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The Faith Factor:
A Study on the Responses of Neo-Pentecostal Churches
During the 2014 Ebola Outbreak in Monrovia, Liberia

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Declaration

I, Martha Suzanne Hurst, hereby declare that the work presented in this thesis has not been submitted for any other degree or professional qualification, and that it is the result of my own independent work. Information that is not my original work has been appropriately referenced in the thesis.

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04 September 2020

Date

Abstract

This research explores the impact of faith on health beliefs and responses within the context of the Ebola outbreak in Liberia. It looks at the responses of neo-Pentecostals (NPs) to the Ebola outbreak and containment measures.

In much of sub-Saharan Africa (SSA), faith stakeholders are crucial for community acceptance of health information and recommended behavior changes. While traditional community engagement strategies recognize the need for faith engagement, Christianity is often treated as one broad faith category without acknowledging the many faith subsets that exist within it.

The religious landscape in SSA has changed dramatically in the last few decades. Historically dominated by mainline denominations with roots in the West and linkages to centralized authority structures, Pentecostalism, and more specifically neo-Pentecostalism, has rapidly emerged as the primary expression of Christianity in Africa. NPs are a subset of Christianity known for their beliefs in spiritual causality and divine healing, expressed through prayer and the laying on of hands.

While NPC responses to HIV/AIDS have been discussed in the scholarship, their impact on health behaviors in SSA has not been thoroughly studied. Additionally, there is a deficit of detailed analysis on the barriers and facilitators to their engagement in health initiatives.

This study employed qualitative research methods to examine this faith/health interaction. Interviews were conducted with a broad range of demographics and results were compared with the literature to determine consistency among findings.

This thesis demonstrates that several NP beliefs and characteristics were linked to adherents' perceptions of and responses to Ebola. Their beliefs, culture of independence, and the high degree of trust ascribed to their leaders rendered traditional engagement methods largely ineffective.

This study argues that a 'one size fits all' engagement strategy is ineffective in today's religious climate and hinders faith inclusivity.

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Abbreviations

AIC	African Initiated or Independent Church
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CSM	Condom Social Marketing
DRC	Democratic Republic of Congo
EBPHP	Evidence-Based Public Health Policy
ETU	Ebola Treatment Unit
EVD	Ebola Viral Disease
FBO	Faith-Based Organization
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GPS	Global Positioning System
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IG	Inter-Gouvernemental
INRB	Institute Nationale de Recherche Biomédicale
LCC	Liberia Council of Churches
MDG	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-Governmental Organization
NP	Neo-Pentecostal
NPC	Neo-Pentecostal Church
NREB	National Research Ethics Board

OPA	Organisational Policy Analysis
PI	Primary Investigator
PPE	Personal Protective Equipment
RA	Research Assistant
RN	Registered Nurse
SCT	Social Cognitive Theory
SET	Social Ecological Theory
SSA	Sub-Saharan Africa
TRC	Truth and Reconciliation Commission
TTM	Trans Theoretical Model
ULMO	Understanding Leadership, Management, and Organisations
UMC	United Methodist Church
UN	United Nations
WHO	World Health Organization

Chapter 1: Introduction

It has been long understood that community stakeholder engagement is essential to community acceptance of public health interventions [1]. Stakeholders are individuals of influence. Their support of and engagement with any recommended behaviour change is an important element in the community's process of accepting or rejecting ideas [1]. In cultures that have a high degree of spirituality, as is the case in most of SSA[2], the endorsement of recommendations by faith leaders is crucial to the uptake of behaviour change [3].

There are particular nuances to navigate when science and faith intersect around health interventions. In some situations, faith adherents express a reluctance to adopt a particular behaviour or treatment, relying on faith to protect them [4]. There can be a tension between faith leaders and healthcare professionals as faith leaders insist on keeping what they consider to be essential components of their faith. In contrast, healthcare professionals might feel frustration that faith is used to justify reluctance or refusal to accept scientifically proven health behaviours [5]. Therefore, it is critical to understand the concerns around health interventions within various faiths and co-develop specific strategies for their engagement.

This research aims to explore this faith/health interaction within the context of the 2014 Ebola outbreak in Liberia. It will specifically examine the responses of NPs, a subset of Christianity, to the Ebola outbreak containment measures.

1.1 Research Objectives and Questions

The research objectives and questions that guided this research are as follows:

1. To learn how NPC leaders and constituents in Monrovia, Liberia perceived community engagement measures and Ebola containment protocols.
 - a. What was the response of NPCs to the Ebola outbreak in Monrovia, Liberia?
 - b. Did NPC beliefs in divine healing and spiritual causality affect NPC leaders' and constituents' responses to empirically derived Ebola containment measures?

- c. Did NPC members mirror pastoral opinions of Ebola containment measures, or did their views and reactions differ from those of their pastor?
2. To capture community opinions on the actions of these Monrovia-based NPCs and their leaders during the Ebola outbreak.
 - a. How did community members perceive the actions of NPCs?
 - b. Do the community members' accounts of NPC actions yield a different perspective on NPC Ebola responses?
3. To gather information from Ministry of Health (MOH), intergovernmental (IG) and nongovernmental organizations (NGOs), and healthcare providers with an operational role during the Ebola outbreak in Liberia on their community engagement strategies and how they perceived the role and responses of NPCs.
 - a. Do these perspectives align with community perspectives on the perceived reactions of NPCs during the outbreak?
 - b. Do these perspectives align with NPC statements regarding their responses?
 - c. How did these organizations approach NPCs for Ebola response engagement?
4. To compare NPC Ebola responses in Monrovia, Liberia, with another Monrovia-based Christian denomination response, to examine similarities or differences in responses to determine if NPC responses were unique or similar to other Christian faith responses.
 - a. Did other Christian churches have similar responses to the Ebola outbreak and the Ebola containment measures?
 - b. Did church authority structures play a role in facilitating or discouraging local church uptake of Ebola containment measures?
5. To analyse the insights gathered from the literature, documents, and interviews to identify which actions, on the part of NPCs in Monrovia, Liberia, helped facilitate and which actions inhibited an effective Ebola outbreak response.
 - a. When combining all data from the various perspectives, what themes emerge as to how NPCs responded?

- b. What actions facilitated NPC response, and what actions discouraged a healthy response?
- c. Did NPC beliefs impact NPC responses, on a local church level and among local church adherents?

1.2 Thesis Overview

Chapter 1 - The introductory chapter briefly describes the rationale and impetus for this research and lists the research objectives and questions. It also outlines the framework for this thesis. It then describes the research background beginning with broad strokes by discussing the faith demographics in Africa and a brief, generalized discussion of regional health challenges. Then it narrows down to the research topics, defining NPCs and explaining the choice of focusing specifically on NPCs by discussing their significance in SSA and some key NPC beliefs about health and illness. Finally, it explains why the Ebola virus disease (EVD) and the response in Liberia was chosen as a focused case study to inform the broader research questions on how faith, and particularly Pentecostal faith groups, contributed to and/or inhibited their Ebola responses.

Chapter 2 – The setting chapter gives a brief history of Liberia and the socio-political context leading up to the Ebola outbreak. It also discusses and outlines the Ebola outbreak timeline and responses, in Liberia, according to the literature.

Chapter 3 – This chapter presents a review of the literature on faith and health interactions in SSA. The results of this review will be discussed. A follow-up literature review was conducted in January 2017 to identify more recent publications examining the role of faith in the evolving West Africa Ebola outbreak. This review and its results will be discussed. The chapter concludes with discussion of the results of the two literature reviews.

Chapter 4 – The methodology chapter outlines the methods employed to address the research objectives and questions. It discusses the theoretical framework that guided this research. The Theory of Charismatic Leadership is considered as it was resourced for the development of the semi-structured interview questionnaires and guided the choice of interview participants and demographics. Grounded Theory is also discussed as the framework used to guide the interview process and analyse the data. The chapter describes the research methodology and discusses methodological limitations.

Chapter 5 – The results chapter outlines the data results. The results are presented according to each research objective and questions for research objectives 1-4.

Chapter 6 – The discussion chapter examines all key findings. It considers the primary result themes in light of public health practices and community engagement, thus addressing research objective #5. It provides a list of recommendations for public health organizations operating in SSA. The chapter ends with a conclusion that briefly discusses the possible future impact of the results of this study, including a brief discussion on how these results are particularly poignant in light of the current COVID pandemic.

1.3 Personal Statement

I have lived in Africa for over 25 years, working with a faith-based organization (FBO). My time has been primarily divided between West Africa and Central Africa. Seeing first-hand the spirituality that existed across most of the continent and the impact that faith institutions had on daily life, decision-making, and health issues gave me a passion for developing a better understanding of how to effectively engage faith communities in health education.

While working with local faith communities and observing their responses to the human immunodeficiency virus (HIV) and the subsequent acquired immune deficiency syndrome (AIDS), I recognized the complexities of engaging them in appropriate biomedical responses to a health crisis. I have navigated the path of partnering with faith leaders who have been reticent to respond to HIV/AIDS, primarily due to the sexual aspect of transmission and the subsequent prevention recommendations. I have also seen the impact that these groups can have once they have engaged these issues on a level that allowed them to be true to their beliefs and yet acknowledged and addressed the health problems at hand.

While working with local Christian faith groups on HIV/AIDS responses, I experienced a great deal of frustration over the obstacle of faith beliefs vis-à-vis meaningful engagement in the HIV/AIDS crisis. In my experience, Christian faiths that would be considered evangelical, such as Pentecostals, were particularly challenging to engage. However, their presence and influence in communities was significant. This combination of reticence, or hesitation, in engagement combined with local popularity, provided the motivation to examine this particular ‘brand’ of Christianity and engage it more successfully in the future.

1.4 Integrating Statement

Having worked in Africa on public health initiatives in a faith-based setting for many years, I desired to increase my leadership and program development capacity. I wanted to ensure that I was implementing current best practices and was encouraging others to do the same. I dialogued with numerous colleagues from various public health perspectives and realized that a DrPH was the degree that would enable me to meet these goals. As I investigated various DrPH programs, the one offered by LSHTM was a standout. The DrPH program at LSHTM is designed to equip graduates with public health managerial and leadership skills. Its components serve to increase the student's understanding of scientific knowledge and incorporate this knowledge into public health programming that produces the desired outcomes. The emphasis on applied research and leadership development, combined with professors who had substantial and ongoing international public health expertise, many with a significant focus on Africa, attracted me to this program. I also appreciated the balance between the time spent in London and the time spent in the field. While I travelled to London multiple times during my studies, I was not required to leave Africa for several years to commit to this program.

The LSHTM DrPH program has three components: two compulsory modules, the organizational policy analysis (OPA) research, and the thesis research. The two compulsory modules are Understanding Leadership, Management, and Organisations (ULMO) and Evidence-Based Public Health Policy (EBPHP).

The ULMO course focused on applied theories of leadership and management. We studied and analysed various leadership/management theories during this course and how these impacted leadership styles and effectiveness. The course included a 3-day personal development and discovery workshop where I learned more about my personal leadership style, capitalizing on my strengths, while recognising and strengthening my weaknesses. This was a rich time of self-reflection on past leadership experiences and a time of planning for the future.

The final project for ULMO was to perform a strategic analysis of a public health organization. For this project, I chose to examine a small faith-based organization with whom I work closely. While I was not the director of this organisation, I was a member of its management board. This was a beneficial exercise as the organization was going

through a time of leadership and philosophical transition. Using the tools and theories discussed during this course I was able to critically analyse the past successes and challenges of this organisation while envisioning the potential opportunities for the future and how to best capitalize on these opportunities.

The EBPHP course focused on the bridge between research and implementation. During this course, I learned how to effectively peruse databases to discover existing research on pertinent issues. I developed a greater appreciation for the body of evidence that already exists and is continually evolving, and the importance of using this evidence to ensure best practice in policy and practice.

One EBPHP assignment involved designing a knowledge-transfer strategy to draw attention to an evidence-based issue with a policy development goal to address the issue. For this assignment, I chose to address the issue of emerging non-communicable disease in the DR Congo. The second assignment involved performing a systematic literature review on a chosen health issue currently being studied at LSHTM. For this assignment, I chose to review the literature on the relationship of alcohol marketing and alcohol consumption in American youth. These assignments strengthened my literature review skills and increased my awareness of the vast amount of research that exists and the need to incorporate this research into future research and public health initiatives.

The second component of the DrPH program is the Organisational and Policy Analysis (OPA). This project combines the skills learned from the two compulsory modules. It focuses on observing and analysing a public health organisation and its policies to understand effective organisational management and policy development. This required approximately 4-6 months of fieldwork within the context of the chosen and approved public health organisation for organisational observation, interviews, and policy review.

In order to examine an organisation and policies that would contribute to my ultimate final research and thesis, the role of faith in health decisions during the Ebola outbreak in Liberia, I chose to study the Institute Nationale de Recherche Biomédicale (INRB) in Kinshasa, DRC. This institute is one of the primary DRC governmental, on-the-ground responders when there is suspicion of an infectious disease outbreak, including Ebola. Due to its involvement in multiple Ebola outbreaks and the fact that the DRC has had the highest number of outbreaks globally since Ebola was discovered there in 1976, the

INRB was selected as the focus of this study on organisational policy as it relates to faith engagement during an Ebola outbreak. The study examined INRB partnerships with nongovernmental organisations (NGOs), including faith-based NGOs (FBO) and the local faith responses that INRB staff encountered during the last five Ebola outbreaks in DRC. Policy and protocol procedures were also examined.

The OPA project was extremely beneficial as I had the opportunity to implement what I had learned during the two compulsory courses. Studying an African public health organisations' activities and policies related to multiple Ebola outbreaks allowed me to begin to familiarize myself with the existing literature on Ebola and faith responses. I also gained pertinent insights through personal interviews with INRB staff. In effect, this project served as a starting point for my final research and thesis.

DrPH candidates are also allowed to choose appropriate courses from the school's vast array of MSc-level modules. I was grateful for the opportunity to take advantage of these offerings by LSHTM, both on-site and through distance learning. During my time at LSHTM I took courses on health in humanitarian crisis, principles of social research, disease outbreaks in low- and middle-income countries, control of infectious diseases, research design, management and analysis, and Ebola in context. These courses helped to inform my perspective on infectious disease outbreaks and, ultimately my thesis research design and methodology.

The final component of the DrPH program is the research and thesis. As I studied Pentecostal faith responses to the Ebola outbreak in Monrovia, Liberia, I consistently referred back to what I had learned from the previous projects and degree components. The time I spent working on my DrPH through LSHTM was extremely valuable to my work with FBOs in Africa. I gained valuable skills in leadership, systematic literature reviews, understanding of research methodologies, implementation of evidence-based practices, and writing skills. I also gained an appreciation for the contribution of continued research to public health practices and challenges. I am convinced that my time at LSHTM will guide and inform my public health practices and involvement for many years to come.

1.5 Research Significance

Faith is an essential part of life in Africa. Whether it is Islam, Christianity, traditional religion, or a blend of these, Africans, in general, have deep religious beliefs that affect

much of their daily lives [2]. While there is a wealth of literature on the influential role that faith stakeholders play in community health and behaviour change [3, 6-23], there is a lacuna in regards to specific suggestions on how to engage faith effectively. Many guidelines simply reiterate general stakeholder engagement principles [7, 8, 11, 12] or recommend that further research be conducted regarding faith engagement [3, 6, 8, 15, 21].

Another consideration on the subject of faith stakeholder engagement is that Africa's religious landscape has changed over the past few decades. In SSA, Pentecostalism has rapidly increased, bringing with it its own brand of faith expression and beliefs [24-26]. Therefore, it is crucial to have more information and research on this emerging faith to aid the public health community in understanding and engaging this new reality. Improperly engaging prominent faith groups in a community experiencing an infectious disease outbreak risks prolonging the outbreak and increased mortality and morbidity [3, 27]. Thompson et al. discussed the importance of faith leader engagement in health initiatives. They noted that in situations of generalized fear and panic, such as during an infectious disease outbreak, faith leaders are usually the first entities that the population seeks [11].

1.6 Faith in Africa - A Brief Overview

Africa is an extremely religious continent whose faith population continues to grow, despite predictions of the opposite [28]. The secularization thesis postulated that with modernization and urbanization, rational thought and pragmatism would increase, causing a global decline in religion, and diminishing the scope of religious authority [29, 30]. This theory has had its critics and supporters. Some have dismissed it, given the increase in world religions [31, 32], while others believed that the theory had a degree of validity, depending on the context [29, 33]. However, all agree that the rapid rise of faith in the majority world challenges a generalized application of this theory [29, 31, 32, 34]. In virtually all developing countries, faith adherence has significantly increased over the past few decades [35].

These spiritual realities are evident in Africa as religion is increasingly prominent on the African landscape, at a community level and politically [2]. According to the Berkley Centre for Religion, Peace, and World Affairs, across all areas of Africa, there are no

more than 0.08% atheist and 2.6% agnostic [36-38]. This indicates that almost every person on the continent adheres to some form of belief system.

Amid this high religiosity, SSA's religious demographics have seen a dramatic shift in the past century. It is widely believed that Christianity arrived to SSA around the 15th century[39]. The ensuing centuries saw slow growth in adherence to Christianity as African traditional religions remained the most widely practiced beliefs [40], and at the beginning of the 20th century, it was estimated that there were less than nine million Christian adherents on the continent [41]. However, Christianity became increasingly popular during the 20th century with a growing influx of Western missionaries. It was the 20th century that saw, *"one of the greatest religious changes the world has ever seen ([39], p. 171),"* as Christianity increased to over 50% in SSA, with some countries claiming 60-90% Christian adherents [39]. In this profoundly spiritual context, faith plays an integral part in communities, from birth to marriage to death [42].

1.7 Health in Africa – A Brief Overview

Africa is also a region of significant health challenges. According to the World Health Organization (WHO), the Africa region has not met most of the Millennium Development Goals (MDGs). While varying from country to country, the region has achieved no to very little progress in critical areas such as maternal mortality, malaria incidence, and mortality attributed to emerging chronic diseases [43]. While all regions, including Africa, have made improvements in some health indicators related to the MDGs, Africa continues to carry the heaviest burden, globally, of infant mortality [44], lower respiratory infections, and malaria incidence and deaths [45]. It is also home to sporadic Ebola outbreaks[46, 47] and carries the world's highest burden of HIV/AIDS [48].

1.8 Faith Definitions

Given this context of high religiosity combined with widespread, chronic health challenges and infectious disease outbreaks, this research aims to explore the effect of faith on health beliefs and the uptake of biomedical health recommendations. The study also addresses the gap in research that exists when discussing Christian faith effects on health decisions while categorising Christianity as one broad group and neglecting the diverse subgroups of Christianity, such as NPCs. The terms 'mainline,' 'Pentecostal,' and 'neo-Pentecostal' will be defined to clarify what beliefs and faith groups align within these typologies, as they will be referred to frequently throughout this writing.

1.8.1 Mainline Denominations

Christianity was introduced to West Africa by Portuguese explorers during the 15th century [49]. While Portugal had economic and political motivations for exploration along with West coast of the continent, it also began to support missionary activity in the region, largely via the Roman Catholic Church [49].

The 19th and early 20th centuries saw a Christian spiritual awakening in Europe and America [49]. Its result was a renewed fervour for evangelism which saw European and American Protestant and Catholic churches sending missionaries [49]. As these missionaries arrived to Africa, they began to evangelize and set up churches [39]. These churches were extensions of church groups or denominations from Europe and the United States and were founded upon the same Western doctrines and practices. They remained closely affiliated with their Western counterparts in structure, doctrine, and praxis [39, 50]. These are what this research will call 'mainline churches.' Examples of this are the Methodists, Catholics, and Lutherans [50].

1.8.2 Pentecostals

Protestant Christianity has many different mainline denominations, as defined above, each with its own centralized authority structure [51]. While many sub-groups and belief systems can be categorised as 'Christian,' they do not all respond similarly to interactions with health systems and health professionals. Gyimah et al., in their research on HIV/AIDS, state that it would be, "*overly simplistic ([52], p. 14)*", to generalize faith attitudes towards sexuality, given the diversity of different church beliefs. Miler et al. caution against grouping all Christian churches in the same category in terms of HIV responses, noting that there are essential differences in terms of teachings and activities [53].

Pentecostalism is one of these faith sub-groups. It is the fastest-growing segment of Christianity [54] and is known for its exuberant worship, belief in the supernatural, and the belief in divine healing through the laying on of hands [55]. Asamoah Gyadu states that Pentecostalism, "*relies on direct experiences of the divine, ([50], p. 17)*" rather than on theological creeds and mandates. While most Pentecostals emerged out of Protestantism, they are often distinguished from Protestants due to important differences in beliefs and praxis [56]. Unlike many traditional, mainline Protestants, Pentecostals, according to Asamoah-Gyadu:

...emphasize salvation in Christ as a transformative experience wrought by the Holy Spirit and in which pneumatic phenomenon including 'speaking in tongues', prophecies, visions, healing and miracles in general, perceived as standing in historical continuity with the experiences of the early church as found especially in the Acts of the Apostles, are sought, accepted, valued, and consciously encouraged among members as signifying the presence of God and experiences of his Spirit ([57], p. 12).

Krärkkäinen states that Pentecostalism can be described as a grassroots spiritual movement rather than a denomination or a theological creed [58].

There are several organized Pentecostal denominations that fall under the general description of 'mainline' churches [59]. Examples of these are the Assemblies of God and the Church of God in Christ. Both have their origins in the United States but have spread globally and remain loosely connected to one another and to their Western counterparts [60, 61].

1.8.3 Neo-Pentecostals

This research focuses on the growing number of independent churches that practice Pentecostal beliefs and forms of worship, but have no connection with mainline denominations [59]. Independent Pentecostal churches, referring to their independence from Western-affiliated mainline churches, are a particular subset of Protestant Christianity that is becoming increasingly prominent in Africa [24]. These are, *"African churches with African leaders for African people ([56], p. 52)."* As each church creates its own institution and authority, these churches do not operate within a broader accountability structure, and their sole authority is their lead pastor [55, 62].

Gusman notes that it is challenging to qualify an accurate description for these Pentecostal churches in Africa as there is no general unifying theology or common history [63]. Furthermore, Cox, a professor of religion at Harvard University, stated that, *"...Pentecostalism is not a denomination or a creed, but a movement, a cluster of religious practices and attitudes that transcends ecclesiastical boundaries ([64]", p. 246).*" Despite the apparent difficulty in crafting a universal definition for Pentecostals, Asmoah-Gyadu notes that while Pentecostals have ethnic, cultural, and theological diversities, *"The movement has created a global culture with shared features ([50], p. 12)."*

There are various nomenclatures used to describe NPCs. The term 'charismatic' has been employed when discussing churches with this nondenominational aspect [59]. This term has also been used when referring to a younger generation of Pentecostals who operate outside of classical Pentecostal denominations [57]. A more recent moniker given is 'neo-Pentecostal.' This describes churches that are Pentecostal, or charismatic, in belief and worship, but which have deviated from the mainline denominations and are independent from a broader religious authoritative body. This term is used by Wariboko [65], Robbins [55], Wrogemann [39], and Ayegboyin [66]. Asamoah-Gyuda similarly calls them, "*new Pentecostals* ([57], p. 107)" in one article and, "*neo-Pentecostals*" in another ([50], p. 1), while Burgess and Piot call them, "*neo (or new)-charismatic*" [59, 67]. However, all refer to the rising tide of Pentecostal/charismatic churches that stand-alone, are independent, and indigenous. They are not associated with a larger Western denomination, thus being independent in terms of doctrinal decisions and ecclesiastical authority. Neo-Pentecostals are rapidly becoming one of the most prominent expressions of Christianity in SSA, particularly in Africa's expanding urban centres [68]. Their influence has a multi-faceted effect on societies, affecting health beliefs, politics, and economics [69].

It should be noted that there are Pentecostal churches that are not affiliated with mainline Pentecostals, but who do not neatly fit within the above typologies. Examples of this are the Winner's Chapel movement and the Redeemed Christian Church of God. Both of these churches originated in Nigeria, starting as NPCs with no ties to traditional, Western mainline denominations and no central authority outside of the lead pastor. However, these church movements have spawned a considerable amount of 'daughter' churches, not only in Nigeria but across the continent as well as in many Western countries [70, 71]. While these church organizations function independently, with no connection to a broader, mainline denomination, they have, in effect, created their own denomination. The founding pastor remains the primary church authority, not only for the original 'mother' church, but also exerting influence and authority over the church's offspring. While these church movements share some NPC characteristics in terms of beliefs and a lack of association with a Western, mainline denomination, their significant global expansion resembles the reach of mainline churches. Therefore, while they are mentioned in this study, they were not included in the actual study target demographics and results.

The churches included in this study are those that aligned with the above definition of NPCs. For the purposes of this research, the term 'neo-Pentecostal' will be used when talking exclusively about this particular subset of Christianity.

1.9 Research Topics

In this section, each research topic will be discussed to clarify how it pertains to the overall research goal of examining the possible interaction of faith beliefs and health. This will begin with a brief discussion on Pentecostalism/NPC prominence in Africa and their beliefs, including a review of the literature pertaining to this faith expression vis-à-vis health in the African context. Fundamental Pentecostal beliefs will be discussed to highlight how these beliefs possibly influence adherents' perceptions and responses to illness, death, and biomedical public health recommendations.

This is followed by a brief discussion on the selection of the Ebola outbreak in Liberia as the study context. This includes a timeline of Ebola's presence in Africa, how Ebola is transmitted, and effective Ebola containment measures. This will serve to demonstrate how Ebola's high level of infectiousness demands containment measures that could conflict with cultural and faith beliefs.

As the study setting is in Liberia, there will be a brief overview of Liberia's religious demographics to explain why it was chosen out of the three most affected countries in the West Africa outbreak.

1.9.1 Pentecostalism and Neo-Pentecostalism in Africa

In the mid-1900s, with the end of colonialism, Pentecostalism began to increase in Africa. Currently, approximately 17% of Africa's population claims adherence to Pentecostalism, and in some countries, they represent up to 20% of the overall population [24]. To give perspective as to their rapid growth, as recently as the 1970's less than 5% of the continent was Pentecostal [24]. However, in 2015, 30-40 years later, it was estimated that approximately 17% of the African population was Pentecostal [65]. Pentecostalism continues to multiply across the continent, demonstrating significant increases in some of the most populated and politically powerful countries. In Nigeria, for example, it is estimated that approximately 30% of Nigerians are Pentecostal, giving Pentecostals societal influence and a powerful voice in Nigerian politics [72].

