



Beyond Ebola

From dignified response
to dignified recovery

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Saving lives, changing minds.

 International Federation
of Red Cross and Red Crescent Societies

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Guided by *Strategy 2020* – our collective plan of action to tackle the major humanitarian and development challenges of this decade – we are committed to ‘saving lives and changing minds’.

Our strength lies in our volunteer network, our community-based expertise and our independence and neutrality. We work to improve humanitarian standards, as partners in development and in response to disasters. We persuade decision-makers to act at all times in the interests of vulnerable people.

The result: we enable healthy and safe communities, reduce vulnerabilities, strengthen resilience and foster a culture of peace around the world.

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Cover photo: *A young child in the town of Gueckedou, the epicentre of the Ebola outbreak in Guinea. Moustapha Diallo/IFRC.*

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Members of a Liberian Red Cross Safe & Dignified Burials (SDB) team remove the body of a suspected Ebola fatality from his home in Paynesville, Liberia. Thousands of people have died in Liberia as a result of the Ebola outbreak which began in March 2014. Victor Lacken/IFRC

Foreword

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Ebola will be back unless we change the way we think

Ebola is no stranger to Africa but, for the past year and a half, a West African epidemic has forced us all to rethink how we should respond to health emergencies. **Unless the lessons learned in Guinea, Liberia and Sierra Leone are put into universal practice, the virus disease will return – and a repetition does not bear thinking about.**

The West African outbreak that began in December 2013 is still with us and, while new infections have declined dramatically and success has been booked, an end is not yet in sight. The World Health Organization has reported more than 28,991 cases and over 11,300 deaths.¹

So why has Ebola been so rampant this time around? Over the four decades since scientists discovered it in the Congolese rainforest, we have confronted more than a score of outbreaks, in the Democratic Republic of the Congo, and the neighbouring Congo Republic, in Gabon, South Africa, Sudan and Uganda. It is one of the world's most virulent diseases and, in the past, has had an average case fatality rate of 50 per cent, up to 90 per cent in some outbreaks. But the number of cases was modest compared to recent events, short-lived, and mostly confined to remote places.

West Africa's cultural, political and geographical context, with porous borders and a mobile population, has had much to do with the unprecedented scale of this epidemic. So has the parlous state of health systems, some in countries not long emerged from conflict. Community distrust – of institutions and agencies – has most certainly had an impact. As a consequence, health information campaigns have struggled. More than a year on from the start of the outbreak, pockets of people still refuse to accept that Ebola really exists.

There are lessons for everyone to learn from this. **Communities themselves have to be engaged if the disease is to be eradicated. More than that, they need to be prepared and, better still, in a state to prevent epidemics.** Ebola stops when the public at large understands it, and knows how people can be protected. It stops early when infection is isolated early.

No standard solution can deal with this. No preconceived foreign model. Where we have had success, it has developed from honest dialogue. We have shared information and listened very hard to what communities have had to tell us.

People's mind-sets had to change and the threat of Ebola, through deep-seated cultural practices such as burial rituals had, to be understood. Misconceptions had to be addressed. **Success has come where communities truly were our partners.** We have made our mistakes, as have other organizations, but what we got right was this: our response has been one of solidarity. We have focused on dignity and respect. Now as we move on, **we must ensure that our safe and dignified response leads into safe and dignified recovery. We urge our humanitarian partners to continue along that path as well.**

Engaging communities and their local leaders is essential to achieving lasting health impacts. **At-risk communities and local actors must be the key drivers of change** and at the core of a decision-making process that draws on local knowledge and capacities. **We must continue to build trust with local communities by listening to them, letting them lead and being a partner.**



1 WHO Ebola data and statistics: <http://apps.who.int/gho/data/node Ebola-sitrep Ebola-summary?lang=en>

The Red Cross and Red Crescent is community-based. **Our people were there before the outbreak and they will remain there when it is over** and most of the other responders have gone. It is what we have always been about, and **our volunteers will continue to support communities as they recover, not only in relation to Ebola but also to parallel health and humanitarian challenges.**

What the world must understand is that **West Africa's epidemic has been about more than Ebola** itself. It has shown how weak health systems with insufficient health workers unable to respond to emerging needs can spiral into a severe humanitarian crisis, especially when international response is slow. Whether it be in Ebola affected areas or anywhere else, support for **health and community systems is central to ensuring universal health access, and that is the cornerstone of resilient communities and sustainable development.**

Fragile states like Guinea, Liberia and Sierra Leone, where governments cannot deliver basic services to the majority of their people, present massive challenges in safeguarding health. Half the global deaths of children under five, and one-a third of maternal deaths, occur in fragile states, and Sierra Leone provides a prime example. Its mortality rates are among the world's highest.

Ebola is telling us that illness is universal but access to care is not, and that has to change. All we need are resources and commitment to boost community systems for an effective health response.

Alasan Senghore

IFRC Africa Regional Director

“Ebola is telling us that illness is universal but access to care is not, and that has to change. We need commitment to boost community systems for an effective health response.”

1. Executive summary

More than scale makes West Africa's Ebola epidemic momentous, although that in itself has tested the world's response to the limit, and asked questions of how we respond to insurgent infections in the future.

The geographical spread in Guinea, Liberia and Sierra Leone has brought enormous challenges. Urban and rural, from hotspots in the slums of capital cities to others in remote countrysides, it has even caused concern that sudden surges might be missed or rapid response capacity might simply be insufficient.

The numbers are truly horrific: over 11,200 deaths and more than 27,600 cases by mid-July 2015. Overall the situation was improving, but concerted efforts were still required to get to zero cases and stay there. Even after Liberia was declared Ebola free, new cases occurred there. In Guinea and Sierra Leone, cases were down significantly from those recorded at the end of 2014, but in the week to July 5, Guinea reported 18 cases and Sierra Leone, nine. Weekly case incidence in the region had stalled at between 20 and 30 for six consecutive weeks and cases continued to arise from unknown sources of infection, or were detected only after post-mortem testing.

So the threat to the region continued. As humanitarians firmed up recovery plans, they were aware that response was still needed. The danger of fresh outbreaks, and even re-emergence in areas cleared of the virus, meant response and recovery operations might have to run side by side.

Alongside scale, the epidemic's unpredictability has challenged operations: it has done the most unexpected things. When it was thought the disease would wane, it would simply flare up again. And it has never been so urban.

