Faith and Global Health Practice in Ebola and HIV Emergencies

We examined the relationship between religion and health by highlighting the influences of religion on the response to the 2014 to 2016 Ebola outbreak and the global HIV epidemic.

We recounted the influences of religion on burial practices developed as an infection control measure during the Ebola outbreak in West Africa. We also explored the influence of religion on community outreach and health education. We examined faith-based responses to the global HIV/AIDS pandemic, noting that religion conflicted with public health responses to HIV (e.g., justification for HIV-related stigma) or aligned with public health as a force for improved HIV responses (e.g., providing HIV services or providing social capital and cohesion to support advocacy efforts). We further discussed the similarities and differences between the influence of religion during the HIV/AIDS pandemic and the 2014 to 2016 Ebola outbreak.

We then described lessons learned from Ebola and HIV/AIDS to better inform collaboration with religious actors. (*Am J Public Health*. 2019;109:379–384. doi:10.2105/AJPH.2018.304870)

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See also Foege, p. 378.

Ebola virus disease (Ebola), which was first discovered in 1976 in the Democratic Republic of Congo, is transmitted through contact with blood or bodily fluids of those infected. In early 2014, an Ebola outbreak spread rapidly in 3 countries in West Africa—Guinea, Liberia, and Sierra Leone. The first suspected case was a young boy in Meliandou, Guinea. Although he died on December 26, 2013, the World Health Organization (WHO) did not confirm the outbreak until March 23, 2014.[1]

By the time the outbreak was declared, there were 49 cumulative suspected cases and 29 deaths.[2] Within 6 months, that number rose to more than 7000 cumulative cases, and 3300 deaths.[3] The US Centers for Disease Control and Prevention (CDC) estimated in September 2014 that up to 1.4 million people in the region could contract the disease by January 2015 if transmission trends persisted.[4] Faced with this grim projection, health authorities redoubled their efforts to contain the spread.

Transmission of Ebola during this outbreak was driven in part by religious and traditional spiritual practices, such as washing and wrapping the body during burial rituals.[5] Because these practices involved extensive handling of the body, they represented a common route of transmission of the Ebola virus. Public health officials initially called for an end to such practices. Their efforts were unsuccessful; in fact, they were counterproductive. Religious and local leaders had compelling reasons to continue these longstanding rituals, refusing public health mandates. Across Western African contexts, these rituals express important familial, cultural, and political meanings. They signify and help constitute the societies in which they are practiced and cannot be dismissed merely as a cultural obstacle to be overcome as part of an Ebola response. We describe efforts to establish a common ground by respectfully engaging religious and local leaders to modify burial practices so that the various social meanings of the rituals were maintained while lessening the possibility of transmitting the virus.

South African sociologist Paul Germond developed the concept of the "healthworld" to describe the varied, multiple cultural systems that provide a framework through which we interpret the phenomenon of health. This framework is largely unconscious once we have become acculturated to those systems, operating in the background to provide a lens for making sense of health, illness, and death.[6] In describing the concept, Germond argues that

> many, but not all, healthworlds are empirically suffused by religion, some to the point where there is no conceptual distinction between religion and health; they are a seamless whole . . . . Much of state-sponsored healthcare around the world, usually based on the biomedical model of experimental science, is intentionally separated from religion . . . . On the ground, however, religious people generally construe their search for health in religious terms even when engaging "secular" biomedicine; surgery and prayer go hand in glove.[6(p318)]

The Ebola response revealed the consequences of misaligned healthworlds. In most cases, the initial response efforts developed by organizations (e.g., WHO) reflected biomedical and public health models, although people in local communities used other frameworks to respond. The healthworld of the public health response alienated and offended

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some who experienced the death of their loved ones, because such an approach dismissed the meanings created and maintained through burial rituals that reflected an intimate concern for the dead. Such religious and spiritual frameworks were essential for making sense of illness and death in the context of Ebola.