While demographic data demonstrate the incredible growth of Pentecostal churches in SSA, the literature on religion in Africa supports this as well, with broad consensus on its growth [50, 57, 73-81]. Attanasi and Yong, in their book on Pentecostalism and prosperity, discuss the rapid post-apartheid growth of Pentecostalism in South Africa, stating that over 30% of the country's population is now Pentecostal [82]. Parsitau, in her study on Christianity in Kenya, states that as recently as a few decades ago, Pentecostalism was on the periphery of Christianity, but recently has moved to front and centre [73]. In a second study, she states that Pentecostalism is the fastest-growing expression of Christianity globally, transforming the religious landscape of multiple countries, particularly in the global South [74].

Pfeiffer discusses the proliferation of Pentecostal/charismatic churches in Mozambique, observing that their unprecedented multiplication has facilitated a cultural shift away from traditional healers to people seeking spiritual healing through these churches [79]. Wariboko declares that, "*The Pentecostal movement (including independents and charismatics) have taken Christianity deeper into the African psyche, culture, space, and worldview ([65], p. 6).*" Asamoah-Gyadu says that Pentecostalism is, "*...the fastest-growing stream of Christianity today ([57], p. 1),*" and that it is, "*...reshaping religion in the twenty-first century ([57], p. 1).*" Giving an example of how quickly NPCs are multiplying, Parsitau notes that in Kenya, the Registrar General is overloaded with registration applications from NPCs, receiving approximately 60 new applications every month [74].

When independent Pentecostalism began in Africa, it was often in the form of local prophetic individuals who believed in a spirituality that went outside of the norms of the traditional mainline churches [57]. Some of these visionary leaders described their visions and prophecies as direct words from God, thus making themselves indispensable to their followers [71]. Wariboko states that West African Pentecostalism is defined by the leaders';

...unquestionable private interpretations, shortcuts, and "God's words" become the alpha and omega of any theological analysis.[leaders use] the term theology is used to summon and then flatly and disrespectfully dismiss any quest for alternative ideas, systematic exploration of notions and propositions, nuanced perspectives, or search for balanced intellectual judgment ([25], p. 1).

The Winners Chapel movement provides an excellent example of Pentecostal growth and the godlike claims of some pastors. Located in Nigeria, Winners Chapel was started by David Oyedepo in the 1980's, and in less than 20 years has grown into a network of over 400 churches in Nigeria, with branches in 38 other African countries and beyond [71]. While Winner's Chapel was not included within the NPC definition for this research, due to the significant increase in churches, globally (see section [1.8.3](#)) it began as an NPC and shares many NPC characteristics, as described in the literature. One of these characteristics is the absolute authority of the pastor, who often portrays himself as God's spokesman. Oyedepo, is quoted as saying, "*The Holy Ghost.....has delivered into my hands mysterious instruments that have been used over the years to raise the dead, destroy HIV/AIDS, dissolve cancers....* ([71], p. 260)." Oyedepo also claims that God speaks specifically to him, inferring that what he says should be taken as coming directly from God saying:

Prophetic verdicts are divine verdicts; they are heavenly verdicts. They are God's commands given expression through mortal lips...Every time the prophet says, "Thus saith the Lord," it is actually the Lord Himself speaking. He is only using the prophets vocal system as a microphone ([71], p. 261).

As well as being driven by individual pastors' interpretations of the sacred writings, many authors have noted that in the absence of strong regulatory frameworks, almost anyone can establish a new church. While discussing NPCs in Liberia, Gifford notes that with no regulatory system, anyone could start a church and proclaim to be a pastor, not based on formal training but rather on their own merit [83]. Asamoah-Gyadu also mentions the lack of formal training, explaining that as Pentecostalism is a branch of Christianity that highlights experiences, formal membership classes, or 'catechism,' are unnecessary [50]. As independent churches with no formal organization or accountability outside of their own walls, NPCs do not necessarily have educational requirements for pastors. Without a governing board that regulates credentials, spiritual inspiration is often the main requirement for starting an NPC [55] and, in the words of Robbins have, "*...proven to be hotbeds for doctrinal innovation. ([55], p. 122).*"

1.9.2 Prominent Pentecostal Beliefs in Africa

There are multiple theories as to why Pentecostalism has had such success in SSA, but the core message of an openness to the spirit world with an emphasis on spiritual

domination seemed to touch a felt need on the continent [65]. Asamoah-Gyadu states that in Africa;

...religion is a survival strategy where spirit-possession, with its emphasis on direct divine communication, intervention in crisis and religious mediation, are central to religious experiences. The ministries of healing and deliverance have thus become some of the most important expressions of Christianity in African Pentecostalism ([75], p. 4).

Freeman echoes this, noting that while other forms of Western faith have been present in Africa since the colonial times, these faiths typically did not address the African belief in demons and spirits. She states that, “...Pentecostalism shares the basic Africa ontology of good and bad spirits, and embraces supernatural beings (God, Jesus, demons) that can have a direct influence in the world ([84], p. 3).”

While beliefs can vary, there are two that are cited as being consistent, across the spectrum of NPCs, they are divine healing and spiritual causality. These core beliefs are pertinent to this study as they affect perceptions of illness and death, and frame responses to biomedical and public health initiatives.

1.9.2.1 Divine Healing

Generally speaking, the belief in healing has historically been one of importance in most African belief systems, and it is prominent in Pentecostalism as well [50, 85]. Swiss theologian Walter J. Hollenweger says that while several aspects define Pentecostalism’s identity, the most striking is the ministry of healing by prayer [58].

Multiple studies mention the belief in divine healing [50, 64, 77, 79, 80, 85-94]. Omenyo discusses the importance of this belief as it pertains to NPCs, stating that it directly contributed to the increase of these churches on the African continent [85]. Lartey ascertains that discussion on healing has always been present in African culture. He claims that what these churches believe in, and practice, is very similar to the work of traditional healers. As these beliefs and activities have been present for generations, he cites this as the reason that NPCs have such mass appeal [89].

Omenyo’s writing builds on Lartey’s as he explains that traditional African priests were expected to perform physical and spiritual healings [85]. When Christianity appeared, it was unacceptable that Christian priests and pastors did not perform these practices [85]. The Pentecostal belief in divine healing for both the physical and spiritual realms

provides a natural way to touch the felt needs of communities [85]. Asamoah-Gyadu says that, “...the ministries of healing and deliverance have thus become some of the most important expressions of Christianity in African Pentecostalism ([57], p.4).”

Attanasi states that while there are several rather distinct characteristics to Pentecostal beliefs, the one that is the most prominent, globally, is the belief in divine healing through prayer and the laying on of hands [76]. She quotes Ogbu Kalu who said that in Africa, “...healing is the heartbeat of the liturgy and the entire religious life ([76], p. 3),” explaining that a Pentecostal view of salvation is not only a spiritual salvation but one that touches the physical existence as well [76]. Healing is recognized as a tangible sign of the activity of God’s Holy Spirit in a believer’s life [50]. In effect, it could be said that healing and deliverance from evil spirits make religion a, “survival strategy ([50], p. 164)” for many Africans.

Gifford states that Pentecostalism is defined by a concept often described as, “victorious living ([71], p. 251).” Victorious living indicates success and health in all areas of life, and physical healing is one of its many expressions [71].

Pfeiffer identifies some positive aspects of Pentecostal beliefs in divine healing. In documenting the emergence of Pentecostal churches in Mozambique, he notes that while historically, people had frequently sought traditional healing, community attitudes towards these healers began to change [79]. Traditional healers were known for inciting occultist forces that were viewed as evil and frightening [79]. The use of these forces often involved confrontation and created conflict. This, coupled with elevated service prices, created a for-profit perception [79]. On the other hand, the Pentecostal churches offer a healing that is associated with spiritual protection against these evil forces, and this healing is free [79]. Free healing, available to all, promotes a renewed sense of community instead of divisiveness [79]. Pfeiffer states that this model was similar across Africa and has played a role in the rapid expansion of Pentecostalism on the continent [79].

1.9.2.2 Spiritual Causality

The belief in a spiritual cause and effect, particularly in health, is prevalent across the African continent, especially when dealing with an unknown or challenging health situation [95]. Many people and cultures believe in evil; evil spirits, witchcraft, sorcery,

and potentially angry ancestors [96]. For those that hold these beliefs, considerable time is spent either placating these spirits or combating their evil manifestations through prayers and rituals [96]. When an unfortunate event occurs, such as illness, road accidents, or loss of money, the event is attributed to evil, assuming that the affected family, or individuals' actions somehow created a vulnerability [97]. This aligns with the Theory of Retribution, which, from a religious perspective, believes that all difficulties have a spiritual cause and are, therefore a punishment from God, requiring a spiritual response [98].

It is essential to recognize this widespread belief in a spiritual causality for misfortune as it pertains to how a local population views illness and disease outbreaks. Omenyo discusses this in-depth, stating that, *"nothing happens by chance ([85], p. 234)"* as unfortunate life events, including illness, are often attributed to angry spirits, witchcraft, or malevolent ancestors [85].

The sphere of the supernatural is much broader in the African culture than in any European context. ([85], p. 234)

Manguvo et al. discuss these same beliefs as they apply to the West Africa Ebola outbreak, noting the difficulty in achieving community adherence to containment measures when the educational focus was primarily on transmission pathways [99]. When working with communities that believe in metaphysical and natural causes of illness and death, a purely biomedical explanation creates obstacles for adherence [99]. Bangura also mentions this in reference to the West Africa outbreak, stating that during the early weeks of the outbreak many faith leaders, particularly among the Pentecostals, declared that witchcraft and demonic forces were to blame for Ebola in Sierra Leone [86].

The way people conceptualize the aetiology of a disease generally dictates their response to it ([99], p. 2).

Manguvo et al. also observe that these beliefs are not only relevant when applied to traditional healers, angry ancestors, and evil spirits, but within Christianity's view of God as well. During the Ebola outbreak, many churches initially cited God's judgment against sexual sins as the reason for the outbreak [99]. A church in Monrovia had several Ebola cases that resulted in multiple infections and the death of the pastor's wife.

Transmission was attributed to the laying on of hands during prayer to combat spiritual attacks. A Nigerian pastor reportedly told his congregation that Ebola was not a disease but an evil spirit [100]. These are examples of how this belief can be dangerously applied during an infectious disease outbreak.

While these causal beliefs are widespread among various religions in SSA, they are particularly prevalent in Pentecostal/charismatic churches. Adogame discusses the Pentecostal belief in the foundational struggle between good and evil – God and Satan [86]. He explains that in this belief, Satan is responsible for any obstacle that prevents health, therefore supporting the common belief among Pentecostals that HIV was the result of sin or demonic attacks [86]. One survey out of Nigeria found that over 50% of Christian church leaders believed that HIV was a punishment from God for immoral behaviour [101]. This Pentecostal reaction was common during the early years of HIV and has been discussed in many journal articles [74, 102-106].

The belief in causality motivates Pentecostal believers to devote a great deal of time to ministries of prayer and deliverance. Believing that all adverse life events, including illness, are either the result of sin or evil work of the devil demands constant prayer against evil forces and the need for spiritual deliverance when adverse life events occur.

Understanding these beliefs is vital for public health organizations in Africa as NPCs increase in presence and influence across SSA. These churches also embrace the common Pentecostal practice of the laying on of hands during prayer for divine healing [76]. These practices and beliefs can potentially affect disease transmission and the acceptance of scientific medical recommendations [107]. Featherstone mentions this when examining the role of faith in the West Africa Ebola outbreaks, citing incidents of Ebola flare-ups due to the practice of laying on of hands [108].

Despite this credence and the increasing prominence of NPCs in Africa, there is scant research on the interaction of these beliefs with health decisions and responses. Understanding this interaction could affect NPC community engagement strategies during a health crisis, such as Ebola. Thompson and Bolton point out that NPCs are some of the fastest-growing churches in SSA, yet little is known about them [12]. While examining the faith/health interactions, this research aims to fill this gap in the literature, recognizing that perhaps a 'one size fits all' strategy is not sufficient for religious community engagement during disease outbreaks.

1.9.3 Ebola

While there are other outbreaks or endemic diseases that could have provided the context for this study, Ebola presents a unique opportunity to examine the interaction of faith and health.

There is an abundance of literature that addresses Pentecostal faith regarding the infectious disease crisis presented by HIV/AIDS. Pentecostal stances on sexuality, beliefs in divine healing vis-à-vis antiretroviral (ARV) medications, and strategies for HIV/AIDS education have been well documented [26, 63, 74, 76, 78-80, 86, 87, 90, 92, 93, 109, 110]. It is widely acknowledged that the primarily sexual nature of HIV transmission creates tension for faith engagement, as many view HIV as God's judgment on immorality [101, 106, 111].

Aside from HIV/AIDS, many countries in Africa have sporadic outbreaks of other diseases such as measles and cholera [112]. Malaria and typhoid fever are endemic in West Africa and drive major burdens of morbidity and mortality [113, 114]. However, their endemic nature implies that these illnesses are relatively common, already known by the population. For many illnesses, community-wide involvement in prevention is preferred. However, individual household level responses can also significantly impact many of these endemic diseases [115]. Malaria, for example, is transmitted via mosquito. Therefore many prevention efforts focus on individual behaviour for personal protection, such as using mosquito nets [116].

Ebola outbreak responses provided a compelling case study for examining the faith/health dynamic. While there is a possibility of sexual transmission, unlike HIV, Ebola is not considered a sexually transmitted disease [117] and, therefore, lacks the association to a perceived 'sin' and immorality. However, despite this lack of association with sexual activity, the initial reactions of many Pentecostal churches during the 2014/15 outbreaks in West Africa, were similar to those towards HIV/AIDS. There was widespread refusal of the medical explanation for the outbreak coupled with the belief that Ebola was due to sorcery, a judgment from God due to homosexuality, a corrupt government, or other personal sins [77, 108, 118-120]. Some churches emphasized divine protection, rather than biomedical containment measures, and encouraged participation in prayer meetings, where the laying on of hands unknowingly facilitated its spread [77].

The need for building a bridge between the faith and science sectors was evident during the West Africa Ebola outbreaks [121]. The very nature of Ebola, its seemingly sudden presence, high mortality rate, and high level of infectiousness created panic [122]. Modes of prevention such as isolation of suspected cases, maintaining distance from those who were sick, and an abrupt, mandated change in burial procedures were challenging to accept and understand from some cultural and religious worldviews [123].

Although multiple Ebola outbreaks had previously occurred on the continent, there were many years and many miles in-between manifestations [46]. Up until the 2014 West Africa outbreaks, Ebola remained a largely unknown and mysterious illness that had never appeared in West Africa [47].

In West Africa, Ebola stayed relatively hidden for several months before it gained momentum and began to spread rapidly [124]. By the time it emerged in populated urban areas, including the capital cities of Liberia, Guinea, and Sierra Leone, it had a firm foothold in these countries and was not an individual illness but rather one that devastated entire communities [125]. Due to its infectiousness and rapid spread, the outbreak areas were inundated with international responders setting up treatment tents and wearing personal protective equipment (PPE) [122]. Responders went door to door to promote containment procedures. While some churches tried to deny or spiritualize these events, ultimately, churches in the middle of this crisis could not ignore what was happening around them [126].

In effect, the West Africa Ebola outbreak provided the perfect storm of events around which local faith came face to face with science, and with technology that had an apparent Western influence. This scenario provided an excellent context for examining the faith/health dynamic by comparing and contrasting NPC reactions, vis-à-vis other Christian groups, to the outbreak and the containment measures.

1.9.4 Ebola in Liberia

Since Ebola was discovered in the DRC in 1976, there have been 36 outbreaks, primarily in Central Africa [127]. However, the West Africa outbreak was by far the most deadly with over 28,500 cases (including suspect, probable, and confirmed) and over 11,000 deaths [127]. Of the three most affected countries, Guinea, Liberia, and Sierra Leone,

Liberia had the most deaths, with over 4,800 individuals dying from Ebola Viral Disease (EVD) [127]. Among these three countries, Liberia also has the highest percentage of Christianity, with over 85% of the population self-describing as Christian, while Guinea and Sierra Leone have approximately 10% and 20%, respectively [128]. Given that this research will examine the faith/health dynamic by focusing on the reaction of NPCs to the Ebola outbreak and containment measures, Liberia was, therefore, the most appropriate setting for this research. The context of Liberia will be discussed in further detail in the following chapter.

Chapter 2: Setting

2.1 A Brief History of Liberia

Liberia is situated along the West coast of Africa, sharing a border with the Ivory Coast, Sierra Leone, and Guinea. It was founded in 1822 by freed American slaves and is the only African country that was never colonized [129]. Figure 2.1 shows a map of Liberia and its location in West Africa [130].

Figure 2.1 Map of Liberia and its Location in West Africa



Liberia has a landmass of relatively 43,000 square miles, which supports a population of approximately 3.5 million [131]. It is the most forested country in West Africa with a diverse topography that ranges from mangrove swamps to mountains [132]. Almost one-half of the population lives in urban centres, with the largest urban area being the capital city of Monrovia [132].

Liberia's population has two main groups, indigenous Liberians and Americo-Liberians [133]. The indigenous Liberians are descendants of the African ethnic groups that lived in this part of West Africa before Liberia became a nation [133]. The Americo-Liberians were former slaves who had been born and raised in the United States. In 1847 they relocated to West Africa after the abolition of slavery [134]. Although the Americo-Liberians are the minority of the population (3%), they ruled Liberia for decades, creating a social system that acknowledged them as the superior class and spawning an environment of oppression for indigenous Liberians [135].

2.2 Religious Demographics

Religion, or faith, has historically been an important aspect of Liberian culture [133]. Traditional indigenous beliefs, associated mainly with animism and ancestral worship,

are widely practiced (5). Within these belief systems is the assumption that illness or misfortune is caused by spirits, making it necessary to access a higher spiritual power to appease or overcome these spirits [134]. In his paper on mystical weapons used during the Liberian war, Ellis discusses these beliefs as they were observed by missionary medical doctor George Way Harley, who lived in Liberia from 1926 – 1960 [134]. He described Harley's field notes, saying that Harley:

...noted that the people of Ganta had 'no concept' of the natural, no recognition of natural laws' of the sort that he believed to govern the world. The people he talked to every day, whose illnesses he healed and whose souls he attempted to save, made no distinction between what might, in another system of classification, be regarded as natural, unnatural and supernatural elements in their lives. The world was simply one. ...If something significant happened, whether it was a person dying or being born, or meeting fortune or misfortune, there had to be a cause ([134], p. 226).

Liberia's principle organized religions are Christianity and Islam. Christianity was imported by the Americo-Liberians, who were Christianized while in the United States [136]. The most recent religious survey, from 2008, has Christianity at 85.6% of the population and Islam at 12.2% [137].

In Liberia, Pentecostals represent 10-20% of the population [24]. Most credit an indigenous Liberian prophet named Wadé Harris with bringing Pentecostalism to West Africa, including Liberia [65]. In 1913 Harris began to travel through French West Africa, preaching repentance, baptizing followers, and casting out evil spirits. Within 18 months, he had amassed over 200,000 followers [65]. However, Gifford states that while aspects of Pentecostalism have expressions that originated from traditional African religions, Liberian Pentecostalism, specifically, possesses some American characteristics and influence due to American missionaries and Liberia's close ties with the United States [83].

Heaner notes Pentecostalism's impressive growth in Liberia, primarily since the 1980s [138]. In her ethnographic study on Pentecostals in Liberia, she identifies two main spiritual frameworks that Pentecostal churches operate within; that the Holy Spirit's power is essential for transformation and that this same power will solve all life's problems [138]. She observes that within these frameworks, Liberian Pentecostal's default response to difficulties is one of faith [138]. If one has enough faith, God will

solve any problem. They believe that the root cause to most individual misfortune, as well as to Liberia's problems, is related to sinful thoughts and behaviour, which are most likely influenced by Satan [138].

Heaner also discusses a unique aspect of the Pentecostals that she studied in Liberia, stating that while Pentecostalism is considered a branch of Christianity, many Liberian Pentecostals do not consider committed church members from other Christian mainline denominations as 'Christian [138].' In their perspective, 'Christian' is linked to having a born-again experience, not to church membership. She describes Liberia's NPCs as fiercely independent and somewhat indifferent toward other Christian denominations [138]. Marshall has similar observations of Pentecostals in Nigeria, stating that they view themselves as holy and spiritual compared to other corrupt faiths [139].

2.3 Liberia's Wars

The Americo-Liberian's oppressive rule over the indigenous Liberians caused societal tensions, ultimately resulting in a bloody coup d'état in 1980 [133]. This was the beginning of over two decades of violence as Liberia endured two brutal, back-to-back civil wars; the first from 1980 – 1996 and the second from 1999 – 2003 [140]. The cumulation of these wars destroyed the economy and caused massive displacement as rural Liberians fled to other countries or descended upon the urban areas, particularly Monrovia [129].

When Monrovia was built, a majority of Liberians lived in rural areas. Therefore, its infrastructure was not equipped for this rapid population expansion, putting a toll on the city [129]. Informal settlements, a problem in the 1950s, became even more crowded, where, according to Hoffman this created a, "*...city experiencing the effects of conflict not only as direct violence, but as a further compression of already shifting urban space ([129], p. 11).*"

2.3.1 Religion and War

Similar to wars of the past, many of the protagonists in Liberia's civil wars claimed religious, if not divine, reasoning for their actions [141]. Some of the most barbaric acts committed during the wars were done with references to spiritual symbols and entities [141]. Traditional, spiritual beliefs in the form of appeasing spirits played a role as soldiers sought spiritual weapons to give them victory and to provide protection against

the enemy [134]. Some rebel groups gave as much attention or priority to ensuring that their followers had the proper spiritual protection, as they did to procuring guns and teaching their military protocols [141]. Talk of sorcery and witchcraft was rampant as horrified citizens watched rebel troops desecrating corpses, sometimes even eating the hearts of their victims [134]. These beliefs and practices dated back centuries. The *Liberian Studies Journal* discusses the common practice of young men waging war or raiding other communities, usually searching for material possession or for revenge [142]. Before the raids, these young men often took part in traditional practices that involved acknowledging the spirit world as they invoked the spirits to empower and protect them [142]. To quote Ellis:

The most important social bonds arise from the belief that the ultimate source of power lies in the invisible world of gods and spirits, which leads to a variety of arrangements to control or communicate with these spiritual forces ([141], p. 34).

Although this belief system in appeasing spiritual forces was the reason given for many of the atrocities committed during the war, another belief system(s) was instrumental in bringing about peace. Seeing the impact that the protracted fighting was having on their country and feeling that the international community was not doing enough to stop the war, the Liberian Council of Churches (LCC), an ecumenical Christian organization, began to organize and work towards moderating for peace between the warring factions [143]. They were soon joined by the Religious Leaders of Liberia, a combined Christian and Muslim organization [143]. These organizations were eventually joined by a group of religious women, who began peaceful protests to advocate for ending the war. Starting with a group of Christian women who named themselves the 'Liberian Women's Initiative,' their plea for peace also resonated with Muslim women and soon became a multi-faith movement [144]. While many voices were a part of the ultimate success of the peace accord, multiple sources cited the involvement of faith groups, particularly women's faith groups, as an essential factor in its success [143-147].

2.4 Liberia Post-War

The decades of civil war, characterized by brutal atrocities, left Liberia in a fractured state. Reeling from the brutality of the war, mourning the loss of tens of thousands of citizens, and left with a destroyed infrastructure, Liberia tried to heal itself.

2.4.1 Religion

In most of West Africa, including Liberia, community and family ties are strong [148]. Many families hold onto traditional practices and beliefs, having high levels of religiosity that determine daily life choices [100]. This innate religiosity, coupled with faith leaders' contributions to ending the war, unsurprisingly makes religious leaders some of Liberia's most respected individuals [149]. The politics of war and perceptions of government corruption and public mismanagement after the conflicts created a higher degree of public trust in faith leaders than in government officials [150].

Since the end of the wars, there has been little religious mapping [3]. However, Christianity, particularly Pentecostalism, has had remarkable growth in recent years [83]. Pentecostal conversions, specifically, have been widespread post-war, due to their emphasis on becoming born-again and starting over with a new life [151]. In his research on Pentecostalism's role in post-war healing and forgiveness among Liberian refugees, Ecke discusses how the Pentecostal 'born again' experience has been promoted as a way to break with the past, noting its crucial role in the self-identity of the convert [151]. In conversations with refugee camp residents, he states:

...Respondents also stressed that they have "made a break" with ethnic identity, which many respondents saw as a contributor to the war. The Pentecostalized culture in the camp affected its ethnic relations...there is an absence of ethnic violence in the refugee camp, even though ethnic animosities, along with various other factors such as economic inequalities, contributed to the outbreak of the Liberian civil wars....on the occasions that the topic of ethnicity came up in conversations, respondents suggested that ethnicity no longer dominated, or even affected relationships between Liberians in exile ([151], p. 58).

Refugee camps filled with both victims and perpetrators seemed to find commonality and forgiveness through Pentecostal teachings. Ecke went on to quote respondents who stated that, *"Perhaps the most important reason for the interethnic peace was the work and preaching of the churches in the camp and the religiosity of the camp's inhabitants ([151] p. 58)."* Interviewees discussed Pentecostal preaching, which emphasized reconciliation and religion-inspired forgiveness, apparently affecting the lives of refugees and how they viewed varying ethnic groups within the camp [151]. By the time these refugees were reintegrating to Liberia, 32% of them identified as Pentecostal,

making it the most prevalent faith among those who repatriated and boosting the number of Pentecostals in the country [151].

Heaner also discusses the role of Pentecostals in post-war reconciliation [138]. While Pentecostals typically avoided political affiliations, she observes that they inadvertently served as peacebuilders due to their belief that all battles were fundamentally a battle between good and evil, fought in the spiritual realm. This served to unify members as they fought this spiritual war together, not focusing on the recent civil wars [138]. Their emphasis on being 'born again' meant that the person's past was no longer a part of their life, allowing for forgiveness and acceptance of the war crime perpetrators. Her research ultimately demonstrates that Pentecostal churches played a crucial role in reintegrating war criminals and child soldiers back into society, with better outcomes than Liberia's Truth and Reconciliation Commission (TRC) [138]. While Pentecostals in Liberia have not been active in the socio-political context, organically, through their beliefs, they played a critical role in post-war peacekeeping [138].

Ter Haar has similar observations [152]. She notes that Pentecostal churches provided a platform where former child-soldiers confessed their acts publicly, and received forgiveness from church members, helping to reintegrate them into Liberian society [152].