An epidemic that assumes the proportions it has is of a different order to disasters commonly dealt with. Normally, disaster response starts in the worst situation and plans to work through an improving one. The worst comes first. The Ebola epidemic was the other way round – getting much worse over an extended period before it got better. Conventional disaster response mechanisms were inadequate as a consequence.

With a common disaster, there may be early warning, and on Day One in any case, responders will be there, meeting first needs, assessing the damage, preparing a further plan of action. Day Two will be better, Day Three better still, and so we go on, from relief to recovery, to building back better.

Ebola was a moving target, travelling fast in uncharted ways, and it turned the graph on its head. **What was needed was public health emergency response within disaster management systems. Paradigms needed to be re-examined.** It could be that a modified disaster approach should be developed for future epidemics, building on Red Cross and Red Crescent experience with SARS, cholera, meningitis, MERS, H1N1 and measles. **Ebola is not going to go away, and the international community needs to ask if the response to epidemics can be strengthened.**

A prerequisite the West Africa outbreak has underlined is the **early detection, diagnosis and isolation of the virus.** Surveillance and contact tracing have formed one of five pillars on which our response has stood, along with community engagement, safe and dignified burials and disinfection, psychosocial support, and case management and treatment. Teams of Red Cross volunteers have traced and monitored tens of thousands of people.

“Our volunteers will remain in the communities. Harnessing this resource is key to ensuring Ebola-affected communities are built back stronger.”

Community engagement has been central to much of the response. While information passed on to communities helps to keep them safe, and the virus contained, structured feedback from them helps guide decision making. **The West African epidemic has underlined that we must embed such dialogue into response operations.** It cannot come as an afterthought, a post-response intervention.

The bottom line is, you cannot simply treat your way out of a public health emergency on this scale, and we will not be able to do so during future outbreaks.

Effective community engagement would have been impossible without Red Cross volunteers. Since the start of the epidemic, **more than 10,000 of them now with the Red Cross Society of Guinea, The Liberia National Red Cross Society, and the Sierra Leone Red Cross Society, have been trained specifically for Ebola.** In all, the three societies have double that number on the ground.

Some have laid their lives on the line – a few have died as a consequence – many have faced stigma and discrimination from people who think that because of their work the volunteers themselves may be infected.

Nonetheless, by the beginning of August 2015, along with Red Cross staff, and with support from over 30 Red Cross and Red Crescent partner societies from around the world, they had reached 7 million people through social mobilization and beneficiary communication programmes. They had helped to safely bury 34,448 bodies, see 1,341 people admitted to Red Cross Ebola treatment centres, provide 339,000 people with psychosocial support, and trace and monitor more than 97,000 thought to have had contact with infected people.

Alasan Senghore, the IFRC's Director of Africa zone, pointed out that when the epidemic is over, and the recovery work is done, **those volunteers will remain, within their communities. No other organization has such a resource and harnessing it is key to ensuring Ebola-affected communities are more resilient and built back stronger.**

Our volunteers can be deployed, not only against Ebola, but against other diseases that trouble the region as well, and in immunization campaigns, and the scale-up of established community-based health programmes that are well placed to meet gaps in basic health services. But when the incentives that come with a large-scale response such as this one are gone, and people return to regular occupations and day-to-day struggles, **we must ensure this volunteer base continues to stay engaged and is there when communities need it.**

A call to action

The IFRC urges its membership and all its partners to continue to support our three frontline National Societies. It calls on:

Governments to ensure that Red Cross volunteers are integrated into the community health workforce. As trusted members of the community, they can rapidly deliver crucial and culturally sensitive health messages, enabling communities to make informed decisions, increasing their engagement and access to life-saving preventive and curative measures.

Partners not to abandon the workforce they have trained during these Ebola response operations. We know keeping this workforce engaged will reduce death and suffering significantly.

All humanitarian organizations to embed community engagement into their response operations. The Red Cross saved countless lives during the Ebola outbreak by being able to simultaneously listen to communities' concerns, and educate them on how to keep safe from the disease.

Donors to continue to:

- invest in public awareness and education for changing minds and behaviours of current and future generations. Community engagement through social mobilization and beneficiary communication has been key to ending this outbreak.
- support those who have survived Ebola, as well as affected communities and households as they begin to rebuild their lives. The threat of the virus is not simply to life, but also to livelihoods, and recovery must assist them to become more resilient to future risks and epidemics.



*Hawa Jollah, Ebola survivor
and Red Cross nurse in
Kenema, Sierra Leone. Tommy
Trenchard/IFRC*

2. Ebola in Africa

Around the world, fear and suspicion, myths and misconceptions have accompanied Ebola Virus Disease. A widely known story in Sierra Leone tells of a village woman who left a mysterious box at home when she set out on a journey.

“Do not open it,” she instructed her husband.

The man was curious and opened it, nevertheless, to find there was a snake inside. It warned him he must keep its presence secret or it would slaughter everyone in the village. He again ignored the instruction, told everyone he met, and the snake carried out the threat. The population was wiped out by Ebola.

Ensuring people understand what Ebola really is – and what can be done about it – has been one of the great challenges of West Africa’s current epidemic. Fear spreads faster than any disease, and spreading life-saving information has been a critical undertaking.

Ebola is a rare, severe and often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission. There is currently no cure or vaccine for it, although vaccines are being tested. But dialogue and collaboration for community-driven safety programmes based on a respect for cultural contexts can stop the disease from spreading.

Ebola was discovered in 1976 in a remote part of what is now the Democratic Republic of the Congo. Named after a Congolese river, it had reappeared since then in 23 documented outbreaks among humans in various parts of Africa. The incidence had been modest, mostly less than 500 cases a year, and from 1979 to 1984 none had been reported at all.

All that has now changed. Since the first cases were confirmed in Guinea in March 2014, the West African outbreak has moved on to another scale. It is the largest – and most complex – Ebola occurrence ever, both in terms of caseloads and geographical spread. More people have died in West Africa, indeed, than in all the other outbreaks put together and the figures may even be higher than those reported.

While the spotlight has been on Guinea, Liberia and Sierra Leone, three other countries – Mali, Nigeria and Senegal – have also been affected, albeit to a much lesser extent. Eight deaths were reported in Nigeria and six in Mali before, in due course, all three countries were declared Ebola-free. In mid-2014, a separate outbreak occurred in the Democratic Republic of the Congo as well, but involving a different strain of the virus and unrelated to West Africa’s epidemic.