In the early phases of the outbreak, many in the affected countries feared that the body of their loved one would be removed from the home and buried, possibly in an unmarked grave, without regard for these deeply held rituals. They opted to carry out rituals such as washing (a process also known as ablution) and shrouding the body of their deceased loved one in preparation for burial rather than informing health officials of the death. Many made this choice understanding the exposure risk, especially after emergency protocols were established and information campaigns were launched. From their perspective, infection was preferable to displeasing their ancestors or disobeying God. In the spiritual practices that mark the lives of many residents of West Africa, the formal teachings and practices of religious traditions, such as Islam and Christianity, are combined with traditional spiritual practices to create a complex spiritual worldview consisting of elements from various traditions.

As the epidemic grew, the impact of disregarding these traditional spiritual practices became clear. In August 2014, *The Washington Post* reported that the WHO had implemented specific guidelines for "safe burial practices" that instructed health officials to "'be aware of the family's cultural practices and religious beliefs' and to 'help the family understand why some practices cannot be done because they place the family or others at risk for exposure.'"[7] The story quoted from guidelines cowritten by the WHO and the CDC in 1998 that initially informed the 2014 efforts. Those guidelines addressed religious beliefs and practices only to inform families that such practices must be disregarded.[8(p97)] As the number of new infections kept rising, health officials realized that although the existing protocol might have been scientifically sound in regard to infection control, it was culturally untenable in prohibiting religious practices that were essential for making sense of life and death in the midst of an epidemic. The WHO worked to develop a new approach that elicited input from religious leaders to include religious rituals.

After rapid and extensive consultations with leaders from the World Council of Churches, Islamic Relief, Caritas Internationalis (a global network of Roman Catholic development organizations), World Vision, the International Federation of Red Cross and Red Crescent Societies, as well as scholars in anthropology and religion, the WHO adapted the existing protocol to focus not only on the safe handling of bodies but also to provide religiously appropriate safe and dignified burials.

The new protocol[9] offered guidance for burial of Muslims and Christians. The protocol for a Muslim burial included steps for performing dry ablution, shrouding the body, offering prayers, and conducting the burial. The protocol for a Christian burial provided flexibility for appropriate rituals for both Roman Catholics and Protestants. Both protocols encouraged participation by the family and religious leaders while maintaining infection control. This new protocol reflected an effort—this time on the part of public health officials—to align the healthworld of emergency response and preparedness with the healthworld of the people in the midst of an epidemic. Because of the collision of such worlds in the initial response, such efforts of alignment are worth noting.

Working together in a consortium, World Vision, the Catholic Agency for Overseas Development, and Catholic Relief Services, 3 international faith-based organizations (FBOs) with extensive programs in Sierra Leone, were among the organizations deployed to implement the new approach. A program evaluation was carried out in the district where the consortium worked. In a nonrepresentative survey (n = 101) administered to bereaved families, appreciation for burial practices increased from 4% before the intervention (May–October 2014) to 67% during implementation of the intervention (November 2014–November 2015).[10(p19)]

Although the survey on the FBO intervention was limited only to a small sample of families who participated in burials that used modified procedures in 1 local district, separate representative national surveys on Ebola-related knowledge, attitudes, and practices (KAP) in Sierra Leone yielded similar findings. Adjusting for sociodemographic variations, the knowledge, attitudes, and practices surveys revealed a 3-fold increase in the acceptance of adapted indigenous burial practices to lessen risk of Ebola transmission in December 2014 (n = 2086) after implementation of faith-based interventions compared with before implementation in October 2014 (n = 3540; Jalloh et al., unpublished work).