Shaw, in her study on Pentecostal impact after the war in Sierra Leone, observes a similar phenomenon [153]. She states that while many churches had programs for those displaced by the war, displaced youth seemed to be particularly drawn to the Pentecostal churches [153]. She says that these churches organically provided networks and active support systems, elements that were attractive to confused, post-war youth [153]. She also observes that these churches allowed these displaced youth to, *"...reshape their experience, memory and aspirations, making these speak directly to Sierra Leone's civil conflict, its aftermath and their own predicament ([153], p. 73)."* Interview respondents discussed having recurring nightmares about the war and described how the church helped them deal with these nightmares through prayer:

...insistent fears, bad dreams, and memories of violence that replay again and again are interpreted as deriving from an external, demonic force beyond the sufferer.....For these youth healing is not only an act performed on them by the pastor but

also an ongoing fight which they learn to participate in themselves ([153], p. 88).

Youths stated that church prayers for deliverance and the framing of a spiritual war against good and evil encouraged them. They were able to battle this spiritual war via prayer, helping to alleviate their nightmares and trauma. Shaw states:

By 'forgetting' the war as a direct realist account and relocating it to an Underworld that can be fought through prayer and exorcism in their refashioned deliverance ministry... youth seek to displace their war memories by the Holy Spirit. And by thus renarrating the war through prayer, video viewing, and plays, they learn new forms for forgetting, turning demonic memory into Pentecostal memory. This does not mean that they cease to suffer and to remember. Neither does it mean that they become autonomous authors of their own thoughts and feelings. But they learn to experience their memories in ways that enable them to be worked on, fought, and transformed in the very same way that Sierra Leone's war can itself be worked on, fought and transformed ([153]p. 89).

Gifford also discusses the Pentecostal explosion in West Africa, specifically in Liberia, stating that mainline denominations were unable to deal with the social issues that came after independence and civil wars [83]. It was common for African leaders to offer financial incentives to faith groups, hoping to secure their political support. This resulted in many churches being viewed as aligning with corrupt governments. However, Pentecostalism, and more precisely neo-Pentecostalism, often refused government funding, which increased its popularity. NPCs cultivated a spiritual community and preached about divine healing, help amid suffering, and spiritual comfort [83]. These were much-needed topics after the horrors of war.

In general, Liberians were confused by the war and by their fellow countrymen who participated in the heinous acts. However, Pentecostal beliefs in starting a new life in Christ, the battle between good and evil, and the hope of peace and help from God played an essential role in helping many to navigate post-conflict society [138].

2.4.2 Infrastructure

In the decades leading up to the war, Liberia experienced steady economic growth that mainly benefitted the ruling elite [154]. However, what little was working for the average Liberian before the war, was destroyed during the protracted conflict. The two back-to-back wars took a substantial human and structural toll on Liberia.

Approximately 8% of the population lost their lives, and over 15% were displaced [135]. Liberia's gross domestic product (GDP) fell a staggering 90%, one of the largest economic collapses on record, and the average Liberian income decreased by one-sixth [154]. Table 2.1 shows the multi-sectoral decline after the war.

Table 2.1 Value Added by Sector in Liberia, 1987-2005

	1987	2005	Decline (%)
Real GDP	1167.0	401.7	65.6
Agriculture & fisheries	368.7	177.9	51.8
Rubber	59.9	41.5	30.7
Coffee	0.9	0.1	90.8
Cocoa	5.9	1.2	79.5
Rice	117.1	28.4	75.7
Cassava	57.4	44.0	23.3
Other	127.6	62.7	50.9
Forestry	56.6	59.0	-4.3
Logs & timber	34.4	0.0	100.0
Charcoal & wood	22.2	59.0	-166.2
Mining & panning	124.9	0.7	99.4
Iron ore	116.2	0.0	100.0
Other	8.7	0.7	91.9
Manufacturing	86.9	51.7	40.5
Cement	23.0	14.9	35.5
Beverages & beer	52.5	33.7	35.9
Other	11.4	3.2	71.8
Services	529.9	112.3	78.8
Electricity & water	18.2	2.7	85.3
Construction	39.0	8.0	79.4
Trade, hotels, etc	71.5	19.2	73.1
Transportation & communication	89.5	27.6	69.2
Financial institutions	141.8	10.0	93.0
Government services	129.0	31.5	75.6
Other services	40.9	13.3	67.4

After the war, societal progress and improvements were slow, at best, and life was difficult and unpredictable [138]. Despite all the United Nations (UN) and NGO programs, many Liberians found themselves still in 'survival' mode, something they were eager to abandon after years of trying to survive the wars. This seemed to spawn an attitude of fatalism, accepting continued suffering as God's will, while trying to find peace in the midst of it all [83].

For those who did survive, and remained in the country, the Liberia they had known had disappeared. Health facilities were destroyed [135], there were ruptures in electricity, poor access to water, a generalized lack of access to potable water, and barely passable roads [155]. A majority of the population was living on less than \$1 day [156], making Liberia one of the world's poorest countries [135]. The wars had decimated the country, not only physically but also in terms of human resources [157]. Many of the educated,

including healthcare professionals, had fled during the war, and those that stayed generally had substandard qualifications due to wartime closures of schools and universities [158, 159]. The few remaining health centres were understaffed and undersupplied [155], leaving Liberia with only one physician for every 100,000 people [159].

Healthcare structures struggled to regain their footing. The largest hospital in the country, the John F. Kennedy Medical Centre, located in Monrovia, had been severely damaged during the war [160]. Isolation wards and PPEs were virtually non-existent [161]. Concurrently, those displaced by the conflict caused Monrovia's population to more than double, taxing its already fragile health system [162]. Shortly after the peace accord was signed in 2003, it was estimated that approximately 40% of Liberians had access to basic healthcare [162]. Leading causes of mortality and morbidity were preventable diseases such as malaria, typhoid, and malnutrition [157]. Over a decade after signing the Lomé peace accord, Liberia remained on the UN list of least developed nations [163].

2.5 Ebola in Liberia

Ten years later, Liberia was still trying to recover from the massive destruction, trauma, and displacement caused by the war. By this time, many aid organizations were scaling back their operations as Liberia moved from a conflict zone to the need for rebuilding and development. It was during this vulnerable, post-war context that Ebola emerged [155].

From its discovery in 1976 until 2014, Ebola seemed to prefer the equatorial forests of Central Africa, having never appeared in West Africa [160]. However, all of that changed with the death of an 18-month-old boy in Guinea. To quote the WHO, in West Africa, *“Ebola was an old disease in a new context ([160], p. 4).”*

Ebola entered Liberia via its border with Guinea, and the first cases were confirmed on March 30, 2014 [160]. The situation seemed to quickly stabilize, with few new cases reported and all of them outside the capital of Monrovia. By May, MOH officials believed that the outbreak had been contained and did not declare the situation a public health emergency [149]. Many Liberians doubted the reality of the outbreak, accusing the government of fabricating the story to obtain resources from the international

community [149]. Most responders believed that the outbreak was subsiding, however, Ebola was silently spreading [108].

The calm was disrupted in mid-June when Ebola was identified in Monrovia. Hospitals and health centres did not have the capacity for necessary epidemic containment measures such as testing, contact tracing, and infection control [159]. While the government had been making progress to re-establish essential services that were destroyed during the war, at the time of the Ebola outbreak no hospital in the country had an isolation ward, very few healthcare workers had ever been trained in infection prevention and control, and no PPEs were available [160].

Many of the first Ebola deaths in Monrovia were healthcare professionals. As people became ill and died, panic spread, and many healthcare workers fled their posts [149]. After the war, Liberia was left with few doctors and healthcare workers. However, by the end of 2014, approximately 9 months after the outbreak started, 700 had been infected, with more than half dying from EVD [160].

Widespread community perception held that health facilities were places of transmission, resulting in an avoidance of hospitals while families hid the sick at home and visited traditional healers or faith healers [149, 164]. This reaction was compounded by the initial Ebola prevention messages, which focused on the high mortality rate and lack of treatment [160]. Unintentionally, the hopelessness of these messages discouraged people from going to Ebola Treatment Units (ETUs) as people preferred to take care of their loved ones themselves, allowing them to die at home [165]. Beliefs and culture also contributed to Ebola's spread. There was a generalized mistrust of Western medicine mixed with strong traditional and religious beliefs. Many relied on traditional treatments, believing that Ebola was the result of sin or witchcraft [77].

Combined with the panic and fear were rumours and disbelief. Distrust in politics and government authorities, a hangover from the two decades of civil war, continued to cause suspicion and mistrust in the governments' messages [166, 167]. This created an environment of informal networks of information, which were often considered more trustworthy than official sources [168, 169]. Amid this government distrust, conspiracy theories abounded, such as the belief that Ebola, if it existed, was the result of intentional poisoning of the population [12].

By August, officials had declared a state of emergency and cited, "*...ignorance, poverty, and entrenched religious and cultural practices*" as reasons for its spread ([170], p. 2). To reduce infections, the Liberian government ordered the cremation of bodies [165]. In a context with many traditions and beliefs that focused on the care and cleansing of a body after death and community participation in burials, there was massive resistance to this policy [165]. From a biomedical standpoint, cremation was an effective method of killing the virus. However the policy ultimately created an atmosphere of distrust and fear as people hid the sick and secretly buried those who died [108]. The cremation policy was eventually annulled in December 2014 with the formation of guidelines for burial with dignity. These guidelines decreased the risk of Ebola transmission, while recognizing certain local burial traditions, and proved to be more accepted by the public [108, 165].

Although traditional practices and burial rites were cited as high-risk practices that contributed to many infections, according to the WHO, Ebola, "*...preyed on another deep-seated cultural trait: compassion*([160], p. 6)." Fairhead describes it as, "*...a disease of the social; of those who look after and visit others and of those who attend funerals... Ebola is a disease of the socially good* [171]." In a culture that valued caring for family members during illness and demonstrating the proper respect during death, containment measures were difficult to accept and clashed with the cultural norms of helping those in need [165, 171].

As international responders, often from Western countries, arrived to help in the response, their initial efforts focused on biomedical measures, communicating the severity of the outbreak, and promoting containment protocols [3]. Ebola Treatment Units were established, and Ebola messages were given in a one-way, top-down fashion. These messages communicated scientific-based, factual information on Ebola and its prevention, without considering how to convey this information through the lens of local culture and beliefs [108, 168, 172, 173].

As Ebola infections continued to rise, officials recognized that they needed to operationalize a more grassroots, community-oriented approach [149]. In September 2014, Liberian health officials launched a "*bottom-up*" communication campaign that focused on two-way communication, local volunteers, and community watch groups ([149], p 15). This model proved to be effective as new cases began to decline [149].

Whilst it would not be until January 2016 that West Africa was finally declared completely Ebola-free [174], some responders state that the focus on community empowerment and mobilization played a crucial role in turning the tide in the outbreak [149].

2.5.1 Ebola and Faith Engagement

During times of confusion and fear, such as an infectious disease outbreak, people often go to religious leaders to try to make sense of what is happening [77]. This was true during the West Africa Ebola outbreak as peoples' responses to Ebola were often affected by their faith and the opinions of trusted religious leaders [3].

Despite community engagement delays by the international community, faith groups were among the first responders as they attempted to support and pray for the sick [3]. However, due to the widespread mistrust in government messaging, a lack of grassroots engagement, and their personal beliefs, their initial responses were not always beneficial [108]. Many church leaders declared that witchcraft or sin was the reason for the outbreak. By framing it as having a spiritual cause, they responded within their spiritual frameworks of praying and the laying on of hands, increasing infections [108]. In July, Church leaders from the ecumenical LCC announced that Ebola was a punishment from God for Liberia's immorality [3, 108, 175]. Many faith leaders agreed that Ebola was due to government corruption and overall evil in the country thus denying the medical aspect of the outbreak [18]. These beliefs sparked attitudes of stigmatization towards those who were infected, implying that EVD was punishment for a wrongdoing or due to witchcraft [108].

A frequent response among the majority Christian population in Monrovia was a call to faith in God and prayer [77]. For Pentecostal/charismatic Christians, a large and growing sub-group of Christianity in Monrovia, this was frequently expressed through the laying on of hands during prayers and a belief in God's divine protection [3]. During an infectious disease outbreak, these beliefs resulted in behaviours that went against Ebola containment measures, creating chains of infections [99, 163]. It was estimated that over 30 pastors in Monrovia, most of whom were Pentecostal, died due to these practices [108, 176].

According to Bangura, *“Charismatic healing evangelists are known to affirm that when Christians fall sick, it is their faith in Christ, rather than the medication they take, that brings healing [77], p. 9).”* Falade and Coultas discuss how these beliefs impacted the outbreak, describing the reaction of some religious groups in Liberia as one of faith, claiming that their faith in God would overcome all illnesses, including Ebola [100]. They cited a Liberian newspaper article that told the story of a pastor in Monrovia. This pastor, believing that those infected were under a spiritual attack, insisted on praying for the sick through the laying on of hands. This action caused four people to die, including the pastor's wife [100]. The pastor himself was infected but survived.

As the international community began to scale up its community engagement strategies in September, some organizations found religious leaders more challenging to engage than other community stakeholders [62]. As more and more faith groups began to support containment strategies, sporadic resistance continued, particularly from NPCs, as they insisted that Ebola was a spiritual attack and not a medical problem [108]. However, as Ebola spread and conditions worsened, more faith leaders began to take appropriate action, and responders began to engage them more intentionally [108]. Greyling et al. state that the faith sector's engagement was a critical turning point in the Ebola outbreak [150].

In October 2014, Ebola cases began to decline in Monrovia [177], and Liberia was finally declared Ebola-free in January 2016 [174]. When it was over, Liberia had seen more than 10,000 infections and over 4,800 deaths [178].

2.6 Chapter Summary

Liberia, as a nation, was formed to facilitate the repatriation of former slaves and allow them to return, in freedom, to the continent of their ancestors. However, upon arriving to their new home, these freed slaves oppressed the ethnic groups that were already inhabiting this part of West Africa, creating a social and political system that favoured the elite minority and marginalized the indigenous peoples. Resentment and dissatisfaction with this system ultimately spawned two back-to-back civil wars, which ended in 2003.

Liberia and its inhabitants were significantly affected by these wars. The country's infrastructure was decimated, and the brutal atrocities committed by their own

countrymen exacted a considerable toll on the Liberian psyche. Thousands of Liberians died during the war, and over 15,000 were displaced.

Amid this turbulent time in Liberian history, Pentecostalism began to rapidly increase in Liberia. While most Pentecostals did not actively speak out against the war and its perpetrators, many also refused to accept money and social status from those seeking power. This apolitical stance, combined with a large and visible Pentecostal presence in Liberian refugee camps, increased their adherents, popularity, and influence. Religious leaders became some of the most trusted individuals in Liberian society, receiving more community trust than the government.

It was within this context that the 2014 Ebola outbreak began in Liberia. As a country that mistrusted its government yet relied heavily on traditional and religious beliefs, looking to these faith leaders for guidance, Liberia provides an excellent context to study the faith/health interaction, within the scenario of the Ebola outbreak.

Chapter 3: Literature Review

The literature included in this review was chosen based upon its contribution to an examination of the faith/health dynamic in Africa, with a primary focus on NPC responses to the Ebola outbreak in Liberia. After a review of the literature, the most relevant and applicable studies were chosen for discussion.

An initial literature review was conducted in October 2015, a few months before Liberia was declared Ebola-free. It yielded plenty of scholarship on the presence of NPCs and particularly their responses to HIV/AIDS. However, only one article discussed NPCs and Ebola. Therefore, a follow-up literature review was conducted approximately one year later, in January 2017, to determine if other research had been published addressing faith, particularly NPC faith, and Ebola.

This chapter will discuss both literature reviews. It starts with a description of the search terms and presents the results of the initial literature review. Pertinent findings relating to NPC beliefs and health issues are examined. The follow-up literature review findings will then be presented and summarized, followed by a discussion of similarities or differences in the two reviews' findings.

3.1 Literature Review on the Role of Pentecostal Faith and Health in Africa

There is a wealth of literature on spirituality in Africa and the influential role that faith stakeholders play in community health and behaviour change. Numerous resources discuss various stakeholders in health promotion, health education, and behaviour change [1, 2, 118-120, 169, 179]. However, there is little research on the interaction of specific faith beliefs and health decision making. This research aims to examine the faith/health interaction within the context of NPC responses during the Ebola outbreak in Monrovia, Liberia.

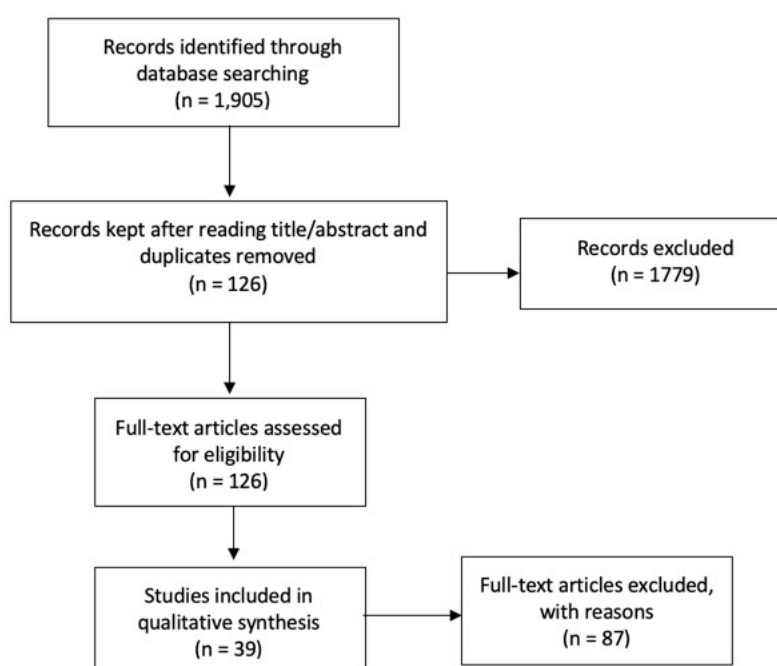
To identify literature that explicitly addressed this branch of Christianity in Africa, a literature search was performed in seven databases (CINAHL, Cochrane, ELDIS, Global Health, Medline, PubMed, Scopus) using the terms "(Pentecost* or Charisma*) and Africa." A total of 1,905 articles were identified and reviewed. Inclusion and exclusion criteria are listed in Table 3.1.

Table 3.1 Inclusion and Exclusion Criteria for Literature Review

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Discussion on the influence and involvement of Pentecostal/charismatic churches in public health • Discussion on Pentecostal/charismatic beliefs vis-à-vis health and healing • Research conducted in Africa • English or French language 	<ul style="list-style-type: none"> • Defines 'charismatic' as a character trait • Discussion on Pentecostal beliefs unrelated to health and healing • Mentions Pentecostals as a part of the study sample but does not explicitly discuss Pentecostal beliefs and reactions to health responses. • Study conducted outside of Africa • Languages other than French or English

After excluding duplicates and elimination by title and abstract, 126 full-text articles were assessed. Thirty-six were ultimately kept for review. Three more articles were found through colleagues' recommendations, bringing the total number of scholarship included in this review to 39. Figure 3.1 outlines the process of articles accepted into this review. Table 1 in Appendix A outlines the articles that were included in this review.

Figure 3.1 Prism diagram of the initial literature review on the role of Pentecostal faith and health in Africa



3.1.1 Results

A considerable majority of the literature discusses NPCs vis-à-vis HIV/AIDS [26, 63, 74, 76, 78, 80, 86-88, 90, 92-94, 101, 106, 109-111, 120, 180-188], as well as two articles that specifically examine Pentecostal beliefs on sexuality and condom use [52, 189]. The prominent Pentecostal belief in divine healing is examined in three studies [71, 85, 89]. One study discusses NPC responses to the Ebola outbreak in Sierra Leone [77], and one examines NPC's contribution to mental health among young street vendors in Zimbabwe [190]. A vast majority of the literature in this review comments on the remarkable increase of NPCs in SSA [26, 52, 63, 71, 74, 76-81, 87, 93, 101, 106, 109-111, 184, 186, 187, 189-193]. This increased presence is noted across all regions of SSA.

3.1.1.1 NPC Beliefs – Divine Healing

Several NPC beliefs were cited as contributing, whether positively or negatively, to general NPC attitudes and responses to HIV/AIDS. A number of papers discussed the Pentecostal belief that any misfortune, including illness, is often blamed on personal sin or witchcraft [26, 63, 71, 74, 77, 79, 85, 86, 94, 111, 185, 190-192]. Accompanying this is the belief that illness requires a primarily spiritual response.

The spiritual response often expressed is that of prayer for divine healing. Twenty-four studies discuss the belief in divine healing [26, 63, 71, 74, 76, 77, 79, 81, 85, 88-90, 92, 93, 101, 110, 111, 185, 186, 190, 192]. Kisenyi, Manglos, Seeling, and Togorasei examine the possible influence that this belief has on ART adherence. The results were mixed. Kisenyi and Manglos found spirituality to be associated with less stress and worry about HIV and a high rate of adherence to ARTs [90, 93], while Manglos argues that the belief in divine healing could be considered as a third therapeutic system due to its holistic nature and effects [90]. Kisenyi, in her Ugandan study, demonstrates that Pentecostal and Muslim adherents score highest on the religiosity scale, a trait that is often associated with poor medical compliance [93]. However, according to her research, these groups are most likely to adhere to ART protocols, which leads her to comment that religious leaders are underutilized. She recommends greater collaboration with these faiths in ART programs [93]. However, studies by Seeling and Togorasei reveal the opposite; that Pentecostals and the belief in divine healing created barriers to ART adherence, citing incidents where Pentecostal pastors encouraged their members to burn HIV medications as proof of faith in their healing [92, 192].

Attanasi's research indicates that the belief in divine healing helps HIV-positive women to thrive [76]. Her study based out of South Africa reveals that these Pentecostal women frequently attend prayer meetings where there is regular prayer for divine healing. Within what is apparently perceived as a safe environment, the women discuss their HIV status, and as they participate in prayer for one another, they bond together, forming a sort of support group, which positively affects their mental and emotional outlook [76]. However, she acknowledges the caveat that some believe that prayer could be used for HIV prevention when faced with an unfaithful partner, an obviously concerning belief that underscores many women's cultural lack of self-efficacy in HIV prevention.

Adogame, in his case study on a prominent NPC church in Nigeria, discusses the common NPC beliefs in the spiritual causality of illness and the spiritual response of prayer for divine healing [86]. While he postulates that there were many NPCs positively involved in HIV support, he acknowledges that these beliefs could cause controversy, as the church in his study claimed to have divinely healed those with HIV. He also discusses the common NPC belief that all illness, including HIV, is a punishment from God and describes the manner of praying against the, "*demon of HIV* ([86], p. 477)," recognizing how this could contribute to the stigmatization of those infected.

3.1.1.2 NPC Beliefs – Sexuality

There is a considerable amount of research on NPC beliefs regarding human sexuality, primarily as it relates to HIV prevention [26, 52, 63, 74, 87, 101, 109, 110, 180-184, 187-189]. Several studies examine NPC beliefs on HIV prevention measures in light of their strict moral stance on premarital sex and controversial beliefs that oppose condom promotion and use [26, 52, 63, 78, 80, 86, 87, 101, 106, 109, 110, 180-187, 189]. This view implies a frustration on the part of some HIV organizations as they attempt to work with NPCs (as well as some other churches) on HIV prevention.

Mpofu and Parsitau conclude that these moralistic messages, while extremely popular in some contexts, promote an unattainable ideal and do not address current reality. In discussions with NPC leaders, both noted resistance in compromising these moral standards and refusing to discuss failures or weaknesses in this moralistic strategy [74, 109]. Gusman and Winskell concur with Gusman stating that the strongly principled messages not only create a silence on HIV but also contribute to HIV stigma as those who do not follow the messages are viewed as sexually immoral [63, 106]. In another

study, he concludes that these messages create confusion around HIV and negatively affect young people trying to navigate the realities of HIV and sexuality [26]. Parsitau takes a more dispassionate approach, acknowledging that while many Pentecostal churches had a delayed and controversial start to HIV responses, most ultimately initiated HIV support and education programs [74]. However, she notes that it is challenging to establish youth compliance to the moralistic prevention messages since noncompliance is described as, “*sin* ([74], p. 50),” thus discouraging transparency.

Interestingly Garner's research shows that despite these controversial teachings, among the faiths examined in his study, only Pentecostalism undoubtedly affects sexual behaviour and decision-making, which could lessen HIV risk [87]. Gyimah, Miller, and Trinitapoli found the same phenomenon after examining conservative sexual beliefs and the church's role on sexual attitudes, saying that these attitudes seem to correspond with less high-risk sexual behaviour, which could be protective in terms of HIV [52, 184, 187].

Smith concurs that moralistic messages, such as those promoted by NPCs, are impractical to follow and contribute to HIV stigma. However, after researching the prevalence and impact of NPCs in Nigeria he states:

If societies are as diverse as we claim, surely there must be multiple avenues to AIDS prevention. Without a doubt, one message is not appropriate for all. The intertwining of HIV/AIDS and Christianity in Nigeria illustrates the inadequacy of imposing simplistic explanations and the limitations of one-dimensional intervention strategies that ignore the extent to which religion, health, sexuality, and morality intersect in people's everyday lives ([110], p. 434-435).

3.1.1.3 NPC Beliefs – Stigma

Numerous articles discuss the effect that religion, particularly NPCs, have on HIV-related stigma [26, 63, 74, 76, 86, 93, 106, 110, 111, 182, 183, 185, 187, 191, 192]. However, there are mixed opinions as to the role that faith plays in stigmatization.

Multiple authors state that the rigid, moralistic messages that are popular with NPCs contribute to HIV-related stigma [26, 63, 93, 106, 110, 182, 192], with Gusman calling it a, “*disease of morality* ([26], p. 72).” Several say that initially, NPCs contributed to HIV-related stigma, but as the epidemic progressed, affecting many church leaders and members, they began activities to combat HIV-related stigma [74, 86, 185, 191].

Adogame acknowledges that stigma can result from the strict, moralistic messages. However, he also notes that the strong social networks, a common by-product of NPC membership, provide support and companionship for those affected by HIV. Combined with a belief system that emphasizes a spiritual identity as a child of God and a born again experience that signifies a new beginning, he states that these NPC characteristics actually work to decrease stigma and provide hope [86].

Miller has similar observations, noting that while conservative teaching on sexuality could be associated with stigma, social acceptance found in church membership and church-related HIV activities seem to provide more positive affirmation than other beliefs or messages that one would assume were stigmatizing [183]. Miller also states that while ample research attempted to demonstrate an association between religious groups and HIV-related stigma, the discussions were primarily anecdotal with no empirical data that explicitly linked stigma to religious groups. She suggests a re-examination of the assumption that moralistic messages inherently created stigmatization [183]. Trintapoli also supported this ideology, stating that while some churches did appear to contribute to stigmatization, there was no evidence of the systematic stigmatization that is often associated with specific faith groups [187]. Zhou et al. state that the moralistic messages seem to contribute to stigmatization; however, their research shows that members were initially more likely to disclose their HIV status to their pastor [111], bringing into question how strong church-related stigma was perceived.