An epidemic unfurls

The first warning signs in West Africa came from Guinea’s south-eastern regions. In December 2013, in a small village near the borders with Liberia and Sierra Leone, a two-year-old boy died after a few days’ sickness. His fever, vomiting and diarrhoea quickly spread through his house. His mother died a week later, followed by his sister and grandmother, the World Health Organization (WHO) has reported.

Mourners from elsewhere came to the funerals and soon cases of the sickness occurred in their villages. Then a health worker died and a doctor, and then patients they had treated, and patients’ relatives living elsewhere.

“Fear spreads faster than any disease, and spreading life-saving information has been a critical undertaking. Behavioural change among people aware of the dangers can stop the disease from spreading.”

“The Ebola outbreak demanded that we put aside our traditions and culture to beat this sickness. It was not easy to do. However, our volunteers were out everyday convincing people to follow the protocols and accept that Ebola is real. We could do this because our volunteers are trusted voices in their communities. Our burial teams have treated the deceased and their families with dignity and respect. At the Red Cross, we do not only speak to communities, we listen to them. We need to ensure that their voices are heard while we look to strengthen Sierra Leone.”

Constant HS Kargbo,
acting Secretary
General, Sierra Leone
Red Cross Society

The boy's home village also fell within a municipality with a busy weekly market. Traders came there from all over southern Guinea, and from across the national borders, from Cote d'Ivoire, Liberia and Sierra Leone. When they went home, some may have taken the virus with them. WHO retrospective case finding found that one of the epidemic's first 14 deaths was in Sierra Leone.

Although the sickness was suspected earlier, poor communications and political and cultural resistance delayed official recognition until March. By then, deaths had been reported from eight towns and villages in Guinea, along with a spate of suspected cases in neighbouring countries. An epidemic was unfurling that would quickly overwhelm health systems and catch the world unprepared for what would follow.

Liberia formally declared an Ebola outbreak at the end of March, Sierra Leone in May, Nigeria and Senegal in August, and Mali in October. Swift and robust crisis management unleashed by government contained the disease in Nigeria and Senegal and they were declared Ebola free in October. Mali was free two months later.

Through 2015, incidence has generally fallen but August's figures show cumulative cases had reached almost 27,900 a timely reminder that until every country is Ebola free, efforts to stop the epidemic should not slacken.

A threat to life and livelihood

The threat of the disease is not simply to life, but to livelihood. Freeing West Africa of Ebola is critical to the economies of the worst affected countries as well.

World Bank estimates warn that in 2015 Guinea, Liberia and Sierra Leone will lose at least US\$1.6 billion in forgone economic growth as a result of the epidemic. It has also wiped out many recent development gains.

Food and income security will be major challenges in many communities. In urban areas, it is reported, Ebola has seriously disrupted employment, and agriculture – upon which two-thirds of West Africa's population depends – has been very badly hit.

Many farmers have abandoned their land out of fear, or simply fled in panic from rural outbreaks. The dread of infection has discouraged people from working together. Meanwhile, access to major food markets has been hampered by cross-border movement restrictions and, along with reduced production, caused food prices to fluctuate.

Long-standing food insecurity can only worsen as a consequence and UN food agencies have warned that more than one million people are at risk of hunger. Norbert Allale, head of the IFRC's regional Ebola operation, says in the already impoverished countryside it is the most vulnerable who will suffer most. Listening to them must be a hallmark of any response or recovery process.

Red Cross recovery programming will aim to restore households not only back to where they were before the outbreak, but assist them in becoming more resilient to future risks and epidemics.

"In the already impoverished countryside it is the most vulnerable who will suffer the greatest. Listening to them must be a hallmark of any response and recovery process."

Norbert Allale,
IFRC, Head of Ebola
operations

3. Red Cross and Red Crescent approach to Ebola in Africa: a radical, respectful rethink

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11 year old Kadiatu Bangura contracted Ebola, along with the rest of her immediate family, after they had cared for a sick neighbour in Freetown. The family was separated for treatment. Kadiatu, on her own, was taken to the Red Cross treatment centre in Kenema, five hours away. She arrived frail and lethargic, but through care, slowly began to improve, and after almost two weeks at the centre, her two Ebola tests came back negative and she was allowed to return home. Here, staff at the centre engage with Kadiatu to get blood for one of the Ebola tests. Katherine Mueller/IFRC.

The community itself must stop Ebola

It has been one of the most challenging public health crises the world has known in recent times, an epidemic of a hugely contagious disease that swept through West Africa at a speed, and on a scale, that caught the world on the hop. Fragile health systems buckled in the onslaught.



Members of a Liberian Red Cross Safe & Dignified Burials (SDB) team talk to relatives of a suspected Ebola fatality in the Clara Town community in Monrovia. Gaining the consent of the community to remove a body for cremation is an important part of the process and is not always an easy task. Victor Lacken/IFRC.

Ebola was known, a deadly but containable disease the Red Cross and Red Crescent had encountered before and, with partners, succeeded in restraining. However, it had been a mainly rural disease. Although some semi-urban areas had been affected, it had occurred predominantly in remote locations, and was a virus that always burned itself out. But now the genie was out of the bottle, and ravenous.

It crossed porous borders, infiltrated towns, and invaded national capitals. The context it found – cultural, political, geographical – eased its passage. Community fear and disbelief, and distrust of ‘outside’ interference, hindered efforts to stem the tide. Violent resistance drove off health workers and as violence grew, parallels to conflict became apparent.

No one could *treat* their way out of this. Treatment would be part of solutions, and early detection, isolation and treatment the main factors in stopping transmission, especially in the initial period, but a radical rethink of emergency response would be needed to deal

with Ebola. First and foremost, the Red Cross and Red Crescent knew, it had to engage communities, based on its volunteer network.

Communication was key, sharing information about Ebola, what it was, how it spread, how people could protect themselves against it. But barriers would first need to be dismantled. Trust would have to be won from people made suspicious by both myth and misinformation. The panic of early media reports only exacerbated the challenges as the Red Cross and other organizations sought to establish smooth response strategies.

Cultural practices – particularly burial rituals – and beliefs that helped the Ebola virus spread, had to be addressed. People’s mind-sets had to be shifted, but to do that responders’ mind-sets had to change as well. There was a need to listen, really listen to people, understand their misgivings and respond in a way that empowered communities.