In interviews and focus group discussions carried out as part of the evaluation of the program offered by World Vision, Catholic Agency for Overseas Development, and Catholic Relief Services, bereaved families recounted numerous instances in which the bodies of their loved ones were treated poorly before the implementation of the new procedures and expressed appreciation after the new procedures were implemented:

> We witnessed horrors and saw hell itself for our deceased loved ones in this community! I saw them drop the corpse of my late child on the ground as though it was a bag of cassava. . . . It was such a painful and sorrowful scene that no one would be happy to see and talk about.[10(p17)]
>
> —A mother from Moyamba district prior to implementation of new procedures

> Before this time [of an approach that re-incorporated religious rituals] those burial people were not polite. They used inflammatory languages against bereaved families and the corpse; and they handled the corpse in a dehumanizing manner. However, we saw them as changed people when we were bereaved. . . . They were very polite; they asked us to provide cloth for the corpse, dig the grave and involved a religious leader to pray. There was no change to what we used to do before Ebola, except for the use of the body bag.[10(p23)]
>
> —A family member from Kono district after new procedures were implemented.

In October 2014, the same month in which the revised protocol was implemented, 6383 new cases of Ebola were reported in the region.[3] In November 2014, the monthly incidence rate was 3884, dropping to 3060 in December 2014. By January 2015, the month in which modeling had initially forecast the possibility of 1.4 million total cases of Ebola,[4] the monthly number of new cases had dropped to 1886. The upward trendline in the outbreak had reversed. Although no research into the impact of the modified protocol on infection rates was carried out in Sierra Leone, data from Liberia attributed containment of Ebola transmission to increased community reporting of deaths to authorities and demonstrated, in turn, that the implementation of various procedures that encouraged safe and dignified burials was the primary factor in such increases.[11]

The effects of religion were not limited to modifications to infection control procedures. Because religious leaders and local faith communities were already integral, valued parts of local communities, and because they could serve as trusted messengers because of their collective social capital, interreligious networks became essential conduits for sharing information and for catalyzing prevention and response efforts in the region. For example, the Interreligious Council of Sierra Leone established a Religious Leaders Taskforce on Ebola. The Interreligious Council met with President Koroma directly and then penned a letter to him detailing their commitment to support the government's Ebola response. That letter read, in part,

> We suggest programs to train, equip and involve community structures in the burial of their loved ones to ensure safe and dignified funerals. As a taskforce, we will make our structures and systems available to facilitate the spiritual aspects of the funeral.
>
> In conclusion, as a religious body, we wish to reiterate our continued and unreserved resolve to work with and support the government and all other partners in the fight to eradicate Ebola from our land.
>
> —*Sheikh Abu Bakarr Conteh and Bishop John Yambasu (personal communication, October 22, 2014)*

The taskforce reaffirmed the central role of local FBOs in responding to the epidemic. Examples of such groups included local Christian Action Groups (CHRISTAG) and Islamic Action Groups (ISLAG) that had been established in the 1980s in every district of Sierra Leone to support childhood immunization and other health initiatives. These groups included religious leaders, some of whom were also local and traditional government leaders. ISLAG and CHRISTAG had already established partnerships and communication mechanisms between local religious leaders and the Ministry of Health. The local responses to the Ebola epidemic were coordinated by FOCUS 1000, a Sierra Leonean nongovernmental organization, with funding from the Department for International Development in the United Kingdom. Through the efforts of FOCUS 1000, Muslim and Christian leaders developed an array of materials for use in local mosques and churches. Drawing on passages from the Qur'an and the Bible, these leaders created curricula and prototype sermons and khutbahs designed to educate local congregations and communities on Ebola prevention while re-enforcing a message of love and compassion in a context in which suspicion and fear were high.[12,13]

In addition, the local action groups worked in collaboration with the Sierra Leone Traditional Indigenous Healers Union in activities that bridged the beliefs and rituals of African Traditional Religion, Christianity, and Islam. By July 2015, FOCUS 1000 had directly engaged more than 3000 indigenous leaders and traditional healers to address Ebola transmission risks. This represented a marked shift. In the earliest outbreak response, the activities of traditional healers were suspended under local government mandates. FOCUS 1000 worked to re-establish collaborations with traditional healers and practitioners of indigenous spiritual traditions, who then played a key role in providing entry into local communities often insulated from outsiders to identify the last Ebola cases.[14–17]