3.1.2 NPC Engagement in Outbreak Responses

Several researchers note the lack of intentional NPC engagement by governments and international NGOs, alluding to a wilful exclusion of this particular faith group [74, 78, 80, 86, 93, 94, 101, 110, 180-182, 191]. Pfeiffer published two studies, included in this review, related to HIV responses and Pentecostals in Mozambique. One examines a condom social marketing campaign (CSM) in an urban area of Mozambique that had a high percentage of NPCs and adherents [78]. He notes that while these churches had a remarkable following, they were not included in the campaign's development. Due to their exclusion and subsequent lack of recognition of their beliefs, they and their adherents did not support the campaign. This led to the disaffection and alienation of a large portion of the campaign's targeted population [78]. Like Kisenyi [93], he says that

while public health institutions are not obligated to embrace church beliefs, it is counter-productive to ignore their presence and exclude them from the conversation [78]. Pfeiffer encourages pastoral involvement in creating HIV prevention messages, rather than approaching them with an already developed, pre-packaged response and expecting their endorsement and support [78].

Describing the rapid growth of NPCs in Mozambique, Pfeiffer remarks that while interviewing the predominantly Catholic National Health Service employees, they had little to no awareness of NPC's existence or beliefs [78]. He highlights the importance of acknowledging their presence and influence while designing inclusive strategies for their engagement [78, 80]. Pfeiffer encourages international organizations to view NPCs as partners, not as obstacles, suggesting that they find, "*shared strategies ([80], p 167).*" While NGOs should not be pressured to endorse beliefs and responses held by NPCs, or any faith group, he says that it is likewise unrealistic to expect NPCs to accept all NGO responses, noting that both entities should find common ground [80].

Ucheaga agrees with Pfeiffer's suggestion, stating that most NPC leaders who participated in his research were interested in collaborating with the government, with the caveat that this did not require condom promotion. He says that it is not realistic to expect religious leaders to endorse an intervention that is contrary to firmly held religious beliefs [101]. Mantell et al. also address the tension between conservative Christian groups and secular aid agencies, stating that it is unrealistic to expect them to accept one another's viewpoints and encouraging them to find areas of agreement or acceptable compromise [182].

Adogame observes that many Western development groups consider religion a private matter, a separate entity from the realm of development. He ascertains that this mentality leads to a lack of faith engagement and a mindset of considering faith as a possible obstacle to development [191]. While acknowledging that religion, "*...occupies a complex position in the everyday lives of Africans ([191], p. 476),*" he says that given its prominence and influence in Africa, it should not be ignored or excluded.

Prince echoes this observation. While recognizing that the moral messaging of some Christian groups, most notably NPCs, brings tension to their partnership, he states that engagement motivation can be:

...coloured by secular Western observer's deep dislike of fundamentalist forms of Christianity (particularly Charismatic Christianity and the Pentecostal churches popular among many Africans...) and their belief that religion is contradictory to development or modernization ([185] p. x).

Pfeiffer also notes that one barrier to NPC engagement is the, “*negative preconception ([80], p. 166)*” of foreign aid workers towards this faith. He writes, “*However, I argue here that the failure to include or engage these dynamic movements is also, in part, the result of the same deepening inequalities that have helped produce the epidemic ([80], p. 166).*”

Overall there is broad acknowledgment of NPC presence and influence in SSA with many authors suggesting that future research should examine their impact and acknowledge the importance of actively incorporating them into responses [78, 80, 86, 92-94, 101, 110, 180-182, 186, 191]. However, there were few concrete suggestions as to how to accomplish this.

3.1.3 Summary

The vast majority of the literature comments on the rapidly increasing presence and popularity of NPCs across SSA. There is broad discussion on the prevalent Pentecostal beliefs in divine healing and morality as they relate to sexuality and condom use or promotion. Most of the literature recognizes that these beliefs influence how NPCs construct and frame HIV responses, with varying views on whether these responses are helpful or not. There was some discussion on the belief in divine healing vis-à-vis HIV/AIDS, but most was centred around NPCs’ moralistic teachings on abstinence, fidelity, and a generalized disdain for condom promotion.

While ample scholarship views the moralistic messages of NPCs as harmful and impractical, multiple studies on sexual decision making demonstrate that Pentecostal youth delay onset of sexual debut and have fewer sexual partners, while Pentecostal men score higher on faithfulness to their partners. All of these behaviours are considered to reduce the risk of HIV.

Multiple authors discuss HIV-related stigma, with some firmly stating that NPC beliefs on sexuality contribute to stigma. However, while acknowledging that many NPCs initially stigmatized those with HIV, the majority of scholarship states that ultimately many NPCs began to address stigma positively. Furthermore, while there are particular

messages that many assume are stigmatizing, communities and church members do not seem as harmed by these messages as they are encouraged by other messages, beliefs, and actions of NPCs.

Multiple studies state that NPCs were marginalized in HIV response coordination, funding, and research due to ignorance of their presence or a tension between evangelical Christian beliefs and Western organization's inflexibility on the components of a proper HIV response and prevention messaging. Numerous studies encourage responding organizations to find a compromise that includes NPCs in specific components of their responses. These authors acknowledge that trying to force religious groups to promote beliefs and behaviours contrary to their faith is unrealistic and ultimately alienates large portions of targeted populations, concluding that without widespread buy-in of a message (i.e., in a highly populated NPC area), messages should be reconsidered. Green sums this up by pointing out that there are plenty of HIV programs that promote and offer condoms. Therefore, it is appropriate to allow for teaching on abstinence and fidelity, by religious groups, as there is room, and demand, for both messages.

3.2 Literature Review Update

While the original literature review provided numerous studies that examined the faith/health dynamic in Africa, and specifically NPC faith, these studies primarily examined this dynamic within the context of HIV/AIDS. There was only one study on Pentecostal beliefs and Ebola. This is likely due to the time that the initial review occurred, shortly before the end of the West Africa Ebola outbreak. Therefore, another literature review was conducted approximately one year later to search for currently published research on the Ebola outbreak.

To locate papers specifically on Pentecostal responses during the West Africa Ebola outbreak, the original search terms employed were Ebola and (faith or religi* or Pentecostal*). These terms were used in the Cochrane, CINAHL, Global Health, Medline, PubMed, and Scopus databases resulting in 175 pieces of scholarship. After deleting duplicates and papers according to titles and abstracts, 18 remained. This literature search's inclusion criteria were broader than the initial search due to the lack of studies that specifically addressed faith and Ebola, particularly Pentecostal faith and Ebola. The majority of articles were not specifically on faith and Ebola; however, papers that

discussed the importance of faith or religious engagement during the Ebola outbreak were included.

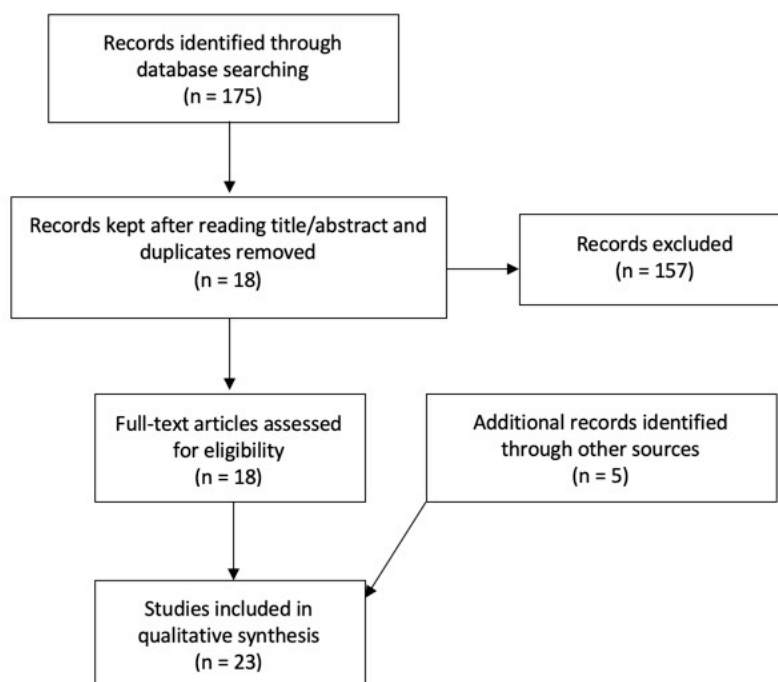
Table 3.2 outlines the inclusion and exclusion criteria for studies in this follow-up literature review.

Table 3.2 Inclusion and Exclusion Criteria for Follow-up Literature Review

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • The study discusses the importance of engaging local faith leaders • The study discusses local, grassroots faith reactions • The study took place in Africa • The study discusses Christian beliefs that affected Ebola perceptions 	<ul style="list-style-type: none"> • Research conducted outside of Africa • Faith is discussed as a coping mechanism for Ebola responders • Faith pertained to Islam or traditional religion • Research pertained to organized FBOs rather than local churches

Another five articles were added through a manual review of bibliographies, bringing the total academic or grey literature to 23. Figure 3.2 outlines the process of articles accepted for this review. Table 2 in Appendix A lists a review of the 23 studies included in this review.

Figure 3.2 Literature review update on Pentecostal responses during the West Africa Ebola outbreak



3.2.1 Results

Of the 23 studies included in this review, only ten were specifically on faith responses [3, 77, 99, 108, 119, 120, 126, 150, 169, 179]. Nine of the ten discussed faith in a general manner, oscillating between the broad categories of Christianity, Islam, and traditional religion. Of these ten, only one was explicitly on Pentecostal responses [77]. Prominent themes from these studies will be highlighted and discussed.

3.2.1.1 Importance of Faith Engagement

All 23 of the published articles and grey literature emphasized the importance of including faith leaders in outbreak responses, citing the high degree of public trust and respect that these leaders are accorded [3, 17, 18, 62, 77, 99, 100, 108, 118-120, 126, 150, 163, 165, 166, 169, 179, 194-198]. Seventeen note that faith leaders were not included in early outbreak responses during the West Africa outbreak and recommend that this be considered in future outbreaks [3, 17, 62, 77, 99, 108, 119, 126, 163, 166, 169, 179, 194-198]. Seven studies attribute an important portion of the ultimate success of community engagement strategies to faith engagement [3, 108, 120, 150, 165, 169, 179] with Featherstone stating that the, "...action from faith leaders has subsequently played an important role in turning the tide on the Ebola outbreak ([108], p. 23)."

3.2.1.2 Faith Responses

Fifteen papers describe faith responses and their impact as both a catalyst and an obstacle to community acceptance of Ebola containment measures [17, 18, 77, 99, 100, 108, 119, 120, 126, 150, 163, 165, 179, 195, 196]. Several state that grassroots faith groups were first responders, but having little information or training, their responses were mixed and often limited to burying the dead while consoling the living [108, 119, 126, 150, 179]. It was noted that many risked their lives to respond and encourage their communities [195]. Featherstone states that, "*While the assistance they provided was often modest, it was frequently among the earliest and provided much-needed support to those affected by the disease...([108], p. 19).*"

Several studies note that some initial faith reactions conflicted with Ebola containment measures. The most frequently mentioned response was framing Ebola as a spiritual problem that required a primarily spiritual solution [17, 18, 77, 99, 108, 119, 165, 196]. Multiple studies discuss the belief that Ebola was a punishment from God for sin, usually described as relating to homosexuality or government corruption [18, 77, 196]. Others attributed Ebola to the devil, a curse, or witchcraft [18, 77, 100]. Framing Ebola as a spiritual issue provoked spiritual responses, particularly praying for those infected, which was often accompanied by the laying on of hands [17, 77, 99, 100, 108, 119, 126, 163], a high-risk activity during an infectious disease outbreak.

Falade and Coultas describe a church in Monrovia whose pastors insisted on praying for the sick by the laying on of hands. This activity was connected to multiple infections and at least four deaths [62]. Shultz et al. also note that this form of praying was, "*strongly implicated ([163], p. 7)*" in Ebola infection.

All studies that discuss faith reactions agree that the vast majority of faith groups ultimately contributed positively to the outbreak response. They identify faith responses as providing Ebola education and insisting on social distancing during services, advocating against stigma through the support of Ebola survivors and orphans, [150], and actively helping communities to mobilize against Ebola while providing support for those who were affected [196]. Faith leaders were also instrumental in creating the burial with dignity policy, and facilitating its acceptance in communities [120, 165].

3.2.1.3 *Stigma*

Numerous studies discuss the impact of faith on Ebola-related stigma [3, 77, 108, 118-120, 126, 150, 169, 195, 198]. Bangura notes that NPC beliefs that Ebola was linked to voodoo or a curse implied that those who were infected had been involved in witchcraft, thus promoting stigma [77]. However, most studies state that religion played positive and negative roles, both driving and confronting stigma [3, 108, 120]. Some elect to discuss the positive contributions of religion without mentioning the negative impacts [119, 126, 195]. Several link religions' experiences with HIV to their Ebola responses, noting that faith communities had learned from their HIV experiences and were better able to confront stigma [108, 150, 169, 198].

It should be noted that in a majority of these papers, 'faith' was referred to generically, usually only differentiating between Christian and Muslim faiths. While different mainline faith groups were sporadically mentioned when giving specific examples (i.e., the Methodist or the Catholics), faith was generally not broken down into the subsets of various faiths and their responses.

3.2.1.4 *Pentecostals*

Only five of the 23 articles mention Pentecostals by name [77, 118, 119, 126, 198], and only one of the five is specifically about Pentecostal responses [77]. This is a paper by Bangura, who looked at Pentecostal/charismatic reactions during the Ebola outbreak in Sierra Leone. He notes that in a country with a poor health infrastructure, such as Sierra Leone, it was a natural reaction for people to seek out faith healing churches, which gave these faith leaders influence on public opinions about the outbreak responses. The initial response of most NPCs, according to Bangura, was one of distrust towards the government and health services, coupled with judgment towards those who were infected, leading to fear, misinformation, and stigmatization [77]. Bangura relates these responses to the NPC belief in a spiritual cause and effect for illness and an initial lack of concentrated effort to engage religious leaders [77].

Two of the five articles that specifically mention Pentecostals are not about faith but have a section on the importance of faith and its inclusion in outbreak response. Both note that while Pentecostalism is the fastest-growing Christian faith in Liberia, they were not as visibly involved in the Ebola response or as aggressively engaged by Ebola responders as mainline denominations [118, 198]. Two other documents also note that

Pentecostals were not profoundly involved, distinguishing them from other faith groups and stating that they were more resistant and suspicious of containment measures. They also observed that NPCs were challenging to locate due to not having the hierarchical authority of mainline denominations, with a centralized church headquarters and communication system [119, 126]. This characteristic (of decentralization and lack of universal authority) made them challenging to locate and time-consuming for Ebola responders to engage in outbreak responses [119, 126].

3.2.1.5 Recommendations

Several studies present recommendations regarding broad faith inclusion in the Ebola outbreak response. These recommendations are to: include faith leaders in funding opportunities; seek their input at higher levels of discussion; and involve them in message creation and communication [18, 169, 179]. Others discuss the importance of acknowledging core beliefs by creating solutions that respect beliefs while supporting prevention methods [3, 99, 120, 169]. Oosterhoff and Wilkinson note that the culture of the response needs to accommodate the culture of the community [197], while Manguvo and Mafuvadze write:

...the use of scientific methods alone without a holistic consideration of other contextual factors is not sufficient to control the disease...The way people conceptualize the etiology of a disease generally dictates their responses to it. Given that in some affected communities in West Africa, Ebola was linked to the metaphysical realm, it is not surprising that diviners and spiritual healers were often consulted for treatment. Given the potential influence of etiological beliefs on people's response to prevention and treatment, an understanding of beliefs of the people in affected communities on causes of Ebola is pivotal in mitigating the negative impact of such beliefs on the transmission of the disease. ([99], p. 1,2).

There is a broad consensus on the importance of faith leader engagement; however, there were no specific strategies offered on how to facilitate this engagement or on ensuring broad faith representation. A study written by the American Anthropological Association and the article by Thompson and Bolton [118, 198] note the lack of Pentecostal inclusion in the Ebola response, despite their prevalence in Liberia. However, they do not specifically discuss how to facilitate this inclusion.

Two articles mention the need to carefully consider the definition of 'community.' [166, 197]. Both postulate that it would be easy to overlook smaller sub-communities, placed within larger communities, when the definition of community is too broad, as could be the case with Christianity and NPCs.

3.2.2 Summary of Second Literature Review

While 23 papers qualified for this review on faith responses to Ebola, most of the studies are not specifically about faith but rather address other aspects of the Ebola outbreak response, including a short section on faith. While all 23 papers recognize the necessity of the involvement of faith leaders in public health responses, there was not considerable scholarship specifically on this subject, particularly as it relates to the engagement of grassroots faith groups. Of the 23 studies included in this review, only nine are explicitly about faith involvement. Thirteen papers were from the grey literature, including five authored by FBOs and seven by non-faith entities. This leaves ten documents that were published in academic journals, including two that were published in religiously themed journals. All papers except for the one by Bangura treat faith broadly, only distinguishing between Christianity, Islam, and traditional African religion, but not acknowledging or discussing the faith subsets that existed within these three broader categories. Only one article had a specific focus on NPCs.

The overarching theme of this literature review was the importance of faith involvement in outbreak response. However, there were few suggestions on engagement strategies or on how to ensure broad faith inclusion. There was an overall consensus that a majority of faith responses contributed to Ebola's decline, with only a few that discuss faith reactions as an obstacle to a healthy response. These discussions centre on beliefs regarding the aetiology of the Ebola outbreak (punishment for sin) and the belief in divine healing through the laying on of hands.

3.3 Chapter Summary

Both literature reviews describe faith beliefs that conflict with HIV and Ebola epidemic responses. In the case of HIV/AIDS, responses focusing on harm reduction through the promotion of condoms were the most frequently discussed as these responses provoked strong reactions from Pentecostal communities, resulting in their refusal to promote that strategy of HIV prevention. While morality was not a strong driver of reactions to Ebola, there was an equally forceful backlash to Liberia's mandatory

cremation policy, with many faith groups performing secret burials to avoid the cremation of their loved ones.

The belief in a spiritual causality for illness was discussed in both reviews. Literature from both contexts cited faith groups as claiming that each disease (HIV and Ebola) was a punishment from God for sin, usually described as homosexuality or government corruption. In both instances, multiple authors felt that this contributed to the stigmatization of those impacted by these diseases. However, as time progressed with HIV/AIDS research, more studies stated that while it seemed to be a logical conclusion that this belief would increase HIV stigma, support of this was primarily anecdotal.

The belief in divine healing expressed through the laying on of hands was discussed as it pertained to both HIV and Ebola. Several studies in the initial review discuss the impact of this belief on ART adherence, with mixed conclusions. When discussing specific faith practices related to Ebola containment, several authors mention this belief, linking it to clusters of infection and death. The literature on the Ebola outbreak also identified that beliefs in disease causality and divine healing contributed to beliefs that Ebola was not real or was spiritual in nature and therefore demanded a spiritual response. While these beliefs and practices are often associated with Pentecostalism, the lack of faith precision in the second reviews' studies impede the ability to draw a reliable comparison between the two literature reviews.

In the case of HIV and Ebola, there is a perception of delayed faith engagement in the crisis. The literature on HIV/AIDS frequently discusses faith group's resistance to engagement. However, as time passed, many studies note the increasing responses of Pentecostal faith groups to the HIV/AIDS crisis. In the writings on Ebola, the blame for delayed engagement is often cast on responding organizations that did not launch community engagement strategies early on. While there is some acknowledgment of faith groups displaying more resistance than other sectors of society, most studies express very positive contributions on the part of faith, once engagement occurred.

There is plenty of literature on the African faith response to HIV/AIDS, and literature directly related to NPCs is readily available. For the most part, these studies do not apply the concepts of 'religion' or 'faith' generically. When discussing Christian responses, the bulk of the scholarship included in the initial review does not categorize all Christian groups under the same umbrella. Pentecostal beliefs and responses are specifically

discussed as researchers recognize the distinct differences in sub-groups of the same broad faith category, such as the case of NPCs to Protestant Christianity.

A wealth of articles comments on the impressive growth of NPCs in SSA and its influence on communities. NPC beliefs in illness causality, divine healing, and their strict moral code are often linked to what the public health world frequently perceives as ineffective, reckless HIV prevention responses that promoted stigma. There are multiple calls to acknowledge the increasing Pentecostal presence, deepen understanding of their beliefs, and ensure that NPCs are engaged in public health responses. While numerous authors appear to struggle with the deeply rooted beliefs of NPCs as they relate to HIV prevention, many recommend identifying areas where compromise could be allowed in order to facilitate partnerships within this belief system.

Articles specifically on Pentecostals and responses to Ebola are, however, difficult to find. When discussing religion vis-à-vis Ebola, it is rarely broken down into specific denominations or sub-groups. While there are distinct similarities between faith responses regarding HIV/AIDS and Ebola, it is difficult to draw a comparison due to the generality with which faith is discussed in the Ebola literature.

The bulk of the literature on Pentecostalism and HIV/AIDS included in this research was published several years before the West Africa Ebola outbreak. But, in the subsequent articles on Ebola, there is little mention of targeting Pentecostalism in Ebola awareness campaigns and is not explicitly discussed in the literature on successes and failures of community engagement during the outbreak.

Chapter 4: Methodology

In studying the faith/health interaction, this research aims to examine past events in an attempt to understand possible interactions between NP beliefs, perceptions of the Ebola outbreak in Liberia, and the uptake of Ebola outbreak containment measures. It intends to explore whether NPC leaders' and members' individual and collective responses to the recommended Ebola containment measures, were or were not influenced by NP beliefs. It is hoped that by examining these responses, a clearer picture will emerge as to the beliefs of this rapidly emerging faith group and the possible role that these beliefs had in engagement with biomedical responses during the Ebola outbreak in Monrovia, Liberia. In examining the potential role that faith beliefs had in Ebola responses, barriers and facilitators to NPC engagement will also be identified, affecting future community engagement strategies in areas of high NPC prevalence.

The methodology for this study was designed to address the following research objectives:

1. To learn how NPC leaders and constituents in Monrovia, Liberia perceived community engagement measures and Ebola containment protocols.
 - a. What was the response of NPCs to the Ebola outbreak in Monrovia, Liberia?
 - b. Did NPC beliefs in divine healing and spiritual causality affect NPC leaders' and constituents' responses to empirically derived Ebola containment measures?
 - c. Did NPC members mirror pastoral opinions of Ebola containment measures, or did their views and reactions differ from those of their pastor?
2. To capture community opinions on the actions of these Monrovia-based, NPCs and their leaders during the Ebola outbreak.
 - a. How did community members perceive the actions of NPCs?
 - b. Do the community members' accounts of NPC actions yield a different perspective on NPC Ebola responses?
3. To gather information from Ministry of Health (MOH) officials, intergovernmental (IG) and nongovernmental organizations (NGOs), and healthcare providers with an operational role during the Ebola outbreak in

Liberia on their community engagement strategies and how they perceived the role and responses of NPCs.

- a. Do these perspectives align with community perspectives on the perceived reactions of NPCs during the outbreak?
 - b. Do these perspectives align with NPC statements regarding their responses?
 - c. How did these organizations approach NPCs for Ebola response engagement?
4. To compare NPC Ebola responses in Monrovia, Liberia, with another Monrovia-based, Christian denomination response, examine similarities or differences in responses to determine if NPC responses were unique or similar to other Christian faith responses.
- a. Did other Christian churches have similar responses to the Ebola outbreak and the Ebola containment measures?
 - b. Did church authority structures play a role in facilitating or discouraging local church uptake of Ebola containment measures?
5. To analyse the insights gathered from the literature, documents and interviews to identify which actions, on the part of NPCs in Monrovia, Liberia, helped facilitate and which actions inhibited an effective Ebola outbreak response.
- a. When combining all data from the various perspectives, what themes emerge as to how NPCs responded?
 - b. What actions facilitated NPC response, and what actions discouraged a healthy response?
 - c. Did NPC beliefs impact NPC responses on a local church level and among local church adherents?

Table 4.1 describes the methods used to address each research objective and questions.

Table 4.1 Methods and Corresponding Research Objectives

Research Objective/Questions	Methods
<p>1. To learn how NPC leaders and constituents in Monrovia, Liberia perceived community engagement measures and Ebola containment protocols.</p> <ul style="list-style-type: none"> • <i>What was the response of NPCs to the Ebola outbreak in Monrovia, Liberia?</i> • <i>Did NPC beliefs in divine healing and spiritual causality affect NPC leaders' and constituents' responses to empirically driven Ebola containment measures?</i> • <i>Did NPC members mirror pastoral opinions of Ebola containment measures, or did their views and reactions differ from those of their pastor?</i> 	<p>In-depth, semi-structured interviews, or focus group discussions (FGDs) of NPC leaders and members</p>
<p>2. To capture community opinions on the actions of these Monrovia-based, NPCs and their leaders during the Ebola outbreak.</p> <ul style="list-style-type: none"> • <i>How did community members perceive the actions of NPCs?</i> • <i>Do the community members' accounts of NPC actions yield a different perspective on NPC Ebola responses?</i> 	<p>In-depth, semi-structured interviews or FGDs with community members</p>
<p>3. To gather information from MOH, IG, NGOs, and healthcare providers with an operational role during the Ebola outbreak in Liberia, on their community engagement strategies and how they perceived the role and responses of NPCs.</p> <ul style="list-style-type: none"> • <i>Do these perspectives align with community perspectives on the perceived reactions of NPCs during the outbreak?</i> • <i>Do these perspectives align with NPC statements regarding their responses?</i> • <i>How did these organizations approach NPCs for Ebola engagement?</i> 	<p>In-depth semi-structured interviews with organization officials and staff</p>
<p>4. To compare NPC Ebola responses in Monrovia, Liberia, with another Monrovia-based Christian</p>	<p>In-depth, semi-structured interviews with comparison</p>

<p>denomination response, examine similarities or differences in responses to determine if NPC responses were unique or similar to other Christian faith responses.</p> <ul style="list-style-type: none"> • <i>Did other Christian churches have similar responses to the Ebola outbreak and the Ebola containment measures?</i> • <i>Did church authority structures play a role in facilitating or discouraging local church uptake of Ebola containment measures?</i> 	<p>group church leaders, members, and community members.</p> <p>A review of data gathered from Ebola responders that discussed engagement of various faith groups.</p>
<p>5. To analyse the insights gathered from the literature, documents, and interviews to identify which actions, on the part of NPCs in Monrovia, Liberia, helped facilitate and which actions inhibited an effective Ebola outbreak response.</p> <ul style="list-style-type: none"> • <i>When combining all data from the various perspectives, what themes emerge as to how NPCs responded?</i> • <i>What actions facilitated NPC response, and what actions discouraged a healthy response?</i> • <i>Did NPC beliefs impact NPC responses, on a local church level and among local church adherents?</i> 	<p>A review of the literature, including grey literature.</p> <p>Inductive and focused coding of in-depth interviews and FGDs using NVivo software</p> <p>Data triangulation using NVivo software</p>

This methodology chapter presents the methods that were employed to address research objectives and questions 1-4. Research Objective 5 will provide the framework for the discussion chapter.