“This is what will stop the outbreak,” said Birte Hald, head of the IFRC’s Ebola Coordination Team, one year on from the start of the epidemic. The region was still a danger zone, no one was letting up, but a dramatic reduction in new cases had brought hope the response was on the right track.

“What we call beneficiary communications has shown its value,” she said. “It is an intervention in its own right, a component of community engagement, with its own distinct skills and methodologies. It is time everybody acknowledged that.”

Rather than solutions developed abroad, in Geneva perhaps, or Rome or New York, that are then hoisted onto local communities, West Africa needed a new approach which took into account its cultures, beliefs and attitudes.

“There’s no point coming here thinking: why don’t these people just stop all their dangerous practices?” Birte Hald insisted. “If you do, you will fail because you don’t understand. You’ll never get rid of the virus. You must get to the root of what people believe, what they are all about. You listen to them and then you have a chance of getting your strategies correct.”

Key challenges turn thinking on its head

It is here, there and everywhere. Containing the spread of Ebola, removing the threat of geographical creep, remains a great challenge for the region.

The re-emergence of cases in what were thought to be cleared locations has tested resolve as well. Where new cases have fallen dramatically, resources have moved on to other hotspots only to be needed, once again, back where they have come from. Ongoing vigilance in surveillance, and a thorough tracing of contacts with infected people, are critical, first in getting case incidence down to zero, and then maintaining it there.

The people who do that are among the thousands of volunteers the Red Cross has working within communities. Across the three most affected countries, more than 10,000 volunteers have now been trained specifically for Ebola, working hand-in-hand with community people in a village-to-village, door-to-door approach. Early detection is essential, and the way the disease has spread itself increases the risk that spikes in caseloads may go unnoticed. The volunteers’ role (see more below in “Five pillars of response”) has never been more pivotal.

More challenges come from West Africa’s porous borders, colonial lines often drawn through homogeneous ethnic groups that have never really observed them. Ebola is a virus without borders and population movement helps it travel.

A failure to contain it in the countryside made control even more problematic. Ebola has made it to towns in previous outbreaks, and been seen in small-town hospitals. But

“Ebola came to Sierra Leone, Liberia and Guinea and found us there. It found three National Societies already on the ground. It found 20,000 Red Cross volunteers who did not have to go in from outside because they were there already, in the communities to which they belong. And then they started doing what they do best, responding in solidarity and with respect.

Let us understand what this is about. Let’s understand how we can use the power of communities to make appropriate choices that will help them protect themselves. And, by protecting themselves, they will protect the whole world.”

*Elhadj As Sy,
Secretary General,
International
Federation of Red Cross
and Red Crescent
Societies*

Garmai Sumo, a member of one of the Liberian Red Cross burial teams, disinfects her hands after taking a sample from the body of a suspected Ebola fatality in Paynesville, Liberia. Victor Lacken/IFRC.



“The dedication of our volunteers cannot be overstated. Despite their heroism, they have been unfairly stigmatized in the community. This is so heart-breaking because without them, who knows how much worse this crisis could have been.”

Fayiah Tamba,
Secretary General, The
Liberia National Red
Cross Society

those have been relatively minor events and the force with which it now entered urban centres was unprecedented.

“So you had the virus in places with fragile health systems, inadequate housing, poor water and sanitation, and serious poverty,” explained Panu Saaristo, IFRC Emergency Health Coordinator. “Everything was ripe for contagious disease.”

But even in the most troubled places, Red Cross community engagement has paid off. West Point, a notorious slum in the Liberian capital, Monrovia, shows how.

Up to 100,000 people live here in filthy, overcrowded conditions. Ebola brought panic and violence, and in August 2014 the authorities placed it in lockdown after a mob over-ran a quarantine centre and dragged out infected patients they claimed did not come from the slum.

But from an Ebola hotspot, West Point would, in the end, be turned around. Un-

derstanding the disease, learning from Red Cross volunteers what did and did not spread the virus, led to a change in behaviour. Bodies of victims were no longer touched, corpses were safely collected, homes were disinfected. The case incidence fell and the slum saved itself from the virus.

Overcoming fear and stigma has loomed large in the challenge the Red Cross has faced in getting to zero Ebola cases in West Africa. But fear and ignorance in the developed world has hampered the response by impacting on its resources.

Like many other organizations, the Red Cross and Red Crescent was hard-pressed early on to find enough international staff willing to go to West Africa. Partner National Societies have considerable files of professionals willing to deploy in emergencies. They take leave of absence from regular jobs and ship out as Red Cross and Red Crescent del-



Students return to class at WLP Brumksine Methodist Elementary and High School in Buchanan, Liberia. Schools throughout Liberia were closed during the Ebola epidemic but reopened after almost a year due to a sharp fall in the number of reported Ebola cases. The Liberia National Red Cross is urging continued vigilance and good hygienic practices to prevent a resurgence of the viral disease that has killed thousands of people in Liberia. Victor Lacken/IFRC.

legates. But never have so few presented themselves. “We are shocked,” said one human resource manager. “It seems to be down to family pressure.”

Media coverage of Ebola did not help. As hysteria spread with a handful of cases in the West, wives and husbands discouraged spouses. “Lots of delegates are saying they want to go but their families aren’t happy with it,” said Magna Olafsdottir, an Icelandic pre-deployment manager.

Those who did go fell foul of discrimination, some of it official. Forced quarantine periods upon return further discouraged recruitment. The International Red Cross and Red Crescent Movement publicly called on governments to ensure unhindered movement to and from the region for humanitarian workers. An effective global response depended on it, it said, and the work could be done in safety.

“Stigma or discrimination against health workers – including isolating them with no scientific basis – will lead inevitably to a human resource crisis at a time when we need qualified people,” a statement read.

Education was needed everywhere.



Francis Nallu is an Infection Prevention Control (IPC) Supervisor at the IFRC Ebola treatment centre in Kono, Sierra Leone. He oversees a team of 20 IPC staff and 12 nurses. His duties include training new staff to ensure they are properly protected when entering the high risk zone. His team is also responsible for cleaning the centre, including the high risk zone, cleaning up for those patients who are unable, and washing the reusable items from the personal protective equipment. Anna MacSwan/British Red Cross.

Five pillars of response

The only way to end West Africa’s epidemic is to educate communities, isolate Ebola patients, trace and monitor anyone who has had contact with an infected person, and provide safe and dignified burials for those killed by the disease. And to do these things simultaneously.