Such efforts to engage local healers side by side with Christian and Muslim leaders revealed a bias and limit in the WHO protocol: the failure to include ritual practices and belief systems outside of Christianity or Islam. Social networks established through collaboration among the Sierra Leone Traditional Indigenous Healers Union, CHRISTAG, and ISLAG were undoubtedly important in reaching some of the last communities affected by Ebola in Sierra Leone. However, we could not help but wonder why local healers were not included in efforts to adapt protocols for burial so that rituals beyond Christianity or Islam might be included. Although there is no way to know what effect the inclusion of such rituals might have had, it is important to note that the adapted protocol did not fully reflect the healthworld of many people in Sierra Leone, a healthworld informed by indigenous spiritual beliefs and practices alongside Christianity or Islam.

Other innovative campaigns were carried out through religious networks. The United Methodist Church coordinated messages on local radio and established a daily text messaging service that reached hundreds of thousands across the region with Ebola prevention information, appropriate Scriptures and prayers, and contact information for obtaining targeted services.[18]

Religion is a social phenomenon with varied effects. In the case of the 2014 to 2016 Ebola outbreak, not all of those effects furthered the public health response to the epidemic. Developing strategies to align the public healthworld and the cultural healthworld was often difficult, and religion sometimes contributed to the collision of those worlds. For example, not all religious leaders articulated strong messages of support and compassion or sought to allay fears. In some instances, they spread misinformation, stoked fears, or re-enforced suspicion of health officials and the broader public health response.[19–22] In other instances, religious proclamations blamed stigmatized communities for the outbreak, effectively making them scapegoats.[22]

Ebola offers a compelling case study into the varied influences of religion on public health. On the one hand, public health leaders believed that minimizing the risk of infection when handling the bodies of those who died was paramount, even if this could only be achieved by foregoing important religious rituals. On the other hand, people in many parts of West Africa believed that abandoning these traditional practices "essentially constitutes heresy and, in the eyes of friends and family members, dooms the dead to a grim hereafter or leaves them to walk the earth as ghosts, vengefully haunting those among the living who failed to provide proper passage into the afterlife."[13] Bowenson Phillips, the former Chief Administrator for the Freetown (Sierra Leone) City Council put it this way: "The terror the living face from not carrying out the burial rituals is more than the fear of contracting

Ebola from a corpse."[21] Many of the challenges that vex interdisciplinary practice and research in the emerging field of religion and public health reflect the simple fact that the variability of religion as a social force means that public health and religion will be both in conflict and in alignment in relation to most issues of health, illness, life, and death at any given time. Ebola offers ample evidence of this, as does HIV.

RELIGION AND GLOBAL HIV

For the last 3 decades in parts of the world with the greatest HIV disease burden, faith-based health facilities have been essential providers of HIV prevention, treatment, and support services. This is especially true in sub-Saharan Africa, where faith-based providers are the largest nongovernmental providers of HIV services.[23(p14)] In 2012, Eric Goosby, then the Director of the US President's Emergency Plan for AIDS Relief (PEPFAR), described FBOs as central to all of PEPFAR's achievements, stating that

> FBOs have long histories and strong community roots, and a deep reservoir of trust on which to draw. Robust participation of FBOs is not optional — it is essential for an effective response to AIDS.[24(p4)]

The 2004 World Health Report published by WHO estimated that FBOs accounted for 20% of all the agencies working on HIV globally.[25] Today, in Nairobi, Kenya, 40% of adults living with HIV on antiretroviral treatment (ART) receive their care from a faith-based facility; that percentage rises to 76% for children living with HIV who receive ART.[26(p652)] Therefore, there is no question that the contributions of FBOs in providing HIV clinical services are essential. Not surprisingly, however, religion remains a double-edged sword in the context of HIV, much as it does with Ebola.