The chapter begins by discussing the rationale for the methods chosen. The research protocol is described in detail discussing ethical considerations and approval, the theoretical approach, the rationale for the research site selection, sampling frame, participant selection, interview process, data collection methods, and data management and analysis. It concludes with a discussion on reflexivity, the PI's personal beliefs, and discusses methodological limitations.

4.1 Qualitative Research

The literature review demonstrated a gap in research on the possible effects of faith on health decisions, specifically NPC faith, to biomedical health recommendations, within the African context. This study aims to address this subject within the context of the

Ebola outbreak in Liberia, to gather specific information on NPC responses to the outbreak containment measures and the drivers to these responses. Qualitative research methods were used to address this topic. These methods were employed to identify the values and beliefs of NPCs and their constituents, how these affected perspectives and responses to the Ebola outbreak, and how the broader community perceived the beliefs and actions of this particular faith group during the Ebola outbreak.

Qualitative methods are considered appropriate for examining the feelings and reasons behind various responses to health initiatives and examining personal reflections on experiences, which could affect how these experiences are perceived [199]. Paget notes that qualitative methods are appropriate if the researcher aims to examine topics that have not been extensively researched and to understand a given demographics' experiences and perspectives on those topics [200]. These research methods allow for the study and description of phenomena as experienced by the study population. In qualitative research, the population describes their experiences and explains their perspectives in their own words. This allows the researcher to, "*...unpack issues, to see what they are about or what lies inside, and to explore how they are understood by those connected with them ([201], p. 27),*" which correlates with the objectives of this study. The PI determined that qualitative methods would provide detailed and rich descriptive insights into NPC reactions and responses during the Ebola outbreak. These methods also allowed for a multi-faceted examination of the perspective from a variety of demographics that interacted with NPCs and observed their responses.

4.2 Ethical Review

This research received ethical approval by the London School of Hygiene & Tropical Medicine (LSHTM) ethics committee. Initial approval was granted on 25 October 2016. The National Research Ethics Board (NREB) of Liberia granted a one-year ethics approval on 08 November 2016. After the initial field study, changes were made to the research design. LSTHM ethics committee approved the new study design on 23 January 2018, and the NREB granted approval on 28 February 2018. All ethics approval documentation can be found in Appendix B.

4.3 Theoretical Approaches

This section discusses the theoretical underpinnings that guided this study. It begins by explaining what theories were considered and why they ultimately were not used. It will

then discuss the Theory of Charismatic Leadership and the Grounded Theory, which were chosen for this study methodology, explain why they were chosen, and how they were used to guide the research methodology.

Many theories address health behaviour and health promotion. A study by Glanz and Bishop looks at research from several decades to identify the most commonly used theories for health behaviour, promotion, and education. They identify four theories that were used consistently over several decades [202]. According to this study, the four theoretical approaches that were the most used and published were the Health Belief Model (HBM), the Transtheoretical Model (TTM), the Social Cognitive Theory (SCT), and the Social Ecological Theory (SET) [202].

All these theories have been broadly applied to public health programs in SSA. The TTM presupposes that health behaviour change occurs as the individual passes through six stages of change [203]. With an initial focus on cessation of addictions, it was found to have positive outcomes when interventions were designed for stage-specific individuals or groups [203]. This model has its limitations, particularly for a public health context, as it ignores the social context of the individual and assumes that people are rational and cogent during the decision-making process, an assumption that is not always correct [204].

In the 1950s, social scientists created the HBM, while trying to understand why people refused to follow disease prevention strategies [205]. This model is widely used in the public health field and is based on the theory that risk perception and perceived personal benefit from taking preventative action influence responses to disease prevention messages [202].

The SET approach looks at decision-making beyond the individual to the interpersonal and societal dynamics that contribute to behaviours and, ultimately, to the decisions made [206]. This theory recognizes that individuals do not live in a vacuum, but are a part of larger systems that interact with and influence how that individual makes health decisions [207]. Like SET, SCT focuses on the internal and external factors that influence behavioural decisions [208].

While all these theories have credibility in health behaviour change and health promotion [202, 206], this research aimed to look at the data without assumptions and

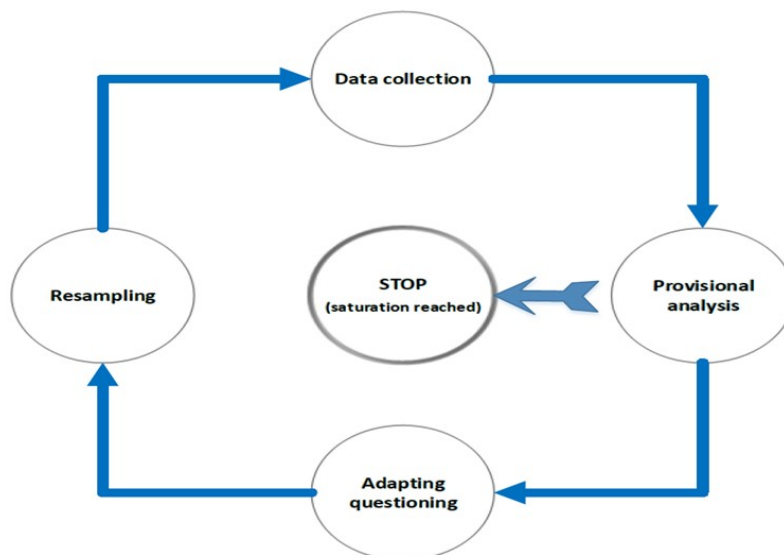
see if new, undiscovered themes and dynamics emerged concerning the faith/health dynamic, within the context of NPC faith and Ebola containment measures in Liberia.

Harding and Whitehead state that it is impossible to enter a research area with no theoretical lens whatsoever; however, they argue that the intent should be to avoid purposefully using one [209]. Avis states that when researching new phenomena, the intentional use of a specific theory could block new insights that emerge from the data [210]. Therefore, Grounded Theory, with its emphasis on discovering theory rather than adding supportive data to existing theory, was deemed appropriate.

4.3.1 Grounded Theory

The Grounded Theory has been widely used and accepted in social research, including in SSA [211]. This theory involves purposeful sampling, analysing the data, and allowing the data to guide the next round of sampling [212]. This process accommodated the sometimes lack of formal documentation on the specific engagement of faith groups, vis-à-vis Ebola, and was used for data analysis as it allows for theory to be developed through the emerging themes found in the data. This process is illustrated in Figure 4.1 [213].

Figure 4.1 The Grounded Theory Method



4.3.2 Theory of Charismatic Leadership

The Theory of Charismatic Leadership guided the selection of interview participants. This theory explains the relationship and characteristics between a charismatic leader and his/her followers [214]. Discussion on charismatic leadership centers around the

characteristics and communications of these leaders such as; articulating a vision that, if followed, implies a better future for the followers, strong value and moral stances with justification, collective identity, high expectations on what followers should do, and a high degree of confidence that the followers are capable of fulfilling these expectations [215]. It describes these leaders as having high self-confidence, a need for power and influence, and a firm conviction that their moral beliefs are correct and justified [216]. According to this theory, followers of a charismatic leader frequently exhibit a high degree of confidence in the leader, along with obedience and unquestioning acceptance of the leader's ideology [217].

Towards the end of the 20th century, a few studies looked at charismatic leadership vis-à-vis religious leaders [218, 219]. However, the majority of the literature on this theory, particularly within the last 20 years, is within the context of organizational leadership, particularly in conjunction with the popular Transformational Leadership Theory as it relates to the concept of charisma [220-222]. The Theory of Charismatic Leadership has primarily been utilized within the context of organizational leadership outside of religion [220]. However, it was chosen as these character traits are described in the literature on NPCs in SSA.

Gifford discusses common themes found in West Africa NPC communications stating that prosperity and success come through the, "*man of God*," thus making the pastor, "*indispensable*" to followers ([71], p. 251). Gillespie, in discussing the West Africa Ebola outbreak, states that Ebola responders noted that there was so much trust in religious leaders that their constituents believed everything that they said [62]. Gusman observes that everything that NPC church leaders say is often considered to be absolute truth by their followers [26], and Prince et al. note that Pentecostal churches, in particular, are driven by the charisma of their leader [185]. Multiple articles discuss the NPC leader's influence in health decision making and perceptions of issues specifically surrounding sexuality and HIV/AIDS [26, 52, 63, 71, 77, 78, 87, 88, 92, 93, 101, 109, 110, 187, 223] as well as several studies on the impact that Christian religious beliefs, and primarily NPC beliefs, had on Ebola containment measures [3, 17, 77, 99, 100, 108, 150, 163].

This theory was used to guide data selection as it addresses not only the leader attributes but also those of the followers. This study aimed to gather perspectives from individuals whose voices were largely absent in the literature regarding NPCs and illness

response (i.e., NPC members and community members). Recognizing that immediate followers of these leaders would likely have a particular perspective as to how they not only viewed the leader but the decisions of the leader as well (i.e., how the leader chose to respond to the Ebola outbreak), this theory guided the development of interview questionnaires. Words were carefully considered when asking about a church's Ebola response to avoid the impression that the interviewer was attempting to fault with the church's response, and therefore, its leader. It was also acknowledged that the further social and emotional distance that an individual had from the leader could lend a different perspective as individuals observing from a distance would likely not possess the follower traits of high confidence in the leader, unquestioning obedience, and acceptance of all decisions. Figure 4.2 demonstrates the social and emotional distance from NPC leaders that other demographics (i.e., non-NPC members) could have. The further an individual is from the NPC leader, as a non-NPC member, the more likely that individual will possibly have a different, unbiased perspective of the leader and the churches' activities.

Figure 4.2 Social and Emotional Distance from NPC Leaders



Therefore, within the methodology of this study, the Theory of Charismatic Leadership was employed to identify the layers of demographics that would lend a broad range of perspectives concerning the attitudes and reactions of NPC leaders and subsequently of NPCs.

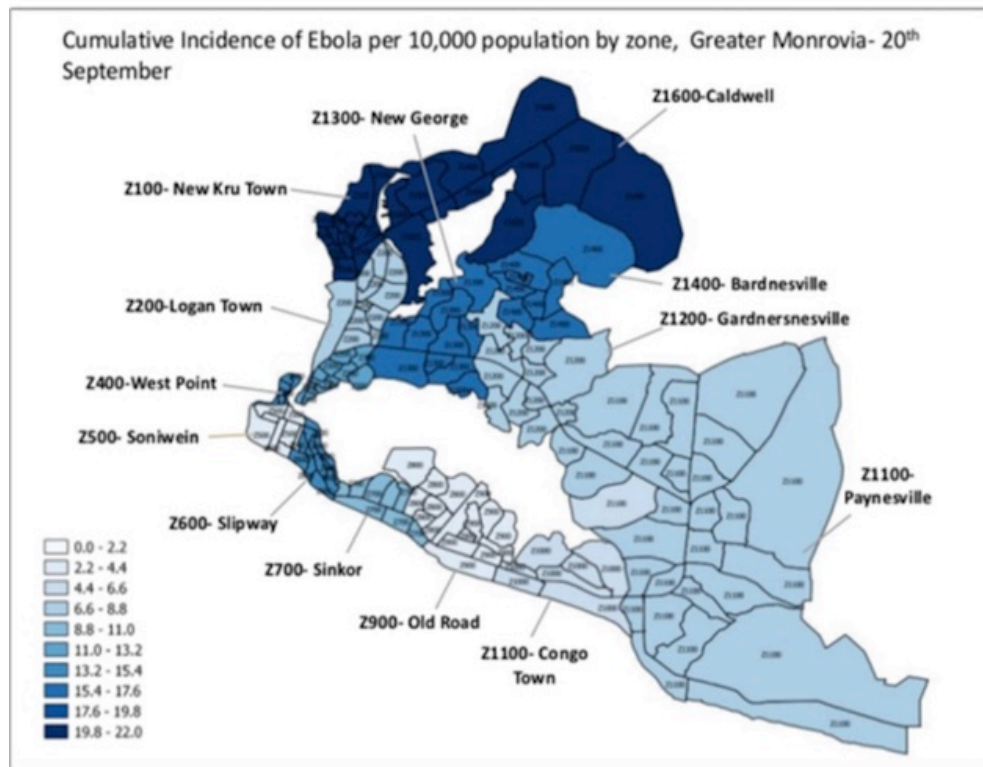
4.4 Site Selection

The purpose of this study is to examine the possible effects of faith on health decisions. This study was conducted within the context of NPC responses to the Ebola containment protocols during the West Africa EVD outbreak. Of the three countries the most affected by the Ebola outbreak, Guinea, Liberia, and Sierra Leone, Liberia had the most Ebola deaths (almost 5,000) [224] and the largest percentage of Christians (85.6%) [225]. Within this Christian population is a considerable number of NPCs [24]. The capital of Liberia, Monrovia, is the largest city in the country and is predominantly Christian. Pentecostalism has been proliferating in Liberia since the 1980s and a large percentage of Christians in Monrovia are Pentecostal [226]. Therefore, Monrovia was chosen as the study site for this research.

The primary data gathering site in Monrovia was a district called New Kru Town. New Kru Town saw the first case of EVD in Monrovia [165] and had a high incidence of EVD home deaths [165]. The neighbouring district of Caldwell was also included. New Kru Town blends into Caldwell, and upon observation, the two districts had similar demographics, living conditions, healthcare options, and faith representation. The MOH verbally confirmed that these two districts were comparable in context and demographics, as well as having similar EVD rates, as noted in Figure 4.3.

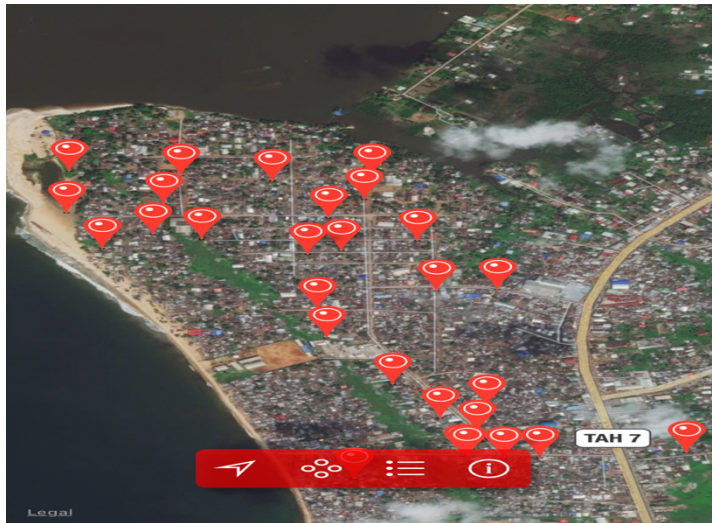
Figure 4.3 shows the incidence of Ebola cases per 10,000 population by zone in Monrovia in September 2014, demonstrating a similarity of EVD occurrence in New Kru Town and Caldwell [227].

Figure 4.3 Incidence of Ebola cases per 10,000 population in Monrovia



As this research was explicitly examining NPC reactions to the Ebola containment measures, it was also crucial for the study site to have a high NPC concentration for the data gathering. The LCC verbally stated that, while there had not been a religious census in over ten years, the number of NPCs in Monrovia had grown considerably within the last decade, including a high concentration in New Kru Town and Caldwell. The PI conducted a preliminary, informal mapping of New Kru Town and identified numerous NPCs, supporting the LCC’s statement as to the prevalence of these churches in a relatively concentrated area. Figure 4.4 shows the red pins where the PI identified NPCs in New Kru Town.

Figure 4.4 NPCs identified in New Kru Town



4.5 Initial Data Gathering

4.5.1 Sampling Frame

Purposive sampling was used to target the populations that would provide the depth and breadth of information needed to meet the objectives of this research. The study sought to encompass a wide range of participants for interviews and FDGs with hopes of yielding a more accurate picture, from different angles, of NPC responses to the Ebola outbreak. Initially, six populations were selected as targets for the sampling frame: NPC leaders, NPC members, community members who lived in the vicinity of an NPC, MOH officials, IG responders, and NGO staff who participated in the outbreak response. The NPC affiliated populations were chosen as they operated within the NPC culture or observed the NPC culture closely from within the community. It was anticipated that they could offer insights into practices, beliefs, and responses to sickness and death, including NPC responses during the Ebola outbreak.

Governmental, IG, and national/international aid workers who were present and active during the epidemic had the perspective of the dynamics involved when engaging NPCs. This information helped identify NPCs that engaged more readily than others, possibly exposing common factors among engaged or resistant churches.

4.5.2 Sample Size

The initial targeted sample size, with corresponding objectives, is outlined in Table 4.2. This targeted sample size would yield a total of 64 – 117 voices, with the possibility of 22 individual interviews and 42 – 95 FGD participants.

Table 4.2 Initial Target Sample Sizes with Corresponding Objectives

Sampling Frame	Interview Method	Planned Sample Size	Objectives Addressed
MOH Officials	Individual	5	Objective 3 Questions a, b, c, d
IG/NGO Staff	Individual	10 (representing multiple organizations)	Objective 3 Questions a, b, c, d
NPC Pastors	Individual	7	Objective 1 Question a and b
NPC Members	Individual or FGD	1-5 per NPC, totalling 7-35 (depending on interview method)	Objective 1 Question b and c
Community Members	Individual or FGD	Minimum of 21 (3 per church), depending on the interview method	Objective 2 Questions a and b

In qualitative research, sample size is often determined within the concept of thematic/data saturation. The principle of saturation originated with the development of the grounded theory [228]. Data saturation is attained when data gathering no longer reveals new information about the phenomenon or theoretical insights [229] and has been considered the ‘gold standard’ in qualitative research [230, 231]. However, the use of saturation for determining sample size in qualitative research has its weaknesses, primarily in terms of definition. Bowen discusses the vagueness in the definition of saturation and states that if saturation is used to defend sample size, it must be clearly detailed and defined [232]. Caelli et al. echo this sentiment, stating that not only does the aspect of saturation need definition, but it also needs a specific definition of its meaning within the context of the study [233]. Francis et al. propose using two guidelines for determining saturation: (a) that the researchers would initially specify a sample size to use for the first round of interviews and (b) establishing a stopping criterion [234].

Several sources identify different types of saturation. Vasileiou et al. discuss data adequacy, referring to the amount of data or evidence acquired [235]. Hennink, Kaiser,

and Marconi consider two types of saturation; code saturation, meaning that no additional issues or themes are identified, and meaning saturation, where no further nuances or insights emerge from the data [236].

In terms of guidelines or precedents for when saturation is attained, Guest et al., in a study of 60 participants, found that thematic saturation was realized after the twelfth interview. Hennink et al. determined that in qualitative in-depth interviews, code saturation was achieved at nine interviews and meaning saturation at 16-24 interviews [236]. These studies are used as general guidelines to demonstrate when others have determined saturation. However, in his PhD dissertation, Tucker remarked that, *"Saturation can also be influenced by a number of factors...Even when saturation is reached, qualitative research may produce new findings and generate new insights at any point in the research process and "reopen" the question of saturation ([237], p. 71)."*

In grounded theory, sample size cannot, or should not, be specifically determined beforehand as it is related to what is being revealed in the data, which in turn determines the need for subsequent data gathering. As this study's purpose was to examine new phenomena, the PI sought to conduct a broad range of interviews, beyond saturation, to understand how characteristic and widespread the emerging themes were and to allow for more observations from the data sources.

4.5.3 Interview Process

4.5.3.1 Participant Selection

Interview participants from the MOH and NGO community were chosen via snowball sampling. The NREB provided a list of recommended contacts at the MOH. These contacts were approached and asked to provide a list of organizations that actively participated in the Ebola response. When interviewed, each organisation was asked to provide a list of their strategic partners and other organizations that they had worked alongside during the outbreak.

NPC leaders were chosen via snowball and convenience sampling. The General Secretary of the Pentecostal Union Fellowship suggested several NPC leaders for interviews. Each leader was then asked to provide names of other NPCs in the New Kru Town and Caldwell districts. If an NPC was identified while conducting fieldwork in these districts, the church was approached and ask for permission to interview.

NPC members and NPC community members were chosen via snowball and convenience sampling as well. While interviewing an NPC leader, he was asked for permission to interview church members and for recommendations of who to interview. Convenience sampling was used if there were individuals in or around the church. These individuals were approached, asked if they were members of the church, and asked to participate in the interviews.

Community members were chosen via convenience sampling by approaching individuals and businesses within the vicinity of NPCs. Non-NPC members were preferred for this sampling group, to gain a broader perspective that provided some distance from an allegiance to the church. However, all consenting adults were accepted, and if there was an NPC affiliation, this was noted.

4.5.3.2 Informed Consent

A participant information sheet was given to all study participants before conducting the interview. This sheet explained the study objectives and detailed the methods for ensuring participant confidentiality. This information was given in printed form and verbally explained, allowing study participants to ask questions and seek clarification. Signed consent was obtained before every interview. The consent form and participant information sheet can be located in Appendix C of this document.

During the discussion of the interview results, in the results chapter, all names are changed to protect interviewee's confidentiality.

4.5.3.3 Interview Tools

Semi-structured, in-depth interviews, in the form of individual interviews and FGDs, were conducted. Semi-structured interviews are beneficial in complex situations where it is necessary to gather in-depth data as the interviewee can express and explain their perspectives while allowing the interviewer to ask clarifying questions [238].

Semi-structured interview guides, consisting of a list of primarily open-ended questions, were developed to direct discussions towards subjects relevant to the research objectives and the demographic of the interviewee (see Appendix D). However, these guides were not strictly adhered to, allowing for spontaneous, flexible, and original interviews. This allowed the interviewee to introduce topics relevant to him/her and provided opportunities for unanticipated yet relevant topics to emerge.

The initial data gathering produced the following interviews, outlined in table 4.3.

Table 4.3 Sample Size Obtained from Initial Data Gathering

Sampling Frame	Interview Method	Number Conducted
MOH Staff	Semi-structured, in-depth interviews	0
NGO Staff	Semi-structured, in-depth interviews	3 (2 from the same NGO)
NPC Pastors	Semi-structured, in-depth interviews	7
NPC Members	Focus Group Discussion	2 FGDs (10 people)
Community Members	Focus Group Discussion, Semi-structured, in-depth interview	5 FGDs (21 people) + 1 individual

4.6 Methodological Adjustments

After the initial data-gathering, a review of the research results, and initial observations from the interviews were conducted. The review team consisted of the PI, the LSHTM research supervisor, and two other research consultants, who participated in the DrPH review. This team recommended the following changes in the research protocol.

4.6.1 Expansion of Sample Size and Demographics

It was deemed necessary to expand the sample size and the range of groups aware of NPCs during this time, but who were not necessarily aligned with an NPC, to broaden the picture of NPC responses. The dynamics previously outlined in the Theory of Charismatic Leadership, of influential, confident leaders and obedient followers who have a high degree of trust in the leader, accompanied by the apparent widespread community membership of these churches, was observed during the initial data gathering period. Therefore, it was decided to widen the interview pool. This was done in recognition that individuals closest to the NPC leader are most likely to demonstrate these ‘follower’ traits, while those further from the leader could lend a different perspective. It was decided to deepen and widen the sampling frame to find more perspectives that came from sources that were unaffiliated with an NPC. While there was much to be learned from interviews with NPC followers, it was deemed beneficial

to see if the responses had more variation among individuals or groups who were more distanced from the NPC leader.

Healthcare practitioners who worked in the New Kru Town and Caldwell areas were also added to the sampling demographics. They had the opportunity to observe how community members, including those associated with local NPCs, responded to illness in general, as well as how they responded to the Ebola outbreak. These practitioners were identified and recruited by approaching the government hospital and community health clinics located in New Kru Town and Caldwell.

It was determined that it would be beneficial to conduct as many interviews as possible, from all populations, within a given time frame of two months, despite possible saturation, to check for consistency of findings. This also allowed for a considerable amount of perspectives and data to be obtained by key stakeholder demographics. Given the lack of research on this subject, it was felt that the breadth and depth of data and perspectives obtained would increase the validity and reliability of the findings.

4.6.2 Comparison Sampling Frame

A comparison sampling frame was added to the study. This served to provide a possible comparison of Ebola outbreak responses, from another Christian group, to determine if NPCs responded differently than other Christian churches.

Criteria for choosing the comparison group were a mainline Christian denomination, non-Pentecostal, and having a significant presence in Monrovia. A Christian denomination was deemed necessary in order to stay within the broader context of Christianity. The criterion of non-Pentecostal helped to compare similarities or differences between Pentecostal and non-Pentecostal responses, thereby keeping the research within the broader category of Christianity but comparing two distinctly different Christian groups.

The LCC stated that the largest mainline Christian denominations in Monrovia were the Catholics and the United Methodist Church (UMC), respectively. Initially, the Catholic Church was chosen as the comparison group. However, after a brief time of data gathering, it was noted that the majority of churches in New Kru Town and Caldwell were NPCs. In an attempt to obtain an adequate sampling of non-NPC churches, it was determined to approach both Catholic and UMCs with the aim of conducting a sufficient

number of comparison groups interviews. Both the Catholic church and the UMC are mainline, non-Pentecostal groups with a centralized authority structure. The targeted populations interviewed for the comparison group were the same as those interviewed for NPCs (church leaders, church members, and community members).

Table 4.4 illustrates the interview populations with targeted sample sizes. However, it was determined that if targeted sample sizes were achieved, interviewing of all populations would continue for the duration of the two-month time frame.

Table 4.4 Targeted Populations and Planned Sample Sizes after Revision

Sampling Frame	Targeted Sample Size
MOH	5
IGs/NGOs	10
NPC	Leaders – 7, Members – 7-35 (depending on interview method) Community Members – Minimum of 21 (3 per church), depending on the interview method
Comparison	Leaders – 7 Members – 7-35 (depending on interview method) Community Members – Minimum of 21 (3 per church), depending on the interview method
Healthcare Providers	10

4.6.3 Research Assistants

The research team was enlarged to include two Liberian research assistants (RAs). As the PI was not Liberian, it was determined that she would likely not be as effective as a local interviewer, due to her position as a foreigner in the culture and not having been present during the outbreak. After the initial data-gathering trip, the RAs conducted all subsequent community-based interviews centred on NPC/Catholic/UMC leaders, members, community members, and healthcare providers. RA1, a Muslim, interviewed NPCs (leaders, members, and community members) and healthcare providers. RA2, a Catholic, interviewed the comparison group of UMC/Catholic churches (leaders,

members, and community members) and healthcare providers. The PI conducted interviews with the MOH, IGOs, and NGOs.

