volunteers (gCHVs) to strengthen their approach; (2) engaging directly with women's groups; (3) improving the transparency of Ebola Treatment Units and the referral process; and (4) linking informal community health care workers to Oxfam's case referral system.

Introduction

Liberia's Ebola epidemic began in May 2014 in Lofa, a county in northern Liberia that borders both Guinea and Sierra Leone. Since August, Oxfam has worked to curb new Ebola infections in Liberia through Public Health Promotion activities. For example, community health volunteers (gCHVs) have successfully conveyed Ebola transmission and prevention information through door-to-door home visits in Montserrado and Nimba counties.

Nonetheless, considerable challenges remained, even as the overall number of reported cases declined country-wide. In November, the epidemiological trend shifted from a high incidence of new infections in concentrated areas, to geographically disparate "hot spots." In mid-November, Oxfam launched a new Active Case Search (ACS) strategy, designed to rapidly identify and refer those with Ebola symptoms to Ebola treatment units (ETUs) or triage centers, thereby preventing further spread of the virus.

This study aimed to support Oxfam's PHP strategy through a rapid qualitative assessment of perceptions of, and reactions to, Ebola response efforts in the communities in which Oxfam works. Research activities were geared towards identifying the remaining social barriers to behaviour change to prevent Ebola infections; as well as refining PHP strategies to enhance the quality, acceptability, and overall impact of Oxfam's intervention.

Methodology

This report presents data collected from beneficiary communities in Montserrado and Nimba Counties, during the period from November 18 to December 4, 2014. Montserrado communities included Clara Town, New Kru Town, and West Point. In Nimba, these communities comprised the town of Saclepea and villages in the area, including Gblah, Yorlay 1, Salay, Boweh, Yeeganpa, Gbeletua, Sangarelay, and Gbanquoi. The selection of these areas highlighted specific characteristics: the Montserrado communities are densely populated, impoverished urban neighbourhoods that contained high numbers of Ebola deaths. The Nimba communities comprised both small towns and remote villages, and included both affected and non-affected communities. At the time of this study, Montserrado experienced ongoing infections, while Nimba had not recorded any new Ebola cases in nearly 45 days.

Multiple qualitative methods were used to triangulate data. Data collection involved focus group discussions (FGDs), in-depth interviews, participant observation, site visits, and review of relevant literature and articles (see appendix). FGDs concentrated on views of Ebola response efforts and changes in health-seeking behaviours over the course of the epidemic. Interviews probed the perceptions and experiences of informal health care providers, religious leaders, and Ebola survivors. Participant observation included informal interviews, direct observation, participation in group activities (such as gCHV trainings), collective discussions, and analyses of documents produced by stakeholders. Finally, site visits to health care facilities assessed the accessibility and transparency of facilities to the communities that they serve. Daily field notes recorded detailed observations.

Findings

By mid-November, the vast majority of Liberians had accepted that "Ebola is real," and that it is a deadly virus. The majority could list its symptoms, modes of transmission, and methods to prevent infection [Abramowitz et al. 2014 (1)]. Most "compliance" issues rested squarely on the ongoing gap between ideal public health practice and the dearth of "staff, stuff and systems" that Paul Farmer noted months before, rather than cultural practices or beliefs [Farmer 2014].

This study focused on Liberians' fears and perceptions of the Ebola response itself, as it appeared that fear and anxiety accounted for the few remaining social barriers to compliance with Ebola prevention and treatment messages. Research activities sought to probe the sources of fear and resistance—often encapsulated in rumours and conspiracy theories. In an FGD with the New Kru Town "Borough Recreational Intellectual Forum" (BRIF), for example, a group of male respondents patiently explained how government and international institutions created the Ebola virus, unleashed the epidemic on West Africa, and then reaped the benefits through emergency funding and the marketing of vaccines and antidotes.

Many in the practitioner community did not know how to interpret such narratives, and tended to dismiss them as isolated examples of ignorance—a problem that can be overcome by yet another "Ebola is Real" billboard. Yet anthropologists have long argued that such narratives do not constitute anecdotal evidence of irrational beliefs. Locally, these stories operate as forms of political protest against valid historical and current experiences of exploitation, neglect, and feelings of powerlessness. Accounting for local narratives helped to illuminate the factors underlying Liberians' apprehensions, examine the effects on our own intervention, and take opportunities to ask respondents how best to address them.