Across the world, the social groups with the highest HIV disease burden are also the same groups facing the greatest social stigma. Global HIV leaders have named these groups—including men who have sex with men, sex workers, people who inject drugs, and young women—key populations. The stigma they face is often religiously motivated.[27–29] A report by Blevins and Corey[27] describes the courageous work of the Ugandan Anglican Bishop Christopher Senyonjo in support of Uganda's LGBTQ+ communities and his advocacy for HIV services. Various public health researchers and policy experts have noted the negative impact of religion on HIV programs, especially programs that focus on services for key populations. In her analysis of PEPFAR, Helen Epstein argued that effective, comprehensive HIV prevention programs were abandoned in favor of abstinence-only initiatives because of the political power of conservative Christians.[30] Scott Evertz, the former director of National AIDS Policy in the George W. Bush administration, argued that religious ideology compromised global HIV efforts and lessened the impact of PEPFAR, with the brunt of these effects most felt by key population groups.[31]

However, religious leaders, local faith communities, and grassroots FBOs also challenge the ideologies that Evertz and Epstein critiqued. A number of faith-based initiatives and grassroots FBOs have responded to the stigma that members of key populations communities face, often challenging stigmatizing religious rhetoric within their own traditions.[22,25] Global religious bodies such as the Ecumenical HIV and AIDS Initiatives and Advocacy platform of the World Council of Churches, the Ecumenical Advocacy Alliance, American Jewish World Service, the International Network of Religious Leaders Living With or Affected by AIDS, the Inner Circle (a Muslim religious community in South Africa), and the Channels of Hope initiative of World Vision each carry out a number of activities that offer support, examine theological teachings, and advocate for compassion and an end to discriminatory laws. For information on Ecumenical HIV and AIDS Initiatives and Advocacy, see https://www.oikoumene.org/en/what-we-do/ehaia. For information on Ecumenical Advocacy Alliance, see https://www.oikoumene.org/en/what-we-do/eaa. For information on American Jewish World Service, see https://ajws.org. For information on International Network of Religious Leaders Living With or Affected by AIDS, see http://inerela.org. For information on the Inner Circle, see http://www.theinnercircle.org.za. For information on Channels of Hope, see https://www.wvi.org/health/publication/channels-hope. Some of these efforts, most notably World Vision's Channels of Hope program, were adapted in West African contexts to address the 2014 to 2016 Ebola outbreak. Various global leaders in the Ebola response effort in 2014 to 2016 modeled their engagement with religious leaders and FBOs on the faith-based platforms developed to respond to HIV.[32–34]

The examples named here are all Christian or Muslim programs. People from other religious traditions have also developed effective HIV programs. The greater knowledge of programs from Christianity and Islam, and the relative lack of knowledge of programs from those other traditions—including indigenous spiritual practices in African cultures—reflects a bias also seen in the Ebola response. For an analysis of the relationship between HIV and indigenous spiritual rituals, both Setel[35] and Rödlach[36] provide a strong introduction to this subject. Much of the work in the emerging field of religion and public health has focused on Christianity and Islam, and research into the relationship between public health and other religious practices is sorely needed.

There are similarities and differences in the faith-based responses to Ebola and HIV. In both contexts, rumors have been widespread and religion may fuel such misinformation or correct it. Similarly, religion has been used both to justify stigma and to challenge it. In addition to stigma, HIV and Ebola have precipitated adverse mental health outcomes among affected populations. Religious leaders and FBOs have offered psychosocial support for Ebola survivors and HIV patients, especially in settings where clinical counseling services may be limited. The need for such services may arise, at least in part, when religion underwrites messages and practices that justify stigma and judgmental attitudes.