Five key public health activities are the pillars upon which the Red Cross and Red Crescent Ebola response is built, each of equal importance and reliant on the others to be effective.

➤ **Community engagement, with social mobilization and two-way beneficiary communication**

Why the Red Cross works with the community to implement interventions, and helps support behaviour change and health education

Red Cross teams go door-to-door and work with community elders and religious leaders to educate families about how the virus is spread, what the symptoms are, and the importance of early treatment.

Myths are debunked, the truth is told. The disease is not airborne, or spread in water, or passed on by witchcraft or evil doers. It comes from direct contact with the bodily fluids of an infected person. From the community in turn, structured feedback can provide a wealth of information and data.

Community engagement is not new but the needs thrown up by Ebola have established it as an essential tool found across the board of operations. Beneficiary communication has even become a key part of safe and dignified burials.

Will Rogers, the IFRC’s former Global Coordinator for Beneficiary Communications, and its community engagement consultant for West Africa’s epidemic, said, “Given the right information, com-

munities themselves will end this epidemic. On the other hand, what we get back should hold the key to our decision making. What comes from the community should drive our operations. You can do amazing things with data management. Our volunteers use a simple Android, phone-based system to feed us the results of surveys. All they have to do is click yes or no in answer to 20 or 30 questions they put to people they visit.”

Besides the door-to-door visits to deliver key messages and enter into a dialogue, the Red Cross is using a range of communication channels, from television soap opera and interactive radio programmes to SMS messaging.

National celebrities and a well-known film producer are lending their support to a Red Cross soap opera in Sierra Leone. Entitled *Advice*, it is aired on a weekly Red Cross television show but the script is also adapted for radio. Using locations and popular figures that ordinary people can relate to, soap operas are one of several key tools for raising awareness about Ebola.

➤ **Safe and dignified burials and disinfection**

Why the Red Cross ensures that every aspect of burials and disinfection is carried out in a safe and respectful manner

So many people were being infected by their practice of touching and washing the bodies of loved ones as part of the funeral process that someone had to be engaged in dead body management. The Red Cross was asked to do it and consented.

But in doing so it changed the terminology. “Safe and dignified burials” underlined the tenet that has run through all of its interventions.

“The Red Cross Red Crescent doesn’t ‘manage’ dead bodies,” said Elhadj As Sy, the IFRC’s Secretary General. “We respectfully, and in a dignified manner, prepare and accompany deceased people to their last place of rest. Our shared humanity does not end with the end of life.”

Highly trained Red Cross burial and disinfection teams now limit the spread of infection by educating communities, and curtailing dangerous practices such as the hugging of bodies in Sierra Leone which is believed to guarantee that family lines continue.

The Red Cross is not always welcome. Grieving relatives can be loathe to forgo well-established funeral rituals and one beneficiary communicator is embedded in every burial team. Among other things they need to explain is why, when preparing a body for burial, they wear protective gear in which they resemble *Star Wars* character Darth Vader.

Daniel James of the Sierra Leone Red Cross Society, coordinates 54 teams in 14 districts of his country. “It can take time to convince people that what you want to do is important,” he said. “You have to talk to the elders, show respect for the dead, explain things to the relatives, and allow them to watch from a distance. The protocol is much the same as their traditional ritual except that, instead of being washed, the body is wrapped in white satin cloth and placed in a body bag. There are open-air prayers, someone says a farewell word and only then is the body buried.

“That’s the difference between dead body management and safe and dignified burials.” It is not just about burying or cremating corpses without getting infected. It is about how to achieve best practice, taking culture into account. The objective is to stop the transmission



A Liberia National Red Cross burial team removes a body of a suspected Ebola fatality from a community in the Bushrod Island area of Monrovia. Safe and dignified burials are an important part of the work that the Red Cross does in Liberia to help stop the spread of Ebola. Victor Lacken/IFRC.

of the virus. Safe and dignified burial is a public health programme.

(See box stories, “Restoring dignity to the dead” and “Risking Red Cross lives to stop Ebola”)

↘ **Psychosocial support**

Why supportive communication and psychological first aid are essential in responding to Ebola

When a deadly contagious disease sweeps through a region it leaves wounds not immediately visible. Stress is common among those who are fighting Ebola, grief is deep and widespread among the population.

Nowhere has the stress been greater than among the Red Cross volunteers who work with safe and dignified burials. Support systems have been established and staff and volunteers taught about peer support and stress management.

Trauma among families mourning loved ones has been addressed, along with the distress of survivors who suffer social exclusion and stigma. Psychosocial support – counselling and the distribution of survival kits that include food, clothing

and hygiene supplies – has been widely provided among the population.

“Sometimes the plain truth about Ebola is enough to improve community situations. When Red Cross volunteers explain how you do and do not contract the virus, they heighten awareness of prevention. Much fear is allayed in the process which helps to restrain social stigmatization”, said Moulaye Camara, IFRC head of delegation in Sierra Leone.

↘ **Surveillance and contact tracing**

How monitoring potential new cases helps to limit the spread of the disease

By the beginning of March 2015, teams of Red Cross volunteers had traced and monitored well over 51,000 people who had been in contact with an Ebola patient. Having found them, they monitored them for three weeks, looking for Ebola symptoms, fever, muscle pain, headache and sore throat, followed by vomiting, diarrhoea and bleeding.

For these contacts the wait can be horrific. The incubation period for Ebola is from two to 21 days and the level of fear grows as time passes. Some authorities place people in quarantine but even

Women volunteers restore dignity to female corpses

Before the Ebola outbreak in Sierra Leone, it was a taboo in most parts of the country for young people to witness the washing and preparation of corpses for burial. In line with tradition, females prepared female corpses and males prepared male ones. However, as the Ebola death toll escalated, most burial teams were composed only of men and boys. The provision for women was passed over.

Seeking to preserve the dignity of loved ones, some families objected to an all-male team tending a female corpse. Burial teams would arrive in a community to find that the deceased had already been washed and dressed. Such contact with potentially contagious bodies could have caused new chains of transmission.

To counter this, the Sierra Leone Red Cross Society specifically recruited women to join its Safe and Dignified Burial (SDB) teams. The Red Cross is a key player in the management of Ebola victims and some 54 teams provide about 45 per cent of all safe and dignified burials across the country. To date they have buried 24,445 people.