Lack of trust in government and international institutions

BRIF's theory highlights Liberians' damaged confidence in government and international institutions, as early responses to the epidemic coupled control with neglect. Numerous respondents observed that a systematic Ebola response was badly delayed and, when it did arrive, upended the most intimate aspects of everyday life: how Liberians treat their families, their neighbours, their sexual partners, their dead, and their own bodies. Government and international institutions appeared to profit from emergency funding, while extending state power through curfews and quarantines—yet entire families still died for lack of medical services [see also Epstein 2014]. "The government just says we should die; we were just waiting here to die," noted a female respondent in Clara Town. "Afterwards you people come in your trucks, your ambulances, just to take the dead bodies."

In some areas, Ebola fatigue had begun to set in. In previously affected communities in Nimba, messages advising Liberians to wash their hands grated against the more immediate, practical problems many now faced in raising money for school fees, or caring for non-Ebola illnesses in the absence of operational medical facilities. In non-affected areas, complacency had started to take over; villagers questioned whether Ebola still held relevance. Gbeletua's town chief noted that his village had only heard about Ebola; no one had seen it "with their own eyes."

In Nimba, witnessing Ebola first-hand played a critical role in whether a particular community viewed the disease as a serious issue. This raises concerns regarding preparedness in non-affected Nimba communities should another outbreak occur.

Recommendation:

Research participants strongly emphasized the need to continue providing practical information and training on how to respond realistically to potential infections—beyond "wash your hands." For example, how can families comply with instructions to both isolate a person with Ebola symptoms and immediately transport them to a hospital, if motorcycles provide the only available form of transportation?

Yorlay's town chief suggested that, in non-affected areas, in-depth prevention and treatment training should be brought on video recordings, so that community members could witness the effects of Ebola. In affected areas, questions (like the above) remained on how to effectively manage an outbreak, particularly in the absence of critical supplies or a functioning health care sector [see also Abramowitz et al. (2)].

Community belonging

This damaged trust—along with fear of the disease itself—led some Liberians to radically reduce the scope of community belonging. This retrenchment of "community" cut several ways. In the non-affected village of Salay, fear of infection by outsiders led village leaders to institute locally-enforced road blocks, market closures, and quarantine zones—actions that can be viewed positively as community-derived Ebola prevention strategies. However, fear of infection also created hostility towards those from neighbouring villages, particularly areas where families had died of Ebola [see also Abramowitz et al. (2)]. As anthropologist Danny Hoffman has cautioned, the mobilization of young men in these communities can, and often does, involve a range of martial and surveillance-like behaviors that can turn rather quickly into a remilitarization of social organization [Hoffman, personal communication]. An affected family in the Old Camp Community described shopkeepers in Saclepea chasing them away when they went to buy food. Before Ebola, Ivoirian refugees in Old Camp said they enjoyed a warm relationship with the broader Saclepea township.

Fear of outsiders also produced discordant definitions of "the community" between organizations engaged in the Ebola response, and their intended beneficiaries. Ebola response messages exhort Liberians to "Protect Your Community," an entity whose scope could be infinitely broad. Organizations including Oxfam deploy gCHVs "from the community" in door-to-door education and ACS activities.[1] Participation observation with gCHVs suggested that most residents responded positively to their efforts. A middle-aged man in New Kru Town remarked that "the way you are approaching is very acceptable," and thanked gCHVs for their work. However, gCHVs did meet resistance and hostility in some quarters: an older man in the

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[1] General Community Health Volunteers in Liberia are volunteers (CHVs), as defined in Liberia's national health policy. The functions of gCHVs include raising health awareness and encouraging healthy behaviors. They provide support in national preventive health campaigns against various endemic diseases. In some remote communities, they are also trained to manage selected childhood diseases.

same area accused them of going door-to-door to poison people. This may have referred to Medecins Sans Frontier's recent efforts to carry out blanket distributions of amodiquine (an anti-malarial) to residents. MSF also distributed pamphlets providing instructions on how to administer the medication, and listing possible side effects. However, those who took the tablets without food—which may have been many, given high rates of poverty and illiteracy—reported feeling weak and nauseated.