At the same time, there are differences. HIV affects socially marginalized communities disproportionately, and religion is a key driver of that marginalization. Ebola made no such distinctions but represented a generalized epidemic. Finally, disease manifestation and the possibility of mortality occurs within a few days to weeks in the case of Ebola, whereas HIV infection may go undiagnosed for years before the onset of AIDS. This leads to different cultural narratives for interpreting each disease as a cultural phenomenon.[37]

In conclusion, a variety of social forces contribute to the creation of healthworlds; for many, both medical frameworks commonly used in public health practice and conceptualizations of health derived from religious teachings and practices contribute to those healthworlds. In the cases of both Ebola and HIV, those medical frameworks and religious teachings may be in conflict. However, religion is a complex social phenomenon, and it can also build alignments. Such alignments cannot happen without some shifts in perspectives from religious and public health contexts. We noted such shifts. In the following, we briefly described 5 lessons learned that could inform such shifts to align religion and public health practice in our shared healthworlds.

LESSONS LEARNED FOR THE FUTURE

Opportunities and challenges arose when working with religious leaders and FBOs in response to Ebola and HIV. Lessons learned from such efforts will be important for responding to the next global health threat—a threat that is surely coming. These lessons include (1) following the varied effects of religion; (2) essential contributions; (3) shared purpose; (4) social networks; and (5) organizational capacity.

1. Religious beliefs and practices are double-edged: they can drive stigma or be used to challenge stigma. Religiously motivated stigma has long been part of various societies' response to HIV; religious messages to challenge such stigma have also been part of compassionate HIV responses. In the 2014 to 2016 Ebola outbreak, leaders used religious texts and practices to address stigmatizing perspectives, encourage compassion, and urge calm.
2. It is possible to organize and catalyze the significant capacities of faith-based partners respectfully and efficiently. The impressive HIV services that FBOs provide in both clinical and psychosocial settings demonstrate the potential contributions that FBOs can make in response to a health need.
3. Public health officials must identify common ground with faith-based partners by showing respect for religious beliefs and practices rather than attempting to suspend them so that the "real work" of disease surveillance can be done. Modifications to religious practices can be made, but this must be done with insiders to religious traditions taking the lead on what those modifications can be.[38]
4. Religious networks are essential for getting resources from the outside to local communities most in need. However, a new social network cannot easily be built during an emergency because trust is essential for building it and difficult to establish in an emergency. Therefore, existing networks must be respected, understood, and maintained over time. There are bridging actors between internally focused, localized community networks and the large-scale, national or international partners. Identifying and nurturing those bridges is important and should not be a one-time activity.
5. Even as social networks are established, maintained, and strengthened over time, organizational networks must also be encouraged. This is especially important in regions of the world with compromised national health systems. In such contexts, those organizational networks—including national-level faith-based health systems such as those found in many countries in sub-Saharan Africa—can supplement national health systems. In public health emergencies, community-based networks can effectively integrate with the health response and provide critical entry into communities through a foundation of long-standing trust, cooperation, and partnership. AJPH

CONTRIBUTORS

J. B. Blevins was the principal author of this article. He developed the outline and article in collaboration with the other authors and revised the article based on the reviewers' input. M. F. Jalloh worked to coordinate Ebola response efforts through FOCUS 1000, a nongovernmental organization in Sierra Leone; that work helped inform the content of the paper. He contributed to the article outline, content, and format. He worked with the principal author and the other co-author to revise the article in response to reviewers' comments. D. A. Robinson served on the Ebola Response Leadership Team of World Vision International, a global faith-based organization with programs in various West African countries impacted by the 2014 to 2016 Ebola outbreak; that work helped inform the content of the article. He contributed to the article outline, content, and format. He worked with the principal author and the other co-author to revise the article in response to reviewers' comments.

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REFERENCES

1. World Health Organization Origins of the 2014 Ebola epidemic. 2015. Available at: http://www.who.int/csr/disease/ebola/one-year-report/virus-origin/en. Accessed June 13, 2018.

2. World Health Organization. Ebola virus disease in Guinea. 2014. Available at: http://www.who.int/csr/don/2014_03_23_ebola/en. Accessed June 13, 2018.

3. Centers for Disease Control and Prevention. Ebola (Ebola Virus Disease). Case counts. 2017. Available at: https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/case-counts.html. Accessed June 13, 2018.