Two RAs were hired via the research department at the University of Liberia in Monrovia. While the ideal was to have one male and one female, the research department recommended two males who had experience in community interviews and who had already done similar work for another organization during and immediately after the Ebola outbreak.

These RAs were trained during a 3-day training session. Training topics included; research description and objectives, definition and discussion as to what churches were considered NPC, confidentiality procedures, including how to confidentially label and code and store the data, transcription of interviews and interview best practice. Practice interviews were conducted, and feedback was given.

4.7 Second Round of Data Gathering

During this second period of data gathering, all interview participants were given the same participant information sheet in writing and verbally. Signed consent was obtained before conducting all interviews.

The RAs initially spent five days in New Kru Town and Caldwell. This time was spent identifying NPCs and marking their location with a global positioning system (GPS). As they circulated in these districts, they geographically pinned all NPCs they identified, using the Pinbox app that was loaded on their phones. One RA also pinned non-NPC churches, to demonstrate the dominant presence of NPCs. This served as an informal mapping of the religious demographics of this part of Monrovia, giving an idea of faith dispersion. Figures 4.5 and 4.6 demonstrate the results of their church GPS mapping in New Kru Town (figure 4.5) and Caldwell (figure 4.6). Each red pin marks the presence of an NPC. In Figure 4.5, black pins mark UMC, green indicates a mosque, and yellow marks all other Christian churches.

Figure 4.5 Houses of Worship in New Kru Town

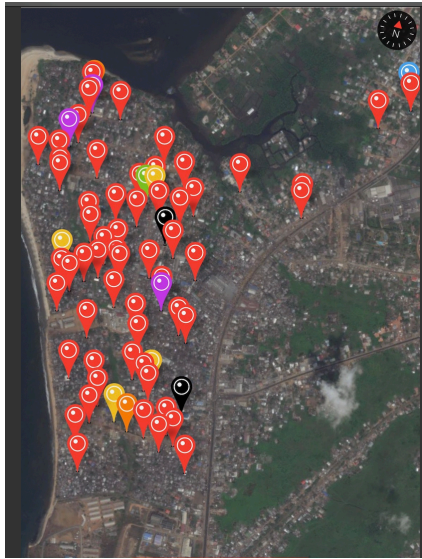
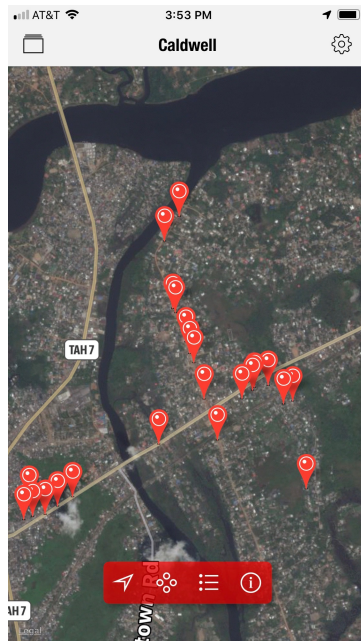


Figure 4.6 NPCs in Caldwell



Once the RAs began the interview process, they sent a weekly report to the PI, including that week's transcribed interviews. Interviews were read, and transcription checks were performed. Each week the PI sent instructions to guide the next week's interview population selection. For example, it was noted that RA2 was interviewing more healthcare practitioners than UMC/Catholic populations. Therefore, he was instructed to focus solely on the comparison group interviews, and RA1 was instructed to include more healthcare practitioners.

The RAs were given eight weeks to conduct and transcribe a minimum of two interviews per week. At the end of this period, they had cumulatively conducted 46 interviews.

4.7.1 Participant Demographics

Interviewees were recruited according to the predetermined, targeted populations. Sex and age (over 18) did not factor into participant selection. As anonymity was guaranteed to all participants, some interviewees refused to provide descriptive information such as age, education, and faith affiliation.

4.7.2 Challenges to Participant Recruitment

There were some challenges to participant recruitment. Both RAs found it difficult to connect with church leaders. While they readily identified the appropriate churches, many church leaders were either unavailable or stated that they were too busy to participate. NPC leaders were easier to connect with than UMC pastors and Catholic priests. This is reflected in the small number of interviews for these demographics.

After several weeks of interviewing in New Kru Town and Caldwell, RA2 reported that the Catholic churches stated that they were instructed by the office of the Archbishop to not participate in the interviews. The PI sent a letter to the Archbishop's office explaining the research with the support of the LCC. The Archbishop responded that he was to be traveling and would address this after his travels, however, further attempts to contact him were futile. Therefore, out of respect to the Catholic leadership structures, no more Catholic churches were approached for interviews.

The total number of interviews per faith group, is outlined in Table 4.5.

Table 4.5 Interviews Conducted per Faith Group

Demographic	NPC	UMC	Catholic
Leader	13	4	0
Member	16	3	3
Community	33	5	5
Total	62	12	8

Additionally, there were 11 interviews conducted with governmental (MOH) and IG personal, seven with NGO personnel, and ten with health workers. The total number of people interviewed for this research was 110.

4.8 Data Storage and Management

Each RA was provided with an individual voice recorder for recording interviews. Recorded interviews were transcribed on their individual, password-protected computers. Consent forms and recorders were kept in a lockbox when not in use. RAs were instructed not to discuss interviewees and interview content with anyone, including one another and professors at the University of Liberia. RAs signed a confidentiality form, agreeing to these procedures. At the end of the two-month interview period, the PI returned to Liberia, collected all hardcopy data, and confirmed the deletion of the interview transcripts and recordings from recording devices and computers.

4.9 Data Analysis

Interview transcripts were read a minimum of two times for familiarization with the data, once upon receiving the transcript and again at the end of the data gathering period. During this initial review of the data, emerging and descriptive themes were noted.

An interpretive and constructivist approach was used for data examination. Charmaz described the interpretive approach as seeking to understand and extract the more profound meaning embedded within the data [239]. With this approach, interviews are not merely read for face value content, facts, and timelines. This method looks for deeper meaning, noting specific descriptive words used and the context in which they were used. An example of this is that several interviewees compared Ebola to war. One interviewee, who was involved in community engagement, discussed NPC pastors accusing him of bringing war on the church, by believing in the outbreak. Recognizing that Liberia had experienced a brutal decades-long civil war in the recent past, the use of the word was noted as possibly demonstrating a depth of meaning and emotion among interviewees.

The interpretive approach was combined with a constructivist approach, as the PI recognized that, while looking for deeper meaning in interviews, her own experiences and presuppositions could ultimately be involved in interpreting the data. Therefore, her views and experiences, in effect, could become part of the data analysis, as well as part of the resulting theory. Charmaz described this approach as trying to understand the 'why' and the 'how' [239]. These combined approaches recognize that beliefs,

reactions, and interpretations of events are affected by multiple constructs. Charmaz stated that:

In this view any analysis is contextually situated in time, place, culture, and situation. Because constructivists see facts and values as linked, they acknowledge that what they see-and don't see-rests on values. Thus constructivists attempt to become aware of their presuppositions and to grapple with how they affect the research ([239], p.131).

4.9.1 Data Coding

Coding was conducted using NVivo 12 software. The previously noted, prominent themes guided the creation of an initial theme list for coding. These themes were reviewed and analysed in an iterative process as data was coded and reread, which allowed for the creation of emerging sub-themes. This reading and coding process, while short in reporting, actually took months as the interviews were read, reread, and meanings were reflected upon. This led to a refining of some coding themes as information given on similar concepts, from different data sources, added to the theme's understanding. Likewise, some data ended up categorized under multiple themes as relationships between themes emerged. Once these themes and subthemes were identified, and all the transcripts were coded, the transcripts were read again to ensure that they were coded properly.

4.10 Investigator Personality

As the primary investigator, I am a development professional of 25 years, working at various development practice levels in Africa. This has primarily included work with an FBO; however, I have also consulted on development funding through the United States embassy in Kinshasa, DRC, and with an international NGO.

I adhere to Christian faith, with some aspects of my beliefs being similar to those of NPCs. Having worked in Africa for many years, I have observed the widespread prevalence of various faith groups and the influence that these groups, particularly their leaders, have on communities. This has given me a personal conviction on the importance of including all faith stakeholders in community development and public health. My work with faith stakeholders has been both rewarding and frustrating over the years as I observed the strength of beliefs, which sometimes superseded biomedical health recommendations. These experiences motivated this research and led towards

an interpretivist leaning. I admit to having assumptions that certain beliefs play a role in health and illness perceptions. Being aware of my own beliefs and experiences, I was aware of the need to remain as dispassionate as possible during data gathering and analysis. This was aided by four factors, 1) I have never worked with faith groups in an Ebola context; 2) I have never been a member of a church that falls within the research's definition of an NPC; 3) I have never worked in Liberia; 4) The use of RAs provided a buffer between myself and data gathering that was conducted near NPCs and their constituents and 5) Final data analysis themes and results were dependent upon these themes appearing across multiple data sources.

4.11 Methodological Limitations

As with all studies, there are limitations to this research that should be presented and discussed. First and foremost is the PI's influence on methodological choices, participant interactions, and data analysis. As a person of Christian faith, I have primarily worked with Christian churches, teaching public health and development in theological institutions and working with faith groups on local community projects. While I have not explicitly collaborated with NPCs, I have worked with denominational Pentecostals and have had the opportunity to teach NPC pastors and observe their churches and community outreaches. While these experiences provided the interest in and motivation for this research, they also contributed to my overall perception of Pentecostal beliefs vis-à-vis health decision making. I cannot deny that my past experiences and suppositions are a part of the research. As with all qualitative studies, the investigator is part of the study. This can be both a strength and a limitation. The strength of my involvement comes from my extensive background and experiences of working with Pentecostals and other Christian faith groups in an African setting. I had a personal, baseline knowledge and understanding of Pentecostalism in Africa many years before starting this investigation. This gave me a great deal of insight to draw from. However, my personal interactions with Pentecostals could also carry a bias, both positively and negatively. To neutralize my reflexivity, semi-structured interview questionnaires were developed to guide the interviews. While the interview process was unstructured enough to allow interviewees to contribute any information that they felt was pertinent, there were specific questions that guided interview topics.

I was also an outsider to the context, having never lived in or visited Liberia before this research and having not participated in the Ebola response. This could be considered a positive aspect as I was researching an event that I had not participated in and therefore did not have my own experiences and perspectives. However, the traumatic experience of having lived through the outbreak was an aspect that I could not relate to. Therefore, two RAs were hired to provide a buffer between myself and the community level interviews and to facilitate more open and honest dialogue during interviews. As the RAs were Liberian and had lived in Monrovia during the outbreak, they could connect with community members by discussing their shared experiences during the outbreak.

While the RAs were a positive addition to the research team, they also brought their personal perspectives and opinions into the interview process. One RA was assigned to NPC and health worker interviews, and the other was assigned to UMC, Catholic, and health worker interviews. While this was done to provide consistency among targeted interview demographics, it should be noted that interview results could be biased as the same RA worked within the same demographics for the duration of the data gathering.

In terms of the interview data, there was the potential for recall bias as the information sought referred to past events. However, the events being examined were not in the distant past; Liberia had been declared Ebola-free less than one year before interviewing started.

Qualitative research, by nature, is not representative of a wider population, but rather provides more detail at an individual and group level. The interview content represents the opinions of the interviewees. Their perceptions of churches and the Ebola response are precisely that - their perceptions, and interviewees chose the aspects that they were or were not willing to discuss. This seemed particularly evident in the interview results with NPC leaders, as all described their responses to the Ebola containment measures as timely and appropriate. It was challenging to find other opinions about specific church responses, creating difficulty in comparing or validating their descriptions.

There was a weakness in the recruitment of NPC members. Members were recruited by asking the pastor for recommendations or by approaching people near or in the church. It is noted that the pastor would likely only recommend people who he trusted to represent his leadership and the church response in a positive light. Individuals that were in or around the church during a weekday could indicate high levels of religiosity

and church involvement, which could affect the objectiveness of their responses about the church. NPC culture and how members viewed their pastor seemed to impact how they described him, only using very favourable terms and seemingly reluctant to say anything that could be construed as a critique. Recognition of these limitations is one reason why numerous interviews, across multiple demographics, were conducted. Responses were triangulated with multiple interview demographics and compared with the literature to identify the common themes across all data sources.

Recruitment for the comparison demographic of Catholic and UMC churches was difficult. Church leaders from these two groups were not as easily found in their churches outside of service times, as NPC pastors were. After conducting several interviews within the Catholic church demographics, the Catholic Archbishop sent out a letter requesting that all Catholic churches not comply with the research. While this impacted the number of Catholic interviews obtained, it also contributed to the data as a demonstration of the influence that a church denominational headquarters can exert over its local churches. While Catholics and UMCs were considered to be numerous in Monrovia, the districts that were the focus of this study had fewer of these churches, compared to NPCs. Ideally, the amount of comparison group interviews would have been similar to that of the NPCs. However, the small number of these churches also served to demonstrate the dominant presence of NPCs. Despite smaller sample sizes for the comparison group, I was satisfied that saturation had been reached after analysing the data gathered from multiple sources that discussed UMC and Catholic responses.

There is also a risk of my own subjectivity in coding and analysing the interviews. However, the number of interviews from multiple demographics and the support of the interview results found in the literature adds to the study's strength and validity.

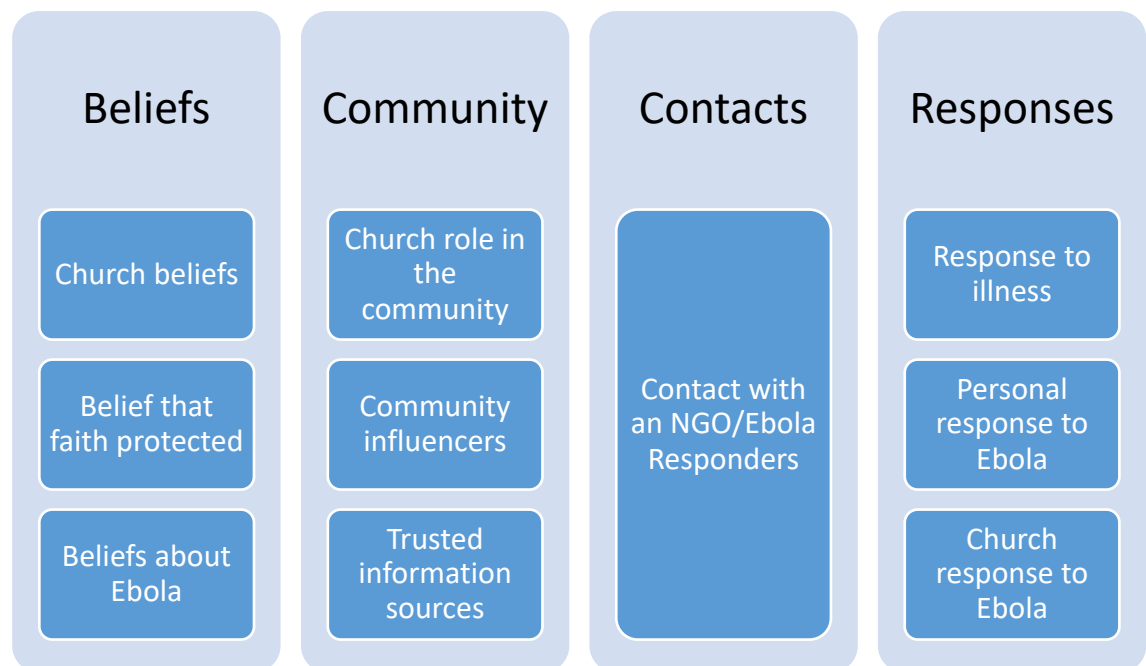
Chapter 5: Results

5.1 Introduction

NPCs are a particularly important stakeholder when discussing infectious disease outbreaks and public health initiatives due to their beliefs in a spiritual causality for illness and divine healing, often expressed through praying for the sick and the laying on of hands. This study sought to gain a variety of perspectives by interviewing those who witnessed NPC reactions and responses from different angles, during the Ebola outbreak. This chapter will discuss the data collected through the interviews. It will discuss prominent themes as they relate to research objectives 1-4. The chapter concludes with a summary of all pertinent results.

After an analysis of the results four themes, with subthemes, were identified. These are outlined in Figure 5.1.

Figure 5.1 Themes and subthemes



My first data-gathering trip to Liberia was approximately ten months after Liberia had been declared, and stayed, Ebola-free. However, the lingering remains of the outbreak, both physically and emotionally, were evident. While this was my first trip to Liberia, I had spent many years in various countries in Africa, including West Africa. I had interacted with Liberians, albeit outside of Liberia, and noted that their cultural proclivity of greeting one another with a handshake was similar to that of many other African countries.

Upon my arrival to Monrovia, one of the first things I noticed was the absence of this all-important handshake. Whether I was at the MOH, in a church, or greeting someone as I walked through neighbourhoods, there was a distinct lack of handshaking.

After many years in Africa, I was accustomed to being surrounded and followed by young children who were enthralled with a fair-skinned visitor. However, as I explored New Kru Town and Caldwell, no children ran up to me. They would stare or peek around corners, but no one approached. I came across an older woman resting under a tree in the heat of the day. Needing a brief break from the sun, I sat down beside her. I told her why I was in Monrovia and listened as she discussed the horrors of the outbreak and how her community of New Kru Town had been affected. She confirmed my observation that people did not greet one another like they used to. There was still a lingering fear of touching.

Another observation was the amount of handwashing stations and the abundance of hand sanitizer. Churches, places of business, and many homes had the now-familiar bucket propped at their entrances. Virtually everyone seemed to have hand sanitizer – from taxi drivers to pastors to random individuals that I observed on the streets. Ebola billboards and awareness messages painted on walls were still evident in prominent areas of high population. Liberia was finally Ebola-free, scientifically speaking, but they were far from Ebola-free in their minds.



5.2 Research Objective #1: Understand NPC Leaders and Constituents Perception of Community Engagement Measures and Protocols

The story of the NPC response begins with the NPCs themselves. This section aims to provide an analysis of the semi-structured interviews and FGDs conducted to answer the first research objective and questions involving the perceptions, beliefs, and actions of NPC leaders and members. It will examine the responses of interviewees regarding their beliefs towards illness. It then explores the possible role that these beliefs did or did not play in how they chose to respond to Ebola.

The section begins with a discussion on NPC leaders' and members' descriptions of their beliefs on illness and appropriate illness responses. This will serve to establish a baseline of health beliefs and illness responses prior to Ebola. It continues with NPC leader and member descriptions of their initial responses to the news of the Ebola outbreak, mainly one of disbelief, why and how this transformed into general belief, and what containment protocols were ultimately implemented. The section discusses a few individuals, outliers within the interviewees, who continued in persistent disbelief. It concludes with a discussion of combined NPC leader and member results, comparing and contrasting results to determine if members opinions were in alignment with those described by the leaders.

5.2.1 NPCs and Illness Beliefs

In total, thirteen NPC leaders were interviewed. This number included eight lead pastors, two assistant pastors, two youth pastors, and one pastor's wife who functioned as the women's leader at her church. Among the eight lead pastors, two had secondary leadership roles among the broader NPC community. Therefore, their interview responses were often, although not exclusively, from the perspective of a broader, more general NPC level (i.e., what they saw among the NPCs with whom they were frequently in contact).

5.2.1.1 NPC Leaders and Illness Beliefs

All NPC leaders discussed similar beliefs and responses to illness, which involved their Pentecostal belief in divine healing and praying for the sick. Several stated that praying for the sick was their first line of response. However, they acknowledged that some illnesses required medical attention. NPC leaders described a formula that combined faith, prayer, and medical treatment. While all leaders interviewed discussed a possible

two-pronged approach to illness (i.e., combining prayer with medical treatment), several also expressed the belief in a spiritual causality for illness, believing that the root cause of illness was usually due to sin, on the part of the sick person, or an attack from the devil in the form of witchcraft. Two NPC leaders discussed the beliefs held by some of their colleagues that pastors would not succumb to illness due to divine protection.

5.2.1.1.1 Spiritual Causality

Several leaders discussed illness as having roots beyond the physical. Terms used were 'judgment' or 'punishment from God,' 'enemies of Jesus,' 'sin,' and a 'curse from the devil.'

Pastor D stated that many of his members believed that all illness was "Africa sickness" or "Africa sign." He explained that this was a local term when one thought that the illness was the result of a witch's curse. He described the responses of those who adhered to this belief:

I see many people today they always claim sickness as only African sign, so many people today they are getting sick with a physical sickness but they are always turning it to African sign so you will notice that they will either go to church or they will go somewhere they call sick bush (traditional healer) first is where they will go try, try, try...

Pastor D did not discuss his own beliefs regarding African sign or how he reacted when approached by a member using this as an explanation for illness. He chose to explain this within the context of the reactions of individual church members, to illness.

5.2.1.1.2 Divine Protection

As interviewees discussed general attitudes towards sickness, two pastors mentioned that some NPC leaders believed that they could not be affected by illness, claiming a divine protection due to Pentecostal beliefs regarding the power of the Holy Spirit.

Pastor M stated:

Sometimes I know in the Pentecostal circles we have zeal, and we play down knowledge. We like to defy. If a health practitioner comes and says that a certain person is sick with a particular sickness, so don't touch them. And I am a Pentecostal pastor, filled with the Holy Ghost, and we want to say, "No, I don't believe this sickness can affect me." I should be in the position to heal someone because I have Christ in me, and I'm loaded. Loaded with

the power of the Holy Ghost. I don't believe that this sickness can affect me.

This topic was always discussed in the third person, as it related to other pastors. No pastor interviewed personally acknowledged having this belief, but many did recognize its popularity among their colleagues. It is difficult to determine if all pastors interviewed for this study did not apply this belief of spiritual protection during the Ebola outbreak, or if they chose to discuss this belief within the context of unidentified 'colleagues.' It is possible they preferred to distance themselves from a belief that, in hindsight, was harmful.

5.2.1.1.3 Divine Healing

All NPC leaders mentioned their belief in divine healing. They described how they prayed for the sick and conducted regular mass healing services. One NPC leader who pastored a church but also served as a leader among the greater Pentecostal fellowship, broadened his response, implying that the beliefs in divine healing through prayer and the laying on of hands were widely held among all NPCs, which aligns with the literature on NPC beliefs.

Pastor M demonstrated this commitment to prayer and the belief in divine healing being a vital response to illness as he described the various ways that this belief was incorporated into the life of his church:

We have been in the healing ministry, also praying for the sick. We go to their homes and pray for them. When people come to the church also, and they are sick, we pray for them.... Spiritually we put more emphasis on the members believing in God. That when sickness comes, God is able to save them. As much as you take preventative measure, you should trust God. It is not just about prevention, you can try to prevent anything, but stuff still happens. But trusting in God and believing in God is better than anything.

Pastor M's comments illustrate the importance of prayer in NPC belief and the various ways it can be incorporated in the churches' teachings and made available to church members. His statement also demonstrated that while he was comfortable combining this belief with biomedical responses, the primary emphasis was on faith and God's ability to heal.

5.2.1.1.4 Combination of Prayer and Medicine

All NPC leaders stated that they readily combined prayer with medical care, when necessary. Respondents described medical care as sending the affected individual to a clinic, a hospital, a pharmacy, or consulting with a healthcare professional who attended the church. Respondents varied in the ways they described how this decision was made. One NPC leader stated that prayer was the initial response. After an indeterminate time of prayer, if the sick person was not better, he/she was then sent to a health facility. Another stated the opposite, saying that the clinic was their first response. However, if the clinic did not yield the desired results, it was deemed that the sickness was spiritual in origin, and prayer was the next step. Another NPC leader stated that depending on how the sickness had manifested indicated whether it was spiritual or physical in origin, which then dictated his recommended response of prayer or recommending seeking professional healthcare.

Several NPC leaders described a different sequence of responses to illness. Their reactions depended on whether they deemed the root of the problem to be physical or spiritual. While these pastors stated a belief in divine healing, regardless of the root cause, they distinguished between illnesses that they felt were primarily spiritual and those that they believed to be physical.

This bifurcated response was illustrated by Pastor C, in the following quote, which demonstrates not only the belief in a medical and spiritual cause for illness but also the role that the pastor plays in deciding the response.

When any member gets sick, the first thing I do is send them to the hospital. Because you have spiritual sickness, and you have physical sickness. So, when someone says, "oh pastor my head is hurting," the first thing I do is send them to the hospital. If it doesn't get better, then I know that something is going on in the realm of the spirit.

His response provides a glimpse into the intimate involvement that many pastors have in the lives and the health decision making of their members. All pastors interviewed reported that their members looked to them for guidance and sought their advice concerning their physical health. They all believed with certainty that their members followed their recommendations.

5.2.1.2 NPC Members and Illness Beliefs

Sixteen NPC members were recruited for this specific NPC demographic in the sampling frame. However, among the other demographics interviewed for this study, several individuals self-identified as NPC church members, although they were interviewed as part of a different, predetermined interview group. Of the 33 NPC community members interviewed, 19 self-identified as NPC members. Among the international community, governmental, and intergovernmental interviewees, 7/19 stated that they were NPC members. While interviewing those who lived in the vicinity of Catholic churches and UMC churches, 4/5 and 1/5, respectively, reported that they adhered to NPC belief and among the healthcare workers, 2/11 were NPC members. These NPC affiliations increased the voices of NPC members to a total of 49.

It should be noted that interviewees from these other demographics were not specifically asked about their faith; however, if they volunteered this information during the interview, it was noted. Some of these NPC members were initially approached for interviews due to their positions within the Liberian government/MOH or an NGO. Therefore, a majority of their interviews centred on their observations as employees of these organizations rather than focusing on their own beliefs or their individual church's responses. When applicable, their opinions are included here.

Member responses strongly reflected those of the NPC leaders on the aspect of prayer and faith as they pertained to illness and health. Their responses supported the importance of prayer and faith, mixed with seeking healthcare. They also emphasized placing considerable importance on prayers and the role of their pastor in their healing.