A focus group of New Kru Town women explained that they do not consider most gCHVs as coming "from their community," if they do not reside in the same subdivision. The group agreed that they were unlikely to trust strangers with sensitive information about sick household members. Leaders in Yorlay likewise observed that gCHVs should come from the same village, noting that "our own son would not bring something bad to us." Conversely, Yeeganpa's town chief expressed concerns over rumours that outsiders had systematically poisoned wells and crops in the area. In the words of one young man in Clara Town, "If the messenger cannot be trusted, the message cannot be believed."

Recommendation:

Despite preferences for more locally-based gCHVs, respondents also said that gCHVs' prolonged, continual engagement with residents could overcome those barriers. As gCHVs continue to provide daily, door-to-door prevention information and medical referral, "people will see that you are really serious," noted a community elder in Gblah. However, the transfer of information must move in both directions: listening and responding effectively to residents' concerns.

Failure compounding fear

Nor do local Ebola Task Forces (ETFs) necessarily enjoy the trust of residents in the areas in which they operate. Multiple respondents reported rumours that members of ETFs demanded money from families before investigating an illness or death. The women's focus group in New Kru Town explained that they trusted their own local chairperson, but not necessarily the other representatives who make up the ETF. They did not regard the ETF as holding legitimate authority in their subdivision. In Salay, community leaders refused to bring in an ETF altogether, preferring a locally-organized referral system. The town chief established a designated quarantine area for those arriving from other areas, and created a referral form for families requesting assistance in transporting suspected Ebola patients to the nearest hospital in Bahn.

Participant observation in Clara Town, New Kru Town, and West Point revealed that ETFs continued to respond slowly, or not at all, to reports of possible Ebola infections and deaths. In New Kru Town, a group of young mothers reported that a next-door neighbour had died of unknown causes two days before. They called the local ETF several times, but the woman's body still lay in the house. The mothers had begun to complain of the smell. In West Point, a local carpenter had been vomiting blood. He called 4455 a day before, but no one had

come. He called again in the morning and no one picked up.[2] The following day, a Clara Town man collapsed and died in the West Point market; his body remained on the road for hours. Neighbours covered the body with a bed sheet; yet children were touching the highly infectious body, pulling back the sheet to see the man's face. "In a tragically literal application of the term 'structural violence,'" wrote anthropologist Sharon Abramowitz, "the Liberian state has become a vector of disease. Ebola hotlines are created and advertised, but even today, no one is there to answer the phones" [Abramowitz 2014].

gCHVs struggled with the distrust and resistance compounded by these failures. By the time the ETF arrived, people with suspected Ebola symptoms had disappeared. The families denied that they reported an illness or death in the first place. In Salay, meanwhile, a women's FGD revealed that few of the town women knew that referral and treatment options for Ebola existed in the first place. When asked what steps could be taken in the event of an Ebola infection, they replied simply that the affected person would certainly die. "Health care provision is a chain," explained a gCHV in Clara Town. "If one part of the chain is broken, then it doesn't hold. People get frustrated."

Recommendation:

ETFs and partner organizations must rebuild residents' confidence in the referral and response process by improving the speed and quality of the response. In these efforts, Oxfam's ACS strategy has been successful: as of December 11, 2014, our teams had referred 15 suspected and 9 confirmed Ebola cases to ETUs for treatment. This encourages early referral. For example, West Point gCHVs met resistance from the family of a young woman with Ebola symptoms. An uncle wanted to take her to the hospital, but the rest of the family refused, saying that the uncle was sending their daughter to be exterminated. After the family saw a neighbour referred to Redemption Hospital, a gCHV persuaded them to allow the daughter to seek treatment. The family agreed, but said they would nonetheless hold the uncle responsible if the daughter died. This nonetheless reflects positive efforts to overcome fear and resistance. Yorlay's town chief provided this metaphor: "If you are sick, and another one rubs your back, you can also rub your own stomach." In other words, when you begin to help people, they also begin to help themselves.