4. Meltzer MI, Atkins CY, Santibanez S, et al. Estimating the future number of cases in the Ebola epidemic—Liberia and Sierra Leone, 2014-2015. *MMWR Suppl*. 2014;63(3):1–14.

5. Reichler MR, Bangura J, Bruden D, et al. Household transmission of Ebola virus: risks and preventive factors, Freetown, Sierra Leone, 2015. *J Infect Dis*. 2018;218(5):757–767.

6. Germond P, Cochrane J. Healthworlds: conceptualizing landscapes of health and healing. *Sociology*. 2010;44(2):307–324.

7. Ohlheiser A. People are struggling to bury the Ebola dead. Here's why. *The Washington Post*. August 7, 2014. Available at: https://www.washingtonpost.com/news/world/wp/2014/08/07/people-are-struggling-to-bury-the-ebola-dead-heres-why/?utm_term=.37290752eebc. Accessed June 13, 2018.

8. Lloyd E, Perry H. *Infection Control for Viral Haemorrhagic Fevers in the African Health Care Setting*. Atlanta, GA: Centers for Disease Control and Prevention; 1998.

9. World Health Organization. How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola or Marburg virus disease. 2014. Available at: http://apps.who.int/iris/bitstream/handle/10665/137379/WHO_EVD_GUIDANCE_Burials_14.2_eng.pdf?sequence=1. Accessed June 13, 2018.

10. CAFOD, CRS, World Vision UK. Protecting the living, honouring the dead: the barriers and enablers to community acceptance and implementation of safe burials. 2017. Available at: https://www.worldvision.org.uk/files/7714/9149/5615/WV_SierraLeone_Report_WEB.pdf. Accessed June 13, 2018.

11. Funk S, Ciglenecki I, Tiffany A, et al. The impact of control strategies and behavioural changes on the elimination of Ebola from Lofa County, Liberia. *Philos Trans R Soc Lond B Biol Sci*. 2017; 372(1721):pii: 20160302.

12. Centers for Disease Control and Prevention. Louise Shaw and Mohamed Jalloh, who worked within the communities of Sierra Leone in West Africa during the Ebola crisis. Available at: https://www.facebook.com/CDC/videos/10155703844596026. Accessed June 14, 2018.

13. Garrett L. Facing death without spreading disease. 2014. Available at: http://foreignpolicy.com/2014/12/11/facing-death-without-spreading-disease-ebola-sierra-leone. Accessed June 13, 2018.

14. Sesay S. Traditional healers on contact tracing drive in the north. Available at: http://www.focus1000.org/index.php/blog-1/150-traditional-healers-on-contact-tracing-drive-in-the-north. Accessed June 13, 2018.

15. Carey N. Ebola and poro: plague, ancient art, and the new ritual of death. Available at: http://www.porostudiesassociation.org/ebola-and-secret-societies. Accessed June 13, 2018.

16. Kamara JA. All secret society activities banned in Makeni. Sierra Express Media. 2014. Available at: http://sierraexpressmedia.com/?p=69930. Accessed June 13, 2018.

17. Koroma D. Focus 1000 supports religious leaders on Ebola prevention. Premier Media. 2014. Available at: http://www.premiermedia.sl/content/focus-1000-supports-religious-leaders-ebola-prevention. Accessed June 13, 2018.

18. Gilbert KL. Life-saving Ebola messages in 160 characters or less. 2014. Available at: http://www.umc.org/news-and-media/life-saving-ebola-messages-in-160-characters-or-less. Accessed June 13, 2014.

19. Agusto FB, Teboy-Ewungkem MI, Gumel A. Mathematical assessment of the effect of traditional beliefs and customs on the transmission dynamics of the 2014 Ebola outbreaks. *BMC Med*. 2015;13(1):96.

20. Fassassi A. Managing rumours and misinformation in West Africa. 2015. Available at: https://www.scidev.net/global/ebola/feature/ebola-rumours-misinformation-west-africa.html. Accessed June 13, 2018.