More than 30 female volunteers are now embedded into SDB teams and in Bo, Sierra Leone's second largest city, Marion Kargbo, a 24-year-old mother of two, became the first female team leader.

She had heard female bodies were not being treated with sufficient respect, especially when young boys were in charge of burial. "This meant most families weren't allowing loved ones who were female to be taken care of by men," she said, "hence the spread of Ebola in some communities."

But before she became a team leader, Marion almost gave up. "One afternoon we went to pick up a corpse in an Ebola hotspot, a village. She was bleeding all over. It so horrible to see a woman lying in her own pool of blood, abandoned by her relatives and friends. I felt so bad I told a colleague that I was going to drop out of the team."



Marion realized, though, that she was making a vital contribution to the effort to stop the disease. Today, although she is the person who directs her team, her personal involvement is the same. "To satisfy families who prefer to have a woman take care of their dead, I still dress up in personal protective equipment to help prepare a body for burial.

"I strongly believe in the Red Cross principles to serve humanity and if women continue to support the fight against Ebola it will soon become a thing of the past."

Risking Red Cross lives to stop Ebola

A year on from the start of the epidemic, Red Cross lives were still at risk in Guinea. Not just from the Ebola virus but from people volunteers were trying to protect.



In Forecariah, Western Guinea, a Red Cross team of volunteers was attacked when they tried to provide a safe and dignified burial for a woman suspected to have had the disease. Reluctant at first to have the Red Cross intervene, the dead woman's family relented when the volunteers explained how important it was that they did (see "Safe and dignified burials"). But as they prepared to disinfect the woman's house, a stone-throwing mob confronted them, accusing the Red Cross of spraying the virus. With no chance to calm the crowd, the volunteers fled but 20-year-old Lopou Topou fell. The crowd caught her and beat her badly. With her colleagues chased away, the young woman feared for her life

when her assailants talked of getting a knife. Lopou was saved by a passing motorcyclist who got her out of the village, and she was taken to a clinic in Conakry, traumatized and suffering from shock.

Such incidents are not uncommon. Since July 2014, there has been an average of ten attacks a month on Red Cross Society of Guinea volunteers responding to the epidemic. Distrust, disbelief, political tensions, suspicion of 'outside' interference, all play a role in the challenge the Red Cross faces as it works to contain the epidemic.

Great strides have been made. Where the Red Cross has raised awareness of what Ebola is and how it spreads, behavioural change has followed. "You can see what has happened in statistics," said Amanda McClelland, Senior Emergency Health Advisor with the IFRC. "Where people have accepted such things as safe and dignified burials and the early isolation of infections, the Ebola incidence has decreased. When that happens regularly you come to the end of the epidemic."

The continued violence and resistance in Guinea reflects Ebola's geographical creep. "Areas where the Red Cross worked months ago have been cleared of the virus. The violence occurs in newly-infected places," McClelland said. There the Red Cross must start afresh, win trust again, gain community acceptance.

Lopou Topou understands that and, though her family has asked her to stop, she wants to continue the fight. "I am not discouraged," she explained. "It's not the time to give up because there's still a lot of fear and misunderstanding." Some communities had not been affected long. "They are still uneducated about the disease and so we need to provide them with accurate information." Far too many rumours were floating around. "Rumours," she said, "spread faster than the truth." It helps that her truth is delivered with respect. Where stones were once thrown, people now listen.

where they do not the contacts may impose it on themselves. The stigma and discrimination they may suffer if they venture into the community can make them prisoners in their own homes.

The stigma can last longer, although besides being inhumane it has no medical grounds. The disease can only be spread to others after symptoms begin, and even then, infection cannot occur without close, direct contact.

Breaking down this discrimination, removing the misconceptions, reassuring and comforting sometimes desperate people as they wait for the virus deadline, is part of the job for Red Cross volunteers engaged in the Ebola response. Psychosocial support is in their brief and the five pillars of response were designed to be interlinked. To quote the IFRC's Secretary General, the volunteers do "what they do best, respond in solidarity and with respect".

But first and foremost, surveillance and contact tracing is about limiting Ebola's next generation of cases. It follows up on potential contacts, reports potential new cases and ensures they are quickly referred to treatment centres. When the disease shows a pattern of geographic spread – as it has done in West Africa – response teams need to know fast about new locations so they can contain it immediately.



Nicolas Beaumont

↘ Case management and treatment

How even in isolation, and where one mismanaged case can cause a resurgence of a deadly disease, patients can be treated with dignity.

It may be one of the world's most potent killers but prompt medical care can increase the chance of surviving Ebola and limit transmission. In Sierra Leone, the IFRC established emergency treatment centres (ETCs) in the eastern districts of Kenema and Kono.

Clearly, they were both built with safety and security in mind. They are places of strictly segregated zones – high risk, low risk, unknown – of barrier nursing and infection control.

The health workers resemble astronauts, concealed beneath what is termed personal protective equipment. Their jumpsuits, boots, goggles and rubber surgical gloves are there to prevent them from being exposed to patients' bodily fluids. They know a simple sneeze or a drop of sweat could be enough to infect them. Another danger, though, is not forgotten. In such a stressful environment, patients can be robbed of their dignity.

"The biggest challenge is that you can't be with your patients 100 per cent of the time," said Amanda McClelland, Senior Emergency Health Advisor with the IFRC who oversaw the setting up of the centres. "They stay within the high-risk zones where we have limited contact time.

"It is hot, it can be humid, and patients wear minimal clothing, or nothing at all. They can be naked and lying on the ground and you can't just walk in there and cover them. With another disease it would be routine."

Sometimes, she said, all you can do in an ETC is look on. "You do your very best all the time, and your care and concern

Survivors: shunned, scared and stigmatized



Jerald Dennis is an Ebola survivor but the day he was discharged from the treatment centre, he discovered his ordeal was not over. His homecoming turned into a nightmare. He found himself an outcast, a social pariah in his native Liberia.

“I was stigmatized,” he said, “and seriously abused by my community.” Even former friends turned their backs on him. “No one wanted to shake my hand because of fear that they might get Ebola. People pointed fingers at me, labelled me Ebola Man and avoided me completely.”

What he describes is a shocking insight into how Ebola survivors – people clinically free of the virus – encounter discrimination not only in Liberia but right across the stricken West African region. And while the fear the disease has engendered brings anguish to them, it can also drive the virus underground. The infected have gone into hiding, discharged themselves early from health facilities, hidden corpses of loved ones, and prevented aid organizations from entering their communities (see box, “Risking Red Cross lives to stop Ebola”).