Seeing gender in the Ebola response:

This response has seen a strong emphasis on engaging community leaders and working through appropriate organizational structures, in order to support community ownership and acceptability of prevention and treatment activities. In general, Oxfam has been working cooperatively and successfully with community leaders. However, rumours about the troubled ETFs highlight the fact that, in any community, there are groups of people who are not served by the system of power in place. In the context of the Ebola response, women may face particular

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[2] Set up by the National Ebola Task Force in August, 4455 was meant to provide a national hotline for Liberians needing assistance with those who had fallen sick or died of Ebola. It rarely worked. In August, Representative George Solo noted that dead bodies lay in his slum constituency of West Point with no member of the Task Force responding to any of the calls; he threatened to deposit the bodies on the steps of Ministry of Foreign Affairs if nothing was done to address the situation [Saywah-Jimmy 2014].

barriers to adequate prevention and treatment, due to preexisting gender norms that privilege men. Although Liberia famously boasts prominent female leaders (including President Sirleaf), the majority of Liberian women face financial and educational disadvantages, including lower literacy rates and earning power than their male counterparts [Liberia Country Brief].

Early in the epidemic, women accounted for up to 75 percent of Ebola deaths, due to their risks as family caregivers, health care workers, and market traders. By the start of this study, however, data from the Ministry of Health appeared to reflect slightly higher morbidity and mortality rates among men, as risks related to mobility and burial work increasingly affected them [MoH SitRep 188]. As a result, Oxfam's strategy did not pay particular attention to gender differences in the Ebola response. If MoH statistics showed a nearly 50:50 mortality ratio between women and men, then it seemed that particular vulnerabilities related to gender may not be relevant.

Yet this study revealed significant disparities in men's and women's access to Ebola prevention and treatment information in rural areas. A meeting with male leaders in Salay demonstrated that men had a firm grasp on Ebola prevention and treatment messages. A concurrent FGD with women found them brimming with questions, misinformation, and apprehensions. A mixed-gender focus group in Yeeganpa also showed uneven access to information, as the women did not have the English language education enjoyed by the men. A preference for educating male children, along with women's labor and family responsibilities, may account for these disparities. Given that rural communities garnered most of their information about Ebola via radio, women who do not have unstructured time or English language education may not receive the same level of Ebola prevention and treatment information. In some areas, women also do not enjoy much authority over their own health. They may require permission from a male relative, elders, or the wider community to seek health care [Lori & Boyle, 2011].

Recommendations:

A women's FGD in New Kru Town strongly emphasized the need to engage directly with women. As primary caregivers, they observed, women are the ones who know whether a relative or neighbour is sick, and circulate that knowledge among other women. Engaging with local women's groups would create a system of community accountability for the referral and treatment of people who fall ill. Traditional Trained Midwives (TTMs) in particular tend to provide a locus of "shared confidentiality" among women, and often make up a critical part of rural health systems.

The final stages of the Ebola response in Liberia may require a more granular approach that accounts for different modes of transmission and risks between men and women. Other groups may also emerge as particularly vulnerable in specific hot spots: for example, reports from gCHVs suggest that Ebola cases in West Point currently cluster in areas where people use heroin.

The ETU as camp

Research participants also conveyed a range of anxieties regarding the processes of surveillance, referral, quarantine, and treatment in ETUs—disparate expressions of disquiet that cohered when several respondents referred to the ETU as a "camp." In conversations with Ebola survivors, affected families, and neighbours, this study revealed that their early experiences with these processes often resonated as much with descriptions of internment as medical treatment. Although the availability and provision of Ebola treatment has drastically improved since the height of the epidemic, it is critical to remember that current perceptions may still be informed by the profoundly terrifying and dehumanizing experiences that many individuals and families underwent mere weeks or months ago.

A young man in New Kru Town, for example, commented that life within the government-imposed state of exception was "like a prison." Under medical surveillance, "you see people coming on reconnaissance," remarked a woman in New Kru Town, regarding the ETF. In Gbeletua, villagers erased the numbers gCHVs had chalked onto house walls to track their progress; residents feared that gCHVs were marking houses for the ETF to come steal their blood—a perception that may be based on stories of contact tracing teams drawing blood to test for Ebola.

For those with symptoms, isolation then sparked a process of abjection in which the sick person became literally untouchable. If an ambulance came, it removed the sick person from the relationships that (in local contexts) constitute personhood, and marked both patient and family as carriers of disease. The family endured quarantine, in which some were simply abandoned. "They just sent me home to infect my family, and in 22 days, no one called to check on me," reported a young woman who had been exposed to a suspected Ebola illness. Fear of ambulances thus constituted a common theme across respondents. In the context of the Ebola outbreak, the arrival of an ambulance prefigured the removal (and possible disappearance or death) of a family member, and the public shunning of the family.