5.2.1.2.1 Prayer and Faith

Prayer and faith in God's healing were the main topics in a large portion of NPC members' responses when asked about approaches to sickness. When choosing to seek healthcare, many respondents emphasized that their priority was to trust in God and to have faith in healing. This was even supported by a healthcare worker who was an NPC member. Louise, who worked in a neighbourhood clinic, stated:

...if you go to the bible, it's like every healing Jesus was doing, he was telling you if you have faith. Even if the people tell you that you have AIDS, in the first place you will have to accept that you have the disease and then believe that whatever drugs they are giving you able to help you in other that you will live longer. So,

our life minus faith everything about us is not workable without because if you go to bible, bible will tell you without faith it is impossible to please God. For those that come to him must believe that he is, and he is the rewarder of them that diligently seek him. So, I believe as a Christian my faith in God should be greater because without faith there is nothing about me. Because even if I say yes tomorrow, I will get this thing I must have the faith that tomorrow indeed I will get it. So, faith plays a kind of major role in the life of every individual.

Louise implied that faith was a priority for Christians in all aspects of life, including in health. According to Louise, even when one was taking the proper medication, it was rendered more effective by the individual's faith.

Hope reflected the same sentiments stating, *"If I don't believe I will be healed, then it (healthcare) doesn't work."*

Mark summed up the dyadic approach to the relationship between faith and illness by saying:

At the bottom of every African you have to say that no matter how educated he is if he doesn't see a way through illness or challenges, he thinks that there's an external power there. He gets to the bottom, for the African man he gets to the bottom and he will think that there is some power because he can't explain science, and something has to be there. No matter how educated he is.

Mark's comments address a worldview that sees adverse life events through the lens of an external cause and effect. If something negative happens and there appears to be no way of achieving a positive outcome, then this worldview attributes some external, spiritual power as the cause. The logical conclusion to this line of reasoning would be that if an external, spiritual power is at work, then the required response would be to seek out another external, spiritual power to advocate on one's behalf.

A doctor who worked for a government organization, Mark, was also an NPC member and had attended a Pentecostal bible school. When discussing the school's position on illness and seeking medical treatment, he stated, *"Extremists would say 'don't go to hospital'the goal was that you can believe God and get well...you could take it (scientific treatment) if you wanted but if you knew you had good faith you wouldn't need it."*

Michael was another physician who was also an NPC member. He discussed his observations on the role that faith played in health for NPCs saying, "*Faith plays a big place, actually, in health. people usually go to churches for prayer. They go to self-prophets who sit in their bedrooms and other places to try and provide healing.*"

Michael's observation that people go to church seeking prayer supports NPC leaders' comments and the comments of most NPC members. Michael described specific individuals who positioned themselves as healing specialists and created specific venues where people could seek healing prayers. His term "self-prophets" is intriguing, implying that these individuals self-proclaim as healing prophets, a title that once taken, the believing public readily accepts.

A few NPC members stated that their first reaction to illness was to seek help at a health facility. While they did not mention prayer and faith, specifically, several were quick to credit God for any resulting healing. A handful of participants did not mention prayer, faith, or God when discussing their healthcare choices. These few stated that when sick, they immediately sought out pharmaceutical or healthcare options.

5.2.1.2.2 NPC Leaders' Prayers

The element of faith was often discussed in combination with faith/trust in the pastor and the belief that the pastor's faith and prayers were paramount to ultimate healing. Several members highlighted the need for their pastor to be praying for them, suggesting that his prayers were the most important and the most powerful. This aligns with NPC leaders' expressions describing their involvement in their members' lives. It also supports their confidence that members followed pastoral instructions. This NPC leader/member relationship underscores the influential role that the church and the leaders play in the health decisions of many of their adherents.

Johnson worked for a government agency but was also an NPC member. In discussing the importance of the pastor's prayers and advice during a health issue, he stated, "*Pastors say 'I can speak to God and God can heal you' ...and the people accept it.*" While Johnson was an NPC member, he talked about the absolute willingness of other members to accept whatever the pastor said.

Leila also talked about the faith and confidence that people had in their pastor. She used an example of a pastor instructing members to do something that common sense would

typically forbid; however, members would do the senseless act out of the belief that the pastor spoke for God; therefore, God had told them to do it. She discussed the belief that one would not be harmed by an unwise action, due to their obedience to the pastor, equating this to obedience to God. She generalized this sentiment beyond herself, including all Liberians, or perhaps all 'Christians' or 'church attending' Liberians stating:

You know, in Liberia, what our pastor tells us is what we believe. If our pastor tells us 'go into the fire and you will not die,' we will go into the fire because what our pastor tells us is next to God; that is how we take him to be. So, we will go into the fire because our pastor told us to go there.

Louise discussed the importance of having the pastor pray for his members, seemingly saying that his prayers were more important and more powerful than the prayers of others:

Like if you go to the pastor and you know as a Christian, I know that I'm sick, and I have taken all the different drugs, and I'm not healed. So, I'm going now to God who is the healer, and the pastor prays for me. If I don't have faith I will not be healed. But my faith joined with the pastor's faith, then I will be healed. First, I should believe that whatever he's telling me will work, and surely it will work. ... The pastor said nothing will happen to you. You are a child of God. Nothing will happen to you, nothing, absolutely nothing.

While Louise acknowledged that God was ultimately the healer, she seemed to believe that this healing was primarily carried out through the pastor, God's chosen instrument. She discussed her belief in God as her father, but also called her pastor "father pastor" and discussed his role in relaying God's will for in her life. Louise's confidence and absolute trust in what the pastor said seems to be directly related to her faith in God, as she felt that the pastor was God's spokesperson for her life.

5.2.2 NPC Responses to the News of Ebola in Liberia

This section discusses how NPC leaders and members described their church and individual responses to Ebola and the Ebola containment measures. It begins with a discussion of the general disbelief in the news that Ebola was in Liberia and the factors that moved communities from disbelief to acceptance. It then analyses NPC leader and member interviews on responses to the recommended Ebola prevention measures, looking for prominent and recurrent themes, comparing and contrasting responses and reflecting on the role that NPC faith did, or did not play in these responses.

5.2.2.1 Disbelief

In March 2014, Ebola entered Liberia via its border with Guinea. Over 350km from Monrovia, the events happening in the North of the country seemed distant, unreal, and unimportant to most inhabitants of Monrovia. As the news began to spread about this strange illness, almost all NPC leaders and members interviewed stated that they had the same reaction of disbelief. This disbelief was attributed to several realities:

- Ebola had no history in West Africa, so it was difficult for people to believe in its presence. Many had never heard of Ebola before this outbreak.
- The initial messages that people received, primarily via the radio, were confusing and conflicting.
- Ebola symptoms were similar to the symptoms of other familiar illnesses such as typhoid and malaria.
- Most messages were coming from government sources, and there was a high level of distrust towards the government. Many believed that the government was fabricating the outbreak in order to receive money from international humanitarian organizations.

Pastor S described the disbelief due to distrust in the government, an aspect that many interviewees mentioned. He said, *“When we first heard about Ebola, to be very frank with you, we doubted it. We thought that the government was making another scheme to try and get money from the international community.”*

NPC leaders and members alike initially struggled to believe the Ebola messages. An inherent mistrust in the government was an obstacle in the Liberian's acceptance of messages about a strange disease that required culturally unacceptable behaviour for prevention. It is essential to note this belief, considering that the Liberian government public health sector was the foremost leader in the outbreak response.

Pastor M also described his disbelief and confusion:

I do not really recall the instant, but when we first started hearing (about) Ebola it was kind of mixed information we were getting about it. Similar to the war. It had not reached the community to see the reality, and people say there is a certain sickness in a certain area, and people are dying, sometimes there was mixed information on the news. The news would say a certain number of people had died from a certain sickness, and then on the same news they would say it was not true. Others would say it's been

dealt with. So, it was mixed information, so many of us did not take it seriously.

Sheila, an NPC member, stated, *“We didn’t take it seriously because we believed in the almighty God.”*

The few interviewees who readily believed that Ebola existed included several individuals who worked with NGOs or government organizations, were educated on outbreaks, and were privy to information. Since they worked closely with the government, they did not have the inherent distrust towards the government that was reflected among the majority of community respondents.

A couple of interviewees simply trusted the news stories. While not in the health field or associated with the government or NGOs, these individuals, took the initiative and began to look up information on the internet. They stated that they immediately trusted the information due to their research. One mentioned that since Western news sources confirmed the outbreak, he immediately believed it and began to look for ways to protect his family.

5.2.2.2 Seeing is Believing

Among the NPC leaders and members interviewed, the considerable majority ultimately did come to believe in Ebola and began implementing the containment measures. This belief began at varying times, but most stated that once Ebola came to Monrovia, and they began to see people dying, they were afraid and began to react. Most cited the months of July - August 2014 as the period when they began to adopt Ebola prevention behaviours.

Pastor B. described the denial of Ebola, and then the subsequent fear as people around him began to die:

At first, for example, for our community here (in Monrovia) when it was first announced, people thought it was just something that would pass, during the day.... but then at night you would hear the sirens, and finally it came close to home – your next-door neighbour is gone and whole families gone. People close to you are gone – there was a young man who lived right on the other side of our fence, and he died. And when it reached home fear struck.

Pastor S echoed this, describing how what he saw ultimately lead to belief and action, *"...and we would see a truck with a lot of bodies in the truck, taking them for cremation. So, we all got panicked. We all got terrified and began to take precaution."*

Many participants described this same sequence of moving from disbelief, or minimalizing Ebola, to acknowledging its awful reality. Several people quoted the well-known phrase 'seeing is believing,' saying that until they saw, for themselves, the effects of Ebola, they and their communities had a hard time believing.

5.2.2.3 NPC Responses

Once this ideological shift occurred, NPC leaders and members alike described primarily the same responses. By this time, the government and the international community had crafted clearer, more concise messages regarding Ebola prevention, and people began to listen. Almost all individuals interviewed stated that they began to implement the recommended prevention measures at this point in the outbreak. Most stated that this was around July or August of 2014, when Ebola was widespread in Monrovia. Measures cited by all respondents included handwashing stations at the church, Ebola awareness during church services, no handshaking, and seating people further apart so that they could not touch one another.

Overall, NPC members felt like their churches ultimately responded appropriately and that their responses were helpful.

NPC member Albert described what it was like to be in church during this time, saying, *"In the church, people were washing hands, and you would go to church and not touch your friend. So, you see your friend, "hello, hello," but you stay far away from your friend. It was something we had not seen before."*

William talked about his pastor teaching on Ebola during church services:

He (pastor) will tell you, how you got to be sensitive, how even self in car you know how you got to sit with somebody in the car, even the person can be your best of friend for long time you never see the person don't go and hug the person. You greet him standing far place you greet one another it will be preferable.

Daniel also described the Ebola prevention and awareness messages that his pastor gave, saying, *"We had many talks on washing hands and awareness. Don't shake hands,*

don't hug somebody. This church is a teaching church.... The pastor was always on the internet, looking on the internet so he would find new information and tell us."

Louise felt that churches ultimately did well with their responses:

Well, the church actually in my own thinking did well. Meaning they were constantly harassing members to be careful. They were helping their members. Like for some churches that I know, when the crisis started and things were getting hard, they were giving food to members, helping their members, and whenever there's one of my person sick oh pastor. Pastor will be doing the praying, and they will be encouraging you to also take the person to the health facility..... Whenever we went to the church, we were asked to take precaution. We washed our hands. We had our buckets. We were not one cup because before we had water that we could drink from one cup. But we were taking every preventive method that we couldn't drink from the same cup. Because if I had the Ebola and then drink from that same cup and you drink from it you could be affected.

These comments described the similar preventative measures that churches implemented. Pastors and member interviews confirmed one another's descriptions of what responses looked like when churches and NPC members finally implemented them.

5.2.2.3.1 Spiritual Beliefs and Responses

Almost all NPC leaders and members interviewed for this study admitted to denial and confusion when the Ebola outbreak began. However, most did not link this denial to their faith and beliefs. A majority also stated that once Ebola began spreading rapidly in Monrovia, they saw people sick and dying, and heard more consistent messaging from the MOH, almost all came to believe that the outbreak was real. Two NPC leaders stated that while they believed Ebola was real and that they followed the recommended preventative practices, they firmly believed that the cause of the outbreak was spiritual.

Pastor R discussed his beliefs regarding the origin of the Ebola outbreak:

....it was sin. Yeah, people say that but me, I don't believe it was so (the scientific explanation). That Ebola may have come from somewhere.... people say that, but me, I believe it was from sin...People say we have to do it (handwashing), even the government, in public places, even if I came to your house they say "please wash your hands", so it was like a tradition, you had to obey.

Pastor R believed that the outbreak was real, but that the cause of the outbreak was spiritual, thus requiring a spiritual response. He did not support the scientific reasoning behind the outbreak nor the prevention measures. While he ultimately enacted the prevention protocols, his comments reveal that he complied out of societal and governmental pressure, "...you had to obey," rather than out of a realization that they were truly necessary and helpful.

Pastor L's thoughts were similar to Pastor R's, attributing sin, and God's judgment as to why Ebola came to Liberia.

...actually, when the Ebola outbreak came about I was really thinking that perhaps it is a punishment of God though God does not give bad thing to his people...we have considered it a punishment from God to allow the devil to yield, to yield this people because some of them are let's say they are very hard to talk to. Hard minded when they say come to God they want to be on their own. So, God I believe in his own way was punishing his people. that's how I considered it.

Samuel, an NPC member, observed churches who did not forcefully enact the prevention protocols, due to their belief that a spiritual intervention was all that was needed.

Really churches did not really adopt. It was individuals that were adopting because many churches to be very realistic to you whenever they get any information, the first thing they seek is spiritual intervention. They only go down on their knees in prayer to God consult God oh so, so and so disaster about to go on. Papa God take control. Whether it is false or true they were only praying to God for him to take complete control. So, churches did not adopt it. So, the churches really believed that this is an issue that needs a spiritual intervention. Whatsoever man cannot understand only God can comprehend it. So, they rather giving it to God in prayer.

Samuel did not mention observing churches that never did believe in Ebola, but rather discussed churches that only implemented a spiritual response to the outbreak, due to a spiritual belief in its cause. He applied his observations to numerous churches and offered a very different picture of the NPC pastors. Aside from Pastors L and R, mentioned above, all those interviewed stated that, even if they felt that Ebola was spiritual in nature and required a purely spiritual response, they willingly embraced the prevention protocols. An NPC member himself, Samuel stated that churches tended to default to spiritual responses, believing God to take control of all circumstances and

remaining focused on that belief, rather than listening to the advice of medical experts. He stated that when a man lacks understanding of a problem, the belief is that only God (i.e., not trained experts) can understand it. Therefore, one should go to God in prayer.

While most NPC leaders and members did not discuss adhering to a belief in a purely spiritual cause for the outbreak, almost all discussed having incorporated a spiritual response that was common among NPCs. Despite a ban on public gatherings and the recommendation of prevention protocols that implied physical distance between people, in general, seven pastors explicitly stated that they had even more prayer services during the week, with increased attendance during the outbreak. They explained that the church was a place of hope and comfort and that people wanted to be there.

Pastor A talked about the increase in people coming to church and the motivating factors for this:

When Ebola started, people were coming to church, and they were having fear in them... but people were coming to church because they were having fear. People carry fear now. So, they come to church because a lot of people know that because there is Jesus, nothing will happen.

Pastor M confirmed this, stating, *"Because one thing that happened during Ebola time is that many people were coming to church. People that were not normally in church were coming..."*

Pastor E said, *"But within that period of time every human being in Liberia wanted to go to church so that they could pray and tell God that they didn't want to die."*

Pastor S contributed to his observation of this phenomenon, saying, *"People run to the Lord when they're scared. Nobody wanted to die, they all ran to God, so people were here every day – seeking the face of the Lord. We had regular services."*

These pastors' comments describe an increased presence in churches as communities sought spiritual help and comfort during the outbreak. They reveal a need to go beyond a physical response of implementing the prevention measures to incorporating a spiritual response as well. This resembles the general responses to illness described earlier in this chapter.

Church members confirmed this increased interest in God. A focus group of four individuals supported the observations made by the pastors. Daniel, one of the group members, summed up this increased spiritual desire saying, "... *everybody wanted to go (to church) during that time. The church was always full. The church was always full during that time.*"

Louise recounted the ways that her church helped those who were affected by Ebola:

For us, whenever we heard in my church that this person is attacked or the family is like this, the church calls for fasting and prayer that we could ask God to intervene no matter the situation. It was how we were doing it every other time in the church, praying for our country, praying for our friends.

Kennedy described his church's activities as they ministered to those affected by the outbreak:

My church in their own way has been going from place to place been helping one or two people, encouraging them that there is a God and there is still a way in life for them not because they have been victimized from Ebola.... my church in New Kru Town was the church who every day they were in, they were used to be in service praying to God, asking God to deliver Liberia, Mama Liberia from this deadly sickness.

These comments illustrate the importance that faith played in the lives of many Liberians during the outbreak. They highlight a natural reaction of many individuals to turn to the church for guidance and comfort during a time of fear and confusion. This reaction did not exclusively belong to already faithful church members, but even those that had not been church adherents were suddenly seeking out faith and comfort in the church.

5.2.2.3.2 Persistent Disbelief

While a considerable majority of NPC leaders and members eventually moved from disbelief to belief during the outbreak, two NPC members interviewed admitted to a longer-term, sustained disbelief that Ebola was not real.

Ellen was one of the two. At the time of this interview, she still did not believe that the Ebola outbreak happened:

I don't believe that the Ebola virus was ever real. There was a lady that lived right over here, she got sick and they carried her to the hospital. The people in the place said it was not Ebola, it was TB.

Yes. But the hospital said the woman died of Ebola, but her people said it was not Ebola. It was TB.... and the boy used to take care of his mother. But Ebola spreads, when the person sweats you can get Ebola. But the boy who was taking care of his mother, he is still living.

Ellen never did believe that the outbreak was real. She attributed all of the deaths to TB or other illnesses and supported this belief by discussing the infectious nature of Ebola, something that she had apparently learned from the Ebola messaging. She noted that the young boy who took care of her neighbour did not get sick, even though the neighbour supposedly died of Ebola, therefore it could not have been Ebola.

Ellen also discussed the fact that her pastor never believed that the outbreak happened as well. She stated:

My church didn't take it seriously, and they closed our church down.... the responders from the MOH. The church didn't take it seriously, so they closed the church down. The pastor was not taking it seriously Because he felt that God was going to protect. He was preaching that if you had faith then God was going to protect. The pastor was just pretending to believe because the people said he had to have a bucket at the church (for the church to stay open).

When asked if the pastor eventually came around to belief, she added, *"No, he didn't. The people said we will close the church down because people are not washing their hands, but he was still pushing God. He never did believe, he did it to keep the church open."*

Ellen stated that her church had reopened after the outbreak. She did not offer the name of her pastor or the name of her church, except to confirm that it was an NPC. The PI does not know if she interviewed this pastor or not. Interviews were conducted in the area, and Ellen stated that her church was close by. Either the pastor was not interviewed for this research, or he chose to portray his Ebola responses differently during the course of the interview.

Albert was the second NPC member who finally did believe; however, his belief came much later than the other respondents. It took more than seeing people sick and dying to convince him of the reality. Albert said that at some point, his church did start discussing Ebola and encouraged the containment protocol. However, despite this, Albert did not believe that Ebola was real until December 2014, nine months into the

outbreak. When asked what led to belief at such a late date in the outbreak, he stated, *"I didn't believe it.... but then I came down with it."*

5.2.2.3.3 Fatal Disbelief

Several NPC members and pastors discussed prolonged disbelief among the NPC community, particularly among some NPC leaders. This was always discussed in the third person, in the form of observations of others' reactions during the outbreak or in personal stories of friends who disbelieved and ultimately died.

Like Ellen's story about her church, Rebecca also alluded that some churches only implemented the containment protocols to avoid being shut down.

"They (the churches) responded the way they did because they never wanted for churches to be closed down. They never wanted for God business to be silent like that. They still wanted to be worshipping God that's why they started to take precaution...."

Her comments support Ellen's description of her pastor implementing the protocols simply to keep the church open. They imply a motivation that stemmed from their perceived spiritual mandate rather than from recognizing the outbreak and its infectious nature.

Mary and Rose, NPC members, also discussed pastors who insisted upon relying only on an extreme spiritual response to Ebola. Mary worked at the local hospital and described her observations:

So, some of them (churches) have their own belief that it was not true, yet they were still spreading the message around. Yet them still, some of the pastors were still coming, wanting to touch patient. Their own believe they said, "Ebola was not going to kill them," in fact Ebola was not true, they didn't believe in Ebola at all. Some of them, yeah some of our pastors did that. Several times they came here we told them not to do it, they want to be touching patient, to be praying we say, "no do not touch the patient," they didn't believe so they had their own believe that, yes, maybe their belief save them, but some of them died also in that process.

Rose told the story of an NPC pastor, who the community referred to as "Bishop."

Bishop of this church, the late Bishop he has a wife and she was a nurse. Somebody was sick she was treating the person and she got encounter with that sickness, then we never knew at that time, and you know and uh... she passed (died)....Always when she

heard somebody is sick, she will go there, treating them....She say, "that not Ebola," she sick she bought oil, she brought it for my husband to pray on it so she can be using it....

Both Mary and Rose described church leaders who insisted on praying, accompanied by the laying on of hands, for those who were sick. In Mary's account, the pastors had a hyper-faith response, vacillating between not believing in Ebola or saying that Ebola could not hurt them. Both Mary and Rose noted that these actions ended in death.

Louise told the story of a Pentecostal church that she used to be a member of:

Other churches other people did not believe so they were not applying it at their churches. Other people did not believe. Oh, this washing hands whole day washing hands put bucket to your door, for me nobody should put bucket to my church. It happened at the XXX church (says the name of the church) in New Kru Town there.... it was the church I was in before I moved here....The man died because when they started they put bucket in front it he said nobody must put bucket nothing will happen. You know sometimes we used the grace of God for so many ways. For him that's how he died.... So, some churches did not believe so they were not responding to washing hands.

Louise's story described the pastor as spiritually defiant towards a biomedical response to the outbreak. He felt that faith should protect the true believer and imposed this on his church members by refusing to have a handwashing bucket at his church. His stance ultimately led to his death. She alluded to the possibility of misusing the Christian concept of grace as a reason to not comply with the Ebola protocols. Her story collaborates with others who stated that there were churches who were resistant to the Ebola containment protocols.

Several pastors discussed other NPC leaders' beliefs regarding Ebola. Pastor M recounted the Ebola deaths of two NPC colleague pastors:

There were two pastors that I REALLY (his emphasis) knew.... They were Pentecostal pastors...and I REALLY (his emphasis) knew them, and they died from it, and the news that came out was that it was Ebola. I saw them like a week, very healthy, before, and we were told that they died from Ebola. In fact, one of the pastors that I knew, his entire family died, his wife and everyone....it was in the middle of the epidemic.

When asked if he thought these colleague pastors did not believe in Ebola or if they just refused to take preventative measures, out of faith, he replied:

Sometimes I know in the Pentecostal circles we have zeal, and we play down knowledge. We like to defy – if a health practitioner comes and says that a certain person is sick with a particular sickness so don't touch them. And I am a Pentecostal pastor, filled with the Holy Ghost, and we want to say, "No, I don't believe this sickness can affect me." I should be in the position to heal someone because I have Christ in me, and I'm loaded. Loaded with the power of the Holy Ghost. I don't believe that this sickness can affect me. I think that some pastors made an error in this, and they touched people and they laid hands on people.

Pastor S. talked about five of his colleague NPC pastors who died, the rumours that accompanied their deaths, and the communities' reactions to the deaths of several pastors:

..... to be frank with you, I knew them, and they were my closest friends. But I can't say what they were doing in their churches and homes, if they were laying hands on people or not. I had a friend whose wife was a nurse (a pastor friend), and apparently, she didn't know much, and she gave someone an injection and got sick and died, and her husband also died. Another friend, pastor, he was sick just a couple of days, and then he was dead. We tried to investigate what had happened. Some said it was Ebola, and some said it was "Africa sickness" witchcraft. But it all happened during the Ebola period – 5 pastors!

Pastor K was a well-known pastor who provided unity among Christian leaders who were interested in intentional fellowship together. He circulated widely during the outbreak, attempting to encourage NPC pastors to partner with the MOH and implement the recommended protocols. He talked about pastors believing that Ebola was purely a spiritual issue. He mentioned one pastor who was very vocal about his disbelief in the outbreak.

.... Pastors believing this was a curse, and some people believed that it was a curse but not from God, that it came from the devil.... There was a young pastor from the Eastern suburb of the city, and it was reported that he was on the radio and telling people that the disease was not real. ... and that people shouldn't fear.

When questioned, he said that this was happening sometime around August, a time of widespread Ebola deaths in Monrovia.

Pastor B was considered an influential pastor in the Pentecostal community. He was familiar with many of the NPC pastors in Monrovia and discussed his observations of some NPC pastors vis-à-vis Ebola containment protocols. He explained his thoughts on

their resistance towards the preventative measures, yet the contradictory behaviour he observed among some vocal resisters. He gave the following example:

...the theology, they believe in deliverance, that they were sealed, and nothing could touch them. That's what they believe in. But they all, even with that, there was still fear...because I visited a pastor's home, and he was admonishing his wife not to buy dry meat.

When seeking clarification, Pastor B explained that he had visited a pastor who publicly insisted that he could not be infected by Ebola due to his faith. However, at the same time, the pastor's wife was leaving to go to the market. As she left, he instructed her not to buy "dry meat," which referred to bush meat. This pastor had heard the prevention messages, some of which instructed the avoidance of bushmeat. Pastor B observed, "Yes, not to buy bush meat (laughs). You see, how can he be professing one thing....."

Pastor S told a story that seemed to support a societal expectation of hyper-faith on pastors. He stated when he saw a group of young men playing soccer, he mentioned to them that in the interest of Ebola containment, it was recommended to avoid public gatherings, "...and the kids said to me, "you are a pastor and you are for Ebola?? You have no faith!"

5.2.2.4 "Pastors are Dying!"

One theme that emerged from the interviews was the impact that the deaths of pastors had on communities. Thousands of people died from Ebola, in Monrovia[240], with the highest percentage being in New Kru Town and the surrounding areas. However, the deaths of these pastors seemed to be particularly shocking, as discussed by several interviewees.

Pastor S described walking through his neighbourhood and hearing people say, "oh, there goes another pastor. Pastors are dying." While many people were dying in that part of town, it seems that the deaths of pastors were particularly remarkable.