Jerald Dennis was already traumatized when he left the Monrovia treatment centre. Seriously ill, he endured a desperate time in the overwhelmed, over-crowded facility. “I saw a lot of dead bodies,” he said. Then he got home and faced hostile neighbours. “They accused me of evil things,” he said, “claiming that I wanted to kill them.” If he sat down in a public place no one came close to him. No one would take his money when he attempted to buy things. “I was seen as the most fearful and terrible man ever to have lived in my community. People stopped me from using public facilities, like the hand pump where I went to get drinking water. The stigma caused me so much distress. I was desperate for love in the end.” It was the Liberia National Red Cross Society which broke his isolation. “Someone came to me and said: do you want to volunteer your services, to the Red Cross and our nation. It restored my lost hope and dignity.”

Today, Jerald works tirelessly in Red Cross social mobilization and awareness raising programmes. He started to appear on radio. On Radio Truth FM, other survivors joined him, speaking out against stigma and discrimination.

Minds have been changed, even in Jerald’s own community, and like other volunteers across Guinea, Liberia and Sierra Leone he follows up with freshly discharged survivors. He ensures they can re-integrate. Critically, too, he convinces people in denial that Ebola does exist.

A question of trust

The Ebola epidemic in West Africa may be bigger and more complex than any previous outbreak, but one thing is common to all. Interventions to stop the virus need the trust, support and participation of affected communities. It is *their* epidemic. *They* are the people to stop it, albeit with some help from their friends. In humanitarian speak, what you need is community engagement.

No one knows that better than Dr Jacques Katshitshi, IFRC's Regional Ebola Advisor. For some, engagement's importance will be among the lessons learned in Guinea, Liberia and Sierra Leone, but for Dr Katshitshi it is only more evidence of what he learned in Central Africa. The former Secretary General of the Red Cross Society of the Democratic Republic of the Congo (DRC) – the country where Ebola was first discovered among humans – has fought the disease since the mid-1990s, in Gabon as well as in his native land.

If you have trust, he says, everything else can fall into place around it. Where organizations have truly engaged communities, and partnered with their leaders, Ebola has been quickly contained. Where they have not, the reverse has been the case.

“Misunderstanding can bring many problems,” said Dr Katshitshi. “We had people saying the Red Cross was taking and selling body parts, and that our teams who disinfected people's homes were in fact spreading the virus. You need to talk many times with communities, really intensify communications, to change wrong perceptions of your interventions.

“When people understand, the Red Cross is welcome and you are able to start. It was the same in Central Africa.” So was the stigma and discrimination of affected people. “It is so important to return and re-integrate into the community. We often met resistance, as we have here, and then our job was to mediate, reassure everyone that these people posed no kind of threat.”

Gabon presented Dr Katshitshi with one of his greatest challenges. “It was a tragic case, of a man who had lost his wife and four children to Ebola. Only he and one small child had survived. The whole village turned against him. They wondered why he had survived and concluded he was a sorcerer, a witch doctor. No one wanted him back and they burned down his house.”

The Red Cross intervened and finally the village accepted him. “I wanted proof this was the case, however, and asked them to put something in writing. They did much better than that. They rebuilt his house. Yes, you must win the people's trust.” It is a lesson learned that has been put into practice in Guinea. “With communities, and based on open and sincere dialogue, we developed strategies which resulted in acceptable and effective measures to stop the transmission of the Ebola virus. Once the community became engaged with us, people become more receptive to public health messages and then took the necessary actions,” said Youssouf Traoré, President Red Cross Society of Guinea.

provide patients with a level of dignity. But it can be very tough to watch them. Patients can even die alone. We've had cases where someone has died in the shower and we haven't known until

we've discovered the body on our next scheduled round.”

“Your safety is a priority,” said Tiina Saarikoski, a Finnish Red Cross health delegate who also helped set up the centre.

“That feels very strange in a profession where patients should always come first. But their dignity is still very much in your mind and there are things you can do about it.”

Despite the restrictions, effort has been made to retain some sense of openness. Fences that segregate the zones in the tented treatment centres have deliberately been kept low. No one is walled in, and though the fences ensure safe distance is maintained, people can talk across them.

“The protocols are obstructive. You can’t rush around and respond to people’s needs as fast as you would want. But for the rest we try to see it as simply another hospital, a place in which we treat human beings. It isn’t a prison where you lock people up,” Tiina Saarikoski insisted.

Visitors have no access to the patients’ zones but there is a visitor area in both locations from where they can see relatives and speak to them with the help of mobile telephones. “We make sure there are points where phones can be charged and if someone has insufficient credit we’ll go out and buy it for them.”

In cases of death, respect is shown, both to the deceased and to their families. A window has been built into the mortuary wall – as it has in Kono – so mourners can see loved ones one last time before the body is buried. And there are no mass graves in the Kenema centre’s cemetery.

“It is a beautiful place,” said Saarikoski, “and there is a name on every grave. People can find their loved ones there, and have their moment with them.”

Amanda McClelland says that when the second ETC was built in Kono, dignity was looked at in design as well as procedure. One change involved the ‘happy shower’, which patients pass through if found to be free of the virus. Going from a high-risk to a low-risk area, they take a chlorine bath and then a soapy shower to remove any possible remains of the virus. The clothes they wore are left behind and fresh ones await them the other side.

In Kenema, the naked patient has to pass through a number of chambers in a process involving a number of people. In Kono, dressing and undressing is done in privacy.

Students of an elementary school run by the Senegalese Red Cross, share their words against Ebola. Students also put on a school play on Ebola to educate communities on how Ebola is spread, and how to keep safe. Nicole Robicheau/IFRC.



Critical role for communicators

Speaking with bereaved family members is difficult at the best of times. During the Ebola outbreak, speaking with them to explain they must give up dead loved ones, and forego traditional burial practices, has been more than difficult. It has been heartbreaking.



Francis O. G. Cooper, beneficiary communicator with a Red Cross safe and dignified burial (SDB) team in Liberia, says, “I have to look upon these communities with compassion and talk with them so they can understand what is happening.”

Beneficiary communications gives communities a say on the issues affecting them and the assistance they need. For safe and dignified burials, it ensures they have exactly the

information they need about what is going on and why it is so necessary.