In triage, health workers tested the patient for Ebola, reducing the person to bare biological facts. In some cases, names and identifying information were lost. The Ebola test then separated citizens from non-persons: rights pertained only to those who were not sick [Park & Umlauf 2014]. If positive, the Ebola patient entered into the camp, becoming "bare life" [Agamben 1998]. To affected families, unknown entities in the camp held power over life or death. In more than a few cases, the patient simply disappeared, leading to widespread rumours that they had been exterminated via medications or chlorine spray. Earlier in the response, those who did emerge did so either as a diseased body that was treated "like garbage" (either cremated or put in a plastic bag)--or as the figure of "the survivor" who existed in a state of exclusion [ibid].

A site visit to Island Clinic and conversations with residents confirmed a lack of transparency. Few respondents knew what happened during the process of referral and treatment, unless they had talked with a discharged Ebola patient. At Island Clinic, a single metal-grate

door provided access to patients. If well enough to walk outside the cell blocks containing patient rooms, a patient could communicate with relatives through the metal grate. Redemption Hospital's MSF triage unit provides a better model. The triage unit features an open layout using transparent mesh barriers to cordon off treatment areas. Patients are provided with plastic chairs outside each room, where they will be completely visible. If well enough to sit, patients can speak with relatives from a safe distance.

Recommendations:

There remains a need to de-mystify ETUs and the ACS process. Providing information is key. In Nimba, some communities remain unaware that any treatment options exist. In Montserrado, a lack of transparency compounds residents' apprehensions. However, Montserrado has benefitted from the increasing presence of those who sought treatment and survived Ebola. According to an interviewee in New Kru Town, "Some people can think negatively about the ETU, but not everybody. Reason being, we have some friends who, can I say, 'graduated' from the Ebola center, who received a certificate. Now you see someone who been sick; she came through, explaining how it look like." Oxfam has engaged survivors to speak with members of their communities at churches and mosques—a strategy that survivors say helps to allay fear and resistance.

Yet information alone may not be adequate. Ebola is an isolating disease—one whose treatment can also feel profoundly dehumanizing. Ebola prevention and treatment dismantled many of the ways in which Liberians previously demonstrated proper relatedness, compassion, and care. To counter fear, each step of ACS needs to be linked to notions of care, compassion, and connectedness—rather than surveillance, isolation, and anonymous death. At each step, we must find ways establish and re-establish the patient as a person, embed them in the relationships that define personhood, and create an ethics of compassion and care.

Self-treatment

Fear of the "ETU camp," compounded by the systemic collapse of Liberia's health care system, left Liberians with few resources to manage illnesses. The burden of non-Ebola illnesses and deaths has risen as hospitals and clinics across the country closed down. As a result, Liberians increasingly turned to self-treatment to cope with illnesses. When a household member fell sick, the primary treatment option was "first aid" administered at home. Treatments included tablets to reduce fever and headache, ORS, and anti-malarial medications. A few respondents also relied on herbal medicines [see also Abramowitz et al. (3)].

If symptoms did not improve after several days, caregivers then sought the advice of local pharmacists, nurses, itinerant drug vendors ("black baggers"), TTMs, and physicians assistants whom they knew through family or community networks. A nurse in Clara Town, for example, explained that his business operated by word of mouth. He kept basic medications at home, buying others from local pharmacies as needed. Without access to lab equipment, he conducted "diagnosis by treatment": if he administered anti-malarials and the patient improved, then the patient had malaria. If anti-malarials were not effective, he might administer medications for typhoid or other conditions. If a person came to him with the early symptoms of

Ebola (fever, headache, running stomach), the nurse suggested that he would start the patient on amodiquine. If the patient did not improve after 3-5 days, he would then refer the patient to one of the hospitals still in operation. If a patient began vomiting, in particular, he would consider the symptoms "above his level" and recommend hospital treatment. Only when home-based care failed would many respondents rush the sick person to a hospital.

Informal health care providers therefore make up a critical part of both urban and rural health systems, particularly as lack of access and lack of trust have forced self-reliance on "first aid treatment." Yet even medically-trained health practitioners with a high level of awareness of Ebola prevention and treatment did not necessarily consider early hospital referral for Ebola symptoms—placing both themselves and their patients at high risk of mortality due to Ebola.