21. Taylor J. Religious practices will trigger Ebola, activists warn. 2018. Available at: https://themediaproject.org/news/2018/1/24/religious-practices-will-trigger-ebola-warn-activists. Accessed June 13, 2018.

22. Suh B. Liberian religious leaders blame "homosexualism" for Ebola outbreak, declare "God is angry." Human Rights Campaign. 2014. Available at: https://www.hrc.org/blog/liberian-religious-leaders-blame-homosexualism-for-ebola-outbreak-declare-g. Accessed October 30, 2018.

23. US Department of State. Building on firm foundations: The 2015 consultation on strengthening partnerships between faith-based organizations and PEPFAR to build capacity for sustained responses to HIV/AIDS. Washington, DC: US Department of State, 2015. Available at: https://www.pepfar.gov/documents/organization/247613.pdf. Accessed June 13, 2018.

24. US Department of State. A firm foundation: The PEPFAR consultation on the role of faith-based providers in sustaining community and country leadership in the response to HIV/AIDS. Washington, DC: US Department of State, 2012. Available at: https://www.pepfar.gov/documents/organization/195614.pdf. Accessed June 13, 2018.

25. World Health Organization. *The World Health Report 2004: Changing History, Community Participation in Public Health*. Geneva, Switzerland: World Health Organization; 2004.

26. Blevins J, Kiser M, Lemon E, Kone A. The percentage of HIV treatment and prevention services in Kenya provided by faith-based health providers. *Dev. Pract*. 2017;27(5)646–657.

27. Blevins J, Corey E. Valuing every human life: how faith-based organizations can support key populations with HIV prevention, treatment, and support services. Atlanta: Interfaith Health Program. 2013. Available at: http://ihpemory.org/wp-content/uploads/2014/06/Key-Populations-Report-Final.pdf. Accessed June 13, 2018.

28. Blevins J, Irungu P. Different ways of doing violence: sexuality, religion, and public health in the lives of same-gender-loving men in Kenya. *J Am Acad Relig*. 2015;83(4):930–946.

29. Blevins J. When sodomy leads to martyrdom: sex, religion, and politics in historical and contemporary contexts in Uganda and east Africa. *Theol Sex*. 2015; 17(1):51–74.

30. Epstein H. *The Invisible Cure: Why We Are Losing the Fight Against AIDS in Africa*. New York, NY: Picador; 2008.

31. Evertz S. How ideology trumped science: why PEPFAR has failed to meet its potential. Washington, DC: Center for American Progress; 2010. Available at: https://www.americanprogress.org/issues/healthcare/reports/2010/01/13/7214/how-ideology-trumped-science. Accessed June 13, 2018.

32. Ross J. World AIDS Day. Q/A with World Bank's David Wilson. 2014. Available at: http://blogs.worldbank.org/health/world-aids-day-qa-world-bank-s-david-wilson. Accessed June 13, 2018.

33. The World Bank. Speech by World Bank Group President Jim Yong Kim at the high-level meeting on response to the Ebola virus disease outbreak. 2014. Available at: http://www.worldbank.org/en/news/speech/2014/09/25/speech-world-bank-group-president-jim-yong-kim-meeting-ebola. Accessed June 13, 2018.

34. World Vision. World Vision Sierra Leone. Available at: https://www.wvi.org/sites/default/files/Sierra%20Leone%20-%20Final.pdf. Accessed June 13, 2018.

35. Setel P. *A Plague of Paradoxes: AIDS, Culture, and Demography in Northern Tanzania*. Chicago, IL: University of Chicago Press. 2000.

36. Rödlach A. *Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa*. New York, NY: Routledge; 2006.

37. Davtyan M, Brown B, Folayan MO. Addressing Ebola-related stigma: lessons learned from HIV/AIDS. *Glob Health Action*. 2014;7:26058.

38. Manguvo A, Mafuvadze B. The impact of tradition and religious practices on the spread of Ebola in West Africa: time for a strategic shift. *Pan Afr Med J*. 2015; 22(suppl 1):9.