SDB supervisor Roselyn Nugba-Ballah says engaging the community is crucial. “Families are distraught. They have just lost their loved ones to this brutal disease, then they have people in white suits turn up to tell them they are taking the body and they won’t get it back. We have to have the best communicators on the scene to hear their sorrow, explain why it is necessary, and negotiate the safety of our teams.”

Francis says the teams, trained in psychosocial support as well, would not gain access to the bodies unless they engaged communities. “Even though print and electronic media do provide the information, making sure people hear it is very difficult. Some don’t have time to listen to the radio, some don’t have time to read. So we have to reach into the community and deliver the message ourselves.”

The Red Cross emblem is the foundation of building trust. “As soon as the community sees the Red Cross vehicle, they come around, so it gives us some benefit. We’re not engaging the bereaved family alone, we’re talking to the whole community.”

At the height of the crisis, the Liberian Government mandated that all deaths during the outbreak should be treated as suspected Ebola cases. The Ministry of Health and Social Welfare mobilized teams to collect bodies for cremation, and later, burial at the purpose-built national cemetery. In July 2014, the Red Cross took over from the Ministry in Montserrado, the country’s worst affected county. Since then, SDB teams have collected more than 3,800 bodies. “Even though we are the Red Cross and people have known us through the wars, this was a new and grievous thing for families to accept. There were times when people would pick up sticks and want to fight. They would threaten to cut the tires or smash the vehicle. We were even threatened with machetes. But I had to remain calm, call in the community chairman and eminent residents to explain to them the danger, and that gave a clear picture in the minds of the people that we are working together with them for their safety,” says Francis.

Is this the hardest work he has ever done? Francis is unequivocal. “On my very first day I saw some horror. One incident made me decide not to do the job. But then I went home and I had another thought, ‘If I don’t do it, no one else will.’ That gave me the courage to keep doing it.”

4. Stepping up Red Cross and Red Crescent Action

When the IFRC issued revised Emergency Appeals in support of National Society operations in Guinea, Liberia and Sierra Leone at the end of June 2015, they were for enhanced and scaled-up response integrated with longer-term recovery.

An additional 89 million Swiss francs (94 million US dollars) was needed to help bring an end to the ongoing outbreak while also supporting people to recover from its impact. The recovery phase, the IFRC underlined, could last longer than the outbreak itself.

A reminder that vigilance was still needed as the Red Cross moved into recovery, came in Liberia. “The country had been declared Ebola-free for seven weeks, people had begun to relax, and then three new cases were confirmed. The Red Cross has always been a strong campaigner of remaining vigilant and avoiding complacency. With the capacity to scale up rapidly, the Liberia National Red Cross Society mobilized trained volunteers to share prevention messages with the affected community, trace contacts, provide psychosocial support, and distribute food to quarantined

Yvonne Kabagari, IFRC Beneficiary Communication delegate discussing with communities about Ebola in the village of Kalebengo, in Guekedou, the epicentre of the Ebola outbreak. Moustapha Diallo/IFRC.



communities. In addition, three safe and dignified burial teams were immediately placed on standby.” Ademola Alao, IFRC programme coordinator, Liberia.

Across the region, the Red Cross will maintain and strengthen response capacity and its immediate priority is to end the epidemic and address the adverse conditions that enabled a localised epidemic to escalate into a crisis with regional and global ramifications. The ultimate goal, however, is to re-establish the conditions for a quick return to a healthy society with viable livelihoods, psychosocial well-being, economic growth and overall human development. Plans would leave communities much more resilient to disease.

The revised appeals, in which the total funding now sought is 215.7 million Swiss francs, aim to reach 23 million people in the three countries and will run through 2017. Recovery operations will focus on health and care, disaster preparedness and risk reduction, food security and livelihoods, and National Red Cross Society development.

Among health plans in Guinea, access to basic care would be improved through the strengthening of 100 primary health posts, high-risk areas would have enhanced community prevention and care, and greater psychosocial support would be available for disasters and post-disaster situations. To reduce vulnerability to epidemics and other disasters, emergency preparedness would be boosted,

To help stop the spread of Ebola, Red Cross volunteers in Guinea visit communities to meet with residents face-to-face. In the village of Kolebengo, a once-resistant community in Gueckedou the epicenter of the outbreak, volunteers raise awareness about the disease to change attitudes and practices that could spread the virus. Moustapha Diallo/IFRC.



volunteers trained on early warning systems, and contingency plans updated and revised annually with a specific focus on cross-border coordination.

Community-based health programmes would be expanded in Liberia as well, and the Red Cross would support the rehabilitation of the national health system by training community health workers and traditional midwives. Many of the water and sanitation services disrupted during the Ebola outbreak would be re-established, and other plans include stronger early warning, disease surveillance and rapid response systems.

To improve access to health care in Sierra Leone, social mobilization will bolster national immunization days, community health clubs will be revitalized, and schools provided with toilets, clean water and hand-washing stations. Safe water facilities will be provided for 180 communities and 45,000 households will be targeted by hygiene promotion campaigns. A raft of interventions also includes training 2,400 volunteers for community event-based surveillance teams as part of disaster risk reduction.

Food parcels, food-for-work programmes, cash grants, the distribution of seeds, tools and livestock, vocational training, and start-up support are among efforts planned to strengthen food security and longer-term livelihoods in all three countries.

There is an urgent need to support those who have survived Ebola as well as affected communities and households as they begin to rebuild their lives. At the same time, it is imperative to continue the struggle to contain the disease. We will never be able to reach – and sustain – zero cases and transmissions unless we can remove the fear, misconception and stigma still attached to Ebola.

This will require a robust investment in retraining and preparing new teams of volunteers to work in communities. Lessons learned so far will be shared and preparedness improved for future challenges.

An epidemic like Ebola is not just an African problem. It is a global one. And we cannot end it on our own. The solution lies in building local, regional and global collaborations encompassing governments, public and private sectors, multilateral institutions and civil society. The resources to fight disease and help communities rebound and recover need to be available now and in the long term.

“We need to prepare our volunteers to move to recovery and help affected communities rebuild their lives while taking measures to face a possible re-emergence of Ebola at any time. Facing such challenges requires sustainability in our approaches. Throughout the outbreak, we have consistently put communities at the center of the response, and we will continue to do so during recovery.”

Constant HS Kargbo,
acting Secretary
General, Sierra Leone
Red Cross Society

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

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