Recommendations:

This situation reflects missed opportunities to engage with local health care providers—critical links in the health care system, whom people trust with sensitive health information. At present, we do not have a clear sense of who these private health care workers are, whether they continue to operate, or where they are located. A future PHP project might map these networks of health care providers, and offer information emphasizing early referral and isolation during the "diagnosis" period. This project should also supply links to our ACS referral system, and protective equipment. TTMs, in particular, have already trained to refer complicated deliveries to nearby facilities; they could easily be provided tools to refer those with possible symptoms of Ebola as well.

Discussion

The number of new Ebola infections continues to drop in Liberia, with mid-December SitReps counting approximately 10 cases per day. Montserrado remains the epicenter of the outbreak, reporting 6.5 out of 10 cases. Nimba County, on the other hand, has not reported a new infection in over 45 days; Ebola-related activities in Nimba now focus on prevention and preparedness. WHO data suggests that, if current trends continue, cases will decrease to approximately five per day within three to four weeks. However, the "long tail" effect may mean that hot spots will continue to spark through March 2015 [Oxfam SitRep 17].

The chances that individuals will survive Ebola, and that Liberia will end the outbreak within its borders, continue to improve. Healing, however, may be a long way off. As noted above, Ebola is a profoundly isolating disease, one whose prevention and treatment disrupted the most intimate facets of social life. Some aspects of everyday life may return to normal, but according to village elders in Gbanquoi, some traditions have been destroyed for good.

In the event of a continuing or new outbreak, we need to know more about alternative modes of care and compassion in Liberian communities. As anthropologists have noted, we now need to shift attention to "*the culture of caregiving* that exists in Ebola-affected cities and towns. We need to better understand how strong and dense the emotional ties that bind families and communities together are and can be, and precisely how Ebola, and the failed Ebola response, is doing violence to those social ties" [Abramowitz et al. (3), emphasis in original].

This raises a number of questions for the future of the Ebola epidemic and the social response: How does one function as a person (and more broadly, how does one function as a society) when such a basic piece of one's humanity—the ability to touch other people—has been taken away? How can we foster alternative modes of care and compassion? How do we reestablish community trust in the wake of widespread prevention messages have enforced the idea that you cannot trust those around you (they might be diseased), and that you yourself cannot be trusted (you might be diseased)? These questions emphasize that *care* encompasses more than merely medical attention; it provides a technology of belonging, which restores community health and security through closeness, intimacy, and trust [Park & Umlauf 2014].

What suggestions might we find and promote from our beneficiary communities on how to demonstrate care, compassion, and connection when people are unable to do the normal things? What do communities need to support these alternative strategies of connection and care? How do we rebuild social life after the epidemic?

Limitations and challenges

Limitations on mobility, access, and prolonged contact with relevant communities placed constraints on the kinds of data that could be collected. Some respondents also expressed wariness regarding the process of data collection itself. Community members in some areas questioned the purpose of data collection and expressed concerns about how personal information would be used. In Nimba County, some FGDs required a translator for those who spoke local languages.

Sources

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[12] Oxfam SitRep #17

Appendix: Methods Chart

Method	County	Community	Stakeholders
Interviews	Montserrado	Clara Town	Survivors (2)
			Health Care Provider (1)
		New Kru Town	Survivors (2)
			Health Care Provider (1)
		West Point	Survivor (1)
	Nimba	Gblah	Pastor
FGD	Montserrado	Clara Town	gCHVs
		New Kru Town	Women's group
			Borough Recreational Intellectual Forum
	Nimba	Yorlay	Community leaders (non-affected)
		Yeeganpa	Community leaders (non-affected)
		Salay	Women's group (non-affected)
		Gblah	Women's group (non-affected)
		Boweh	Traditional Trained Midwives (non)
		Gbanquoi	Community leaders (affected)
		Saclepea Old Camp	Affected family
		Saclepea Airfield	Affected family
		Saclepea Civilized	Youth group
PO	Montserrado	Clara Town	gCHVs
		New Kru Town	gCHVs
			family of gCHV
		West Point	gCHVs
			family of gCHV
		CT, NKT, WP	health commissioners
Site visit	Montserrado	Island Clinic	Administrators
		Redemption Hospital	Administrators
	Nimba	Bahn PHU	
		Boweh Birth Center	Trad. Trained Midwives