NPC member Felix supported this sentiment, saying;

Can you imagine, within the same New Kru Town belt we lost some of our key pastors? Those that preach the word of God, and I will say it, and it get to me VERY strongly. The first person that died that I knew of Ebola, was the late Pastor V's wife. When his wife died it draw my attention, 'what is going on? Can this common malaria kill?' Then it killed Pastor V himself, then it

started to kill some pastors them, great men them.... (he specifically names four other pastors)

Felix expressed how strongly the deaths of these pastors impacted him. His comment regarding how they "preach the word of God" implied a belief that these pastors should not have been vulnerable to illness. Even though Pastor V and his wife did not die until a couple of months after Ebola had entered Monrovia, he cited this as the incident that convinced him to pay attention to the outbreak. The story of Pastor V and his wife seemed particularly tragic to New Kru Town as several people, in different parts of town and on different days, talked about it.

A member of Pastor V's church, Louise, said:

Even one of my pastors, his wife had the Ebola because she, she was a nurse. And she told her husband, "don't touch me." He said, "oh honey nothing will happen." And he touched his wife. So, we were not taking preventive methods. We were not really believing it.... So, it was when it was getting worse and worse. So, when the Ebola came, we never really believed that Ebola could really destroy us in that kind of quick manner. We did not really believe it. He (Pastor V) died at New Kru Town. His wife died first before him. But when she was getting the sickness now, that's how he decided to hold her to pray. But by then he could pray without holding her. But since that was his wife, he didn't really believe that she had the sickness. Through that he contacted it and the both of them died.

Karen was an NPC member, although not a member of Pastor V's church. However, she talked about the death of Pastor V and his wife and the reaction of the community.

For Pastor V woman time, I can remember 2014, August 21st, the rain was falling heavy when her death news came. We ran there, the whole community ran there. Their house right behind this house you are looking at. Everybody ran there.

5.2.3 Research Objective #1: Summary Findings

NPC leaders and members supported one another's statements regarding their general responses to illness. The vast majority of both groups discussed their beliefs in divine healing and the power of prayer through the laying on of hands. However, they also stated that when necessary, they combined this belief with seeking medical attention from a healthcare facility or a healthcare professional. All were relatively vague on the criteria for deciding to seek healthcare. All pastors discussed their very active role in the health decision making of their members as they prayed for them and gave advice. NPC

members supported the importance of the pastor's opinions and prayers during times of sickness. They were particularly adamant about the power of the pastors' prayers. Their comments on the importance of his prayers revealed the high esteem that they held for the pastoral position, putting him akin to God. They expressed not only high confidence in his prayers but also his advice, including for health decisions. Many members commented that God spoke through pastors, lending considerable weight to pastoral comments, opinions, and counsel.

The vast majority of both leaders and members admitted to an initial reaction of disbelief when they first heard about Ebola in Liberia. Most did not attribute this disbelief to a religious reason but instead to an unfamiliarity with Ebola and a distrust in the government amid initial confusing messages about Ebola's presence and prevention.

All pastors and all but two members stated that once they saw the increasing number of Ebola deaths in their communities, they believed that the outbreak was a reality and implemented protective measures, both at home and in the church.

Two NPC members, belonging to different churches, had prolonged, if not terminal, disbelief in Ebola. One belonged to a church whose pastor implemented preventative measures and educated his members. This member was not able to verbalize why he did not believe but stated that it was not until he was infected with Ebola that he finally accepted its existence. This was approximately six months after Ebola had entered Monrovia. The other member never did come to a belief that the outbreak was a reality. She agreed with her pastor that the outbreak had never existed. Their disbelief centred on faith and included a disdain for the scientific preventative measures.

While all NPC leaders and all members, except for the two mentioned above, stated that they ultimately believed and implemented containment measures, there were numerous stories of other churches and members who refused to accept the reality of Ebola and who dismissed the prevention protocols, often leading to the death of the pastor, and sometimes others in the church. These stories all had a primary element of faith and the belief that God would protect and not allow them to be infected by Ebola, leading to a refusal to adopt preventative measures. Except for one NPC member, mentioned above, this resistance was always discussed as it pertained to others.

An unexpected theme that emerged was the shock over the deaths of these faith healing pastors. Several NPC leaders and members described not only their own shock and confusion at these deaths but that of the community as well.

5.3 Research Objective #2: Capture Community Opinions on the Actions of Monrovia-Based NPCs and their Leaders During the Ebola Outbreak

This section will examine the perceptions of NPC community members: individuals who lived or worked in the vicinity of an NPC but had no affiliation with the church. These observations will be compared to the descriptions given by NPC leaders and members regarding their actions during the outbreak, looking for similarities and differences in how NPC responses were described.

Thirty-three NPC community members were interviewed for this research. However, 23 of these self-identified as NPC members, leaving ten NPC community members with no affiliation with an NPC. While this lower number of NPC community members could be interpreted as a research limitation, this also supports the observation of the number of NPCs in the community and their high membership.

All community members commented on the prevalence of NPCs in their community. They all stated that before Ebola, these churches mainly interacted with and assisted their respective church members. They noted that when the churches were out in the community, it was for evangelism.

The prominent themes that emerged, as they related to this research, were that NPCs were generally not visibly involved in the Ebola response, with a few noted exceptions, and that NPCs viewed Ebola as a spiritual problem and therefore responded spiritually, via prayer.

5.3.1 NPC Involvement

All interviewees stated that NPCs were late in responding to the Ebola outbreak, and when they did respond, it was within the scope of their church membership. However, in terms of an NPC response on a broader community level, possibly in collaboration with the MOH and other international Ebola responders, almost all stated that they did not see a clear response, targeting the community. Several commented that they had either heard about a Pentecostal church community response on the radio or saw

individuals they perceived to be from a local church, passing out buckets. However, they could not specify the genre of the church.

Joseph stated that while he did not see any NPC responses during the outbreak, he heard one NPC pastor on the radio talking about the distribution of chlorine and buckets. He added that there should have been a more significant role for these churches, as there were so many in Monrovia, but acknowledged that often the government was not aware of their existence, saying:

There are churches that are established, and they (government) don't know about them. Just like today they decide 'I'm going to establish a church' and build a structure and 'this is my church.' I don't think they (government) know about them.

Paul stated that the churches he was aware of focused on educating their members. He noted that while a few went door to door to evangelize during the outbreak, they mainly took care of their own people.

If you go to the church, the church will tell you say, "we are hearing the information that when this person is sick don't go there." Even Pastors were warned not to lay hands on people when they are sick, yes to not to lay hands. So, they were passing the information around telling their members them, "stay to where you are, be careful, be careful..."

Barnabas talked about one NPC near his home saying:

They responded by giving their place as a meeting grounds for people to discuss (Ebola), and by sharing items and keeping Ebola materials. That's the work I saw from them. They gave their place as a storeroom for all the materials of Ebola crisis.

Most NPC community members had very limited perceptions of NPC responses. It seems that once there were high levels of Ebola infections in Monrovia, most people stayed close to home. Therefore, their impressions of church involvement were relatively limited to what they saw from churches in their immediate vicinity.

5.3.2 Spiritual Response

All community members mentioned the spiritual responses of NPCs, visible through increased times of corporate prayer. When asked to describe how NPCs responded, all mentioned prayer as the primary response.

Henry, himself a Pentecostal however not a member of an NPC, talked about general church beliefs:

Well, the churches, for us who were members of churches we were only believing in God that these things, it couldn't affect us because we were children of God. So, our lives we must just have trust in God. So, members of churches, we were not afraid of one another because we knew that we were not controlling our own lives only God. For me, I'm a member of the (names his church) church. We used to go to church, we be together, we pray to God, we ask God for healing and God carried us through.

5.3.3 Objective #2: Summary Findings

NPC community members who had no affiliation with an NPC had varying responses to the level of community involvement of NPCs during the Ebola outbreak. Their perceptions seemed to be based on the actions of the NPCs near their homes and were, therefore, somewhat limited in scope. While all noted that NPCs did not respond until Ebola was widespread in Monrovia, some stated that they observed or heard about churches handing out buckets and chlorine; however, they could not confirm that these churches were NPCs. Most stated that while they did not see an NPC response towards the broader community, they heard that NPCs gave Ebola prevention messages to their members, and they observed handwashing buckets at church entrances. This generally supports what NPCs had to say about themselves. All NPC pastors admitted that they did not take Ebola seriously until it manifested in Monrovia. None described engagement activities as going outside of their church membership, therefore possibly explaining community members' responses.

All individuals interviewed stated that NPCs engaged in a spiritual response of praying against Ebola and for protection from it. This supports the spiritual response described by almost all NPC leaders and members.

5.4 Research Objective #3: Gather Opinions and Observations from MOH Officials, NGO, and IG Organizations, and Healthcare Providers on Community Engagement Strategies, as they applied to NPCs and their Perceptions of the Role and Responses of NPCs

This objective will explore the observations and opinions of outbreak responders. The specific responders selected by this research included Liberian governmental and global intergovernmental responders local and international NGOs, and healthcare providers, all of whom were involved in the Ebola response and who interacted with and observed

NPC behaviour during the outbreak. Engagement strategies will be discussed, when applicable, to determine how these entities did, or did not, attempt to engage NPCs in the Ebola response. The semi-structured interviews of these demographics will be analysed for recurring themes regarding NPC engagement and responses during the outbreak. These responses and themes will be compared with the responses from the NPC leaders and members themselves and community members to identify commonalities or differences in perspective of NPC activities during the outbreak.

The abovementioned demographics will be discussed separately. The governmental and intergovernmental organization responses will be discussed first, followed by NGO responses, and concluding with local healthcare providers' observations. This section concludes with a summary of all the interview results for objective 3 and compares these results to key themes noted in objectives one and two.

5.4.1 Government and Intergovernmental Interviews

A total of seven individuals who were a part of the Liberian government public health sector were interviewed. Another individual was initially interviewed as a Methodist church community member but revealed during the interview that he worked in the government health sector. His interview covered his impressions from both viewpoints, as a government employee involved in the Ebola response and as a community member living near a Methodist church. This brings a total of eight Liberian government interviews for discussion. All eight individuals were Liberian and were present and working in Monrovia during the outbreak. Of these eight, four individuals voluntarily stated that they were NPC members.

Four interviews were conducted with individuals who worked for one of the United Nations intergovernmental agencies (IG). Three of the four were in Liberia at the time of the outbreak, and one arrived towards the end of the outbreak, approximately six months before Liberia was declared Ebola-free. Two were Liberian, one was from East Africa, and one was from a Western country.

The interviews from these demographics were almost unanimous in their agreement on the initial denial of the Ebola outbreak and the subsequent belief as Ebola entered Monrovia, and people began to see widespread death. This initial denial and consequent belief were reported to have been observed across most faith groups. There was also a

general consensus that most churches, including NPCs, ultimately came to believe in the outbreak and embraced the containment protocols. They confirmed that the measures implemented by these churches were similar to what the churches and members themselves described – handwashing, social distancing, and Ebola education during church services.

The prominent theme throughout the majority of interviews was that, compared to other Christian beliefs, NPCs were the most difficult to engage due to their beliefs in a spiritual cause for the outbreak, a belief in divine healing, and the belief that their faith would protect them from Ebola. Multiple interviewees discussed conversations with NPC leaders who believed that Ebola was the result of sin and, therefore a divine judgment on Liberia. Since they, as Pentecostal Christians, had not participated in this presumed sin, usually described as a sexual sin or corruption, they believed that they would not be affected. It was noted that these beliefs created obstacles to NPC engagement. There were also multiple observations that these beliefs and their accompanying behaviours such as the laying on of hands, seemed to facilitate infection and death. There were also a number of comments on the pastor's observed influence and the effect this had on church members.

5.4.1.1 Engagement Strategies

Several Liberian governmental health sector interviewees acknowledged that community engagement efforts were not initiated promptly. Most stated that community engagement protocols were not fully articulated and implemented until October 2014, approximately six months after the outbreak was announced and 4-5 months after Ebola had manifested in Monrovia. Religious leader engagement strategies, which included all religious leaders, were described as basic stakeholder engagement principles where community stakeholders were identified and invited to a stakeholder meeting. The invitation was usually in written or SMS form or announced on the radio. The same invitation was used for all, regardless of faith or leadership position. The stakeholder meeting was conducted by Liberian government Ebola responders, at times including representatives from key international partners. Most interviewees felt that the Christian church, in general, was well represented at these meetings but could not conclusively specify how many NPC leaders were actually in attendance. When there was a reported problem or resistant church, which was almost

exclusively identified as an NPC, that church was approached one on one by someone within the Liberian government health sector. This one on one method of contacting resistant churches was described in multiple interviews with the Liberian governmental health agencies but was not mentioned by the IG agencies. The LCC, which is the Liberia chapter of the World Council of Churches, was also discussed as a liaison between these government organizations and community pastors.

5.4.1.2 Difficult to Engage

A considerable majority of respondents stated that NPCs were the most challenging group to engage among the Christian demographic. While not all NPCs were difficult, and ultimately most did progress to belief and implementation of the containment protocols, almost all interviewed agreed that among the Christian demographics, they saw or experienced the most resistance from NPCs. There were also multiple stories of outbreaks and deaths that were attributed to this resistance and the often severely delayed acceptance of Ebola protocols.

Leila worked for the Liberian government and was herself an NPC member. She described some of the beliefs that she encountered as she attempted to engage NPCs in the Ebola response. She stated that although the churches she observed had heard the Ebola outbreak containment information, they chose to believe in God rather than implement the containment protocols. According to Leila, they determined that prayer would protect them from Ebola and heal those who were infected. Leila described these beliefs stating:

The Pentecostal churches, they were very, very tough at the beginning for them to believe...They were saying that God cannot send punishment on people that serve him. That was one of the reasons. So, if I am serving God nothing bad should happen to me. Everything that should happen to me should be on the positive side...even some pastors that died from it, and they didn't believe. They said that, "Ebola can't touch me," it can't harm them, but they died from Ebola...we had a church (NPC)...and they said they were not going to agree that Ebola was real, they were not going to wash their hands. They believed that they had a God, and they were going to pray to Him, and He would answer them, and he would heal them from Ebola, or protect them from Ebola. They believed in divine healing from Jesus Christ. They did not believe that we should wash our hands, that we shouldn't touch....

Koko, himself a Christian with pastoral credentials, talked about the extreme denial among many in the Christian faith. He noted that from the beginning, his experience was that Christians were difficult to engage. Some cited the fact that Ebola was not mentioned in the bible as their justification for disbelief. He specifically mentioned Pentecostals, stating that these types of attitudes were particularly prevalent among that Christian demographic. Their belief in divine healing and the laying on of hands made them particularly difficult to engage. He stated:

And some of the Pentecostal churches denied it from the onset... Denied, did not believe it. If I was speaking, and someone said, "there's nothing like Ebola. The God I serve says there's nothing like Ebola." For me, from the onset the Christian community was a little bit more difficult because of denial... Then the Christian faith, especially the Pentecostals. But it was common among the Pentecostals, laying hands "I rebuke it in the name of Jesus," and all of those things. And other pastors did it, they lay hands because Jesus said lay hands, so they did it. But more common among the Pentecostals.

Mark was a Liberian physician who worked in the Liberian government public health division. An NPC member, at one time he attended a Pentecostal bible school for pastoral studies. As Ebola spread in Monrovia, Mark went on the radio to discuss it and encourage the population to embrace the containment measures. He said that some Christians readily embraced the information given, but he faced severe criticism due to his support of the biomedical prevention measures, particularly from NPC leaders. Mark quoted these leaders, who accused him, saying, *"this man is not Christian. He is against the church. He's bringing a war against the church."*

Winnie worked with an IG on community engagement during the outbreak. As a Catholic, she discussed not only the difficulty in engaging NPCs but also the attitude that some NPCs had towards other faiths, such as her Catholic faith.

The Pentecostal/charismatic groups were more difficult to convince. I'm speaking from a general background in personal experience. So basically, they tell you from the Catholic church that you guys don't pray well...that the Catholics don't pray well. We don't rebuke when we are praying saying "Holy Ghost fire" and "heal right now" yeah, so they're like "you guys are weaker. You don't pray for hours, you don't pray well, so you are afraid, and you are weaker about this. This is a curse from somewhere. We have to pray; we have to rebuke." So, there were a lot of pastors from them (NPCs) that were accepting sick people

in the church. They were praying for people, and still having tarried all night, even after the government announced a curfew and no gathering.I know from my own background we stopped touching, we stopped attending the meetings, the regular women's meeting in the heat of the outbreak. But other churches...., they were still having meetings. They were still gathering the people at the churches to pray.

5.4.1.3 Beliefs Contributed to Infections

In discussing NPC resistance and the beliefs that contributed to this resistance, several respondents told stories of Ebola clusters that occurred, possibly linked to NPC beliefs and practices. Koko stated that while some NPCs denied the very existence of Ebola, others felt that they would be healed by the prayers of the pastor or a specific individual who was considered to have a strong prayer ministry. Due to the infectiousness of Ebola, this often resulted in deaths. Koko described the link between the belief in prayer and the laying on of hands, and Ebola infection, stating:

The others (some NPC adherents) felt that there was nothing called Ebola, they denied it. So, some went to the praying centres, and some pastors laid on hands, and this became something very challenging as well because this meant that the virus was passed to the pastors. In the ETU there were pastors in the ETU as well because some pastors got infected, some died. Because of praying and laying hands on people.... So that was a place where we had key issues, the Pentecostal pastors.

Lucy shared some similar observations. Her explanation went a bit further, saying that these church leaders did not see Ebola as a public health or medical problem, but rather as a spiritual problem. This line of reasoning led to seeking a spiritual solution, rather than a medical one. She explained this, saying:

After the Ebola outbreak was declared, some religious leaders believed that it was because God was angry with Liberia, and now sending a plague as a punishment because of the sins committed including corruption, and immorality - so they started promoting prayers to seek God's forgiveness through fasting, etc. Some church leaders were laying hands on people infected with Ebola, seeking healing which contributed to the spreading the virus to themselves, and consequently to their congregation. Several pastors died as a result. The difference in opinion was based on the fact that some religious leaders were in denial and were too slow to believe that the Ebola outbreak was a medical rather than a spiritual condition, and hence not supported the behaviour change messages.

Mark told the story of a prayer meeting that resulted in the Ebola infection of seven pastors and an unspecified number of church members. This provided another example of the belief in a solely spiritual response to Ebola and the resulting infections. This event took place in December 2014, approximately nine months after the Liberia outbreak began, and six months after Ebola appeared in Monrovia. He told the story as follows:

One of the biggest outbreaks I had to deal with was in Dec. 2014 from a church. This guy was sick, and the pastors laid hands on him, and they prayed for him, and he vomited on some of them. Yeah, it was late (in the outbreak,) and the thing that I felt sorry about was the senior pastor, the guy who laid hands on the guy was in the ETU and he was sick and dying, and I called him to speak to him, his wife had died. I called the pastor because it was my job to call them and get information to know if there were any contacts. In all seven pastors were infected in this group. They were Pentecostals. Pentecostals/charismatics. So I called the pastor and I said, "Listen here, can you give me more information of what was happening?" He said "Listen, don't worry it was an attack of the enemy because of our, God is taking us to a new level because of the prosperity of our bishop. This is an attack of the devil." I said, "you still believe that? Your wife died" Oh yeah, and he was in the treatment unit lying there between life and death. He still did not believe that it was Ebola.... the senior pastor was telling me that he didn't believe it was Ebola, that it was a spiritual attack.

Winnie and Jonas told comparable stories. Winnie said:

A pastor denied the issue of Ebola... and he had people in touching and praying for people. That it was some curse that people needed to be prayed for. So, he started praying for people, and then he contracted Ebola.....They were dying in that church.

Jonas cited a similar incident, saying, *"But many people got killed by Ebola from these churches (NPCs) and thing because some pastors were yet and still talking about believing in God and praying over people and thing."*

5.4.1.4 Fear Trumped Faith

Ebola responders noted the impact of these pastors' deaths as events that influenced people's willingness to embrace the containment protocols.

Bernard, who worked for the Liberian public health sector, observed that it was challenging to engage these pastors until they saw their colleagues dying. He stated:

...it was difficult to engage (the pastors) until they saw that the pastors started dying, and there was nobody to continue the healing process.... Seeing a pastor die, who was convinced in healing, that was enough to tell me that I need to listen to health.

When talking about NPC pastors, Leila stated, *“So, when they saw some of their pastor friends starting to die from Ebola, they started to agree to carry on the preventative measure to stop calling sick people into their company.”*

Pastors of the same faith seemed to take note of the deaths of these faith healing pastors. Leila's comments that these pastors stopped encouraging the sick to come to them for healing implies that up to that point, these pastors not only believed that God would protect them from Ebola infection, but they sought out sick people, perhaps as a way to demonstrate this faith. However, ultimately, fear trumped faith as the deaths of these pastors impacted their colleagues and members.

5.4.1.5 Pastoral Influence

Several participants mentioned the power and influence that pastors, and in this case, NPC pastors, had over their constituents. They described how this power impacted adherence, or lack thereof, to the Ebola containment protocols.

Koko stated that:

On the other side we had challenges because some of them (community members) believed in the faith-based aspect. That is that I have to go to my pastor I want my pastor to pray with me, I don't believe that this thing exists... most of the time the person believes in the pastor who lays (hands) and prays with you.

Leila supported this observation of trust in church leadership, saying, *“If he (pastor) said, “this is not truth, the Ebola team is not truth, what is happening in the country is not truth,” they will listen to him.”* And Mark stated, *“The few times I saw the extremes, they (church members) follow their pastor. It's really crucial (to engage the pastor).”*

The voices of Ebola responders who were health professionals, highly educated, and trained in outbreak containment, did not seem to have the same impact as that of the pastor. The pastor had to endorse the recommended protocols before most members would embrace them.

Johnson's observations supported the stories told of the others. He said, *“This is where those churches I'm referring to (NPCs), we had resistance because the pastors of the*

churches feel, "look, I can speak to God and God can heal you." And members of those congregations accepted it."

Johnson not only observed this pastoral power from a distance; he told a personal story illustrating the confidence and trust that members have in the opinion of the pastor and the importance of the pastor's engagement. An NPC member who worked for a public health department in Liberia, Johnson had immediate information on the outbreak. Due to his training and work with public health entities, he immediately believed the news and told his wife what was happening and what they needed to do for self-protection. However, his wife rejected the protocols saying, *"No, I don't believe that... believe in God and God will be our guide."* Johnson said that he did not force the subject as the situation was new, and information was evolving. At that moment, there were no cases in Monrovia, so he did not pursue the matter. However, he decided to talk to the pastor, thinking that he was in a position to educate the church, including his wife, at a very early stage in the outbreak. Johnson said that the pastor was very agreeable and stated that he would start making announcements in church. However, for unknown reasons, this did not happen. Approximately one month passed. By this time, Ebola had moved closer to Monrovia, and Johnson began to worry for his family, so he talked to his wife again about implementing the recommended prevention protocols. She said, *"But it hasn't been announced in the church. Until my pastor announces it, what you are saying to me – God will take control."* Taken aback, he approached the pastor a second time. Again, the pastor seemed very open to discussing it in church and assured Johnson that he would start educating his congregation, but it did not happen. Every time Johnson brought it up with his wife, she would say, *"Okay if that's true then the pastor will announce it in the church."* It took three conversations over a period of approximately six weeks before the pastor finally began to discuss the outbreak in church. One Sunday Johnson's wife came home from church saying, *"Oh, guess what happened?" what you told me about the disease, it's true."* When Johnson asked why she now believed she said, *"...today in the service the pastor announced it, that we should take precautions...it is real."*

5.4.2 NGO Responses

Seven individuals who worked with five different NGOs during the outbreak were interviewed. All were Liberian except for one who was from a Western country. Among

the seven, three voluntarily stated that they were NPC members. One was a physician who was working at a local hospital during the outbreak. When the hospital closed due to Ebola, he then worked with an NGO at an ETU.

The main topics that emerged from an analysis of the interviews reflected those of the governmental and IG responses. Challenging engagement, beliefs, and behaviours contributing to outbreaks, and the influential role of the pastor are the themes that will be discussed.

5.4.2.1 Engagement Strategies

A majority of interviews described engagement efforts similar to those of the governmental and IG entities. Stakeholder meeting invitations were usually written, messaged, or announced on the radio. All stakeholders were invited in the same manner. For the most part, NGO interviewees did not mention seeking out specific or resistant churches on a one by one basis. The exception to this were two interviewees, from two different NGOs.

Bernadette was a sociologist who discussed the nuances of approaching different stakeholders about Ebola. When asked how to approach a Christian pastor, she stated:

When you approach, you don't go with your emblems, you go casually, and then you ask to speak with the leader, you explain the reason you are there, and then you bring up a discussion about the context in general, and you ask for their view on what is going on and what can be done. And then, based on the response that you receive, then you can now devise some direct message for them. Because most of them tend to say what they think. Although there are some that will say something different than what they mean, most of them are honest. If you say, "so what do you think about the Ebola outbreak in general?" some will express fear. Some will express divine knowledge that is something.... So, our message was it is not wrong to practice your belief as long your belief does not affect someone negatively. So, if you wish to continue your spiritual treatment these are what you need to do.

She stated that while there were not many NPCs in the area where she worked, this approach successfully built relationships and gained trust. She also noted that similar to the statements by the Liberian government interviewees, community engagement started several months after Ebola had surfaced in Monrovia. Therefore, most of these

pastors had already seen many people die, including some of their colleagues, and they were relatively open to discussing Ebola containment protocols.

Alex, an NPC assistant pastor, worked with a different NGO. He also discussed the importance of using different types of messages, depending on the demographics. He discussed the importance of the elements of a stakeholder meeting for different demographics, saying:

We had different types of messaging and different target groups...So, to have given it momentum, with the messaging so that they own it we thought that the church, get to the pastors and church leadership, and give them this sort of awareness and they would be the first contact. Then you have this long list of followers that would indirectly be receiving the messages. Because again, the thing that you need to think about, very key, in working with the church, if you want to get to a pastor, you're better off working with a pastor. When you're working in a particular sector you need to understand the way they think and the processes to engage them and get them involved

Both Bernadette and Alex discussed the need to know their audience and use a strategy that accommodated the targeted demographic.

5.4.2.2 *Difficult to Engage*

Almost all interviewed agreed that NPCs were the most challenging group to engage, among the Christian churches. Becky was an anthropologist who worked for an NGO that responded during the outbreak. She was not Liberian and professed to be of Christian faith, although not Pentecostal. When asked if it was problematic to engage NPCs, she stated:

Some were and some were not. Some were like, "no we deny this in the name of, or in the blood of Jesus," or whatever. Like I was saying earlier, this one pastor who came to the ETU, he was a pastor of a church where a family went. This family had gone to Sierra Leone for a funeral and came back infected, then they went to Redemption hospital and some nurses were infected. But they also went to this church where, I believe, it was a Pentecostal church – I'm pretty sure it was – but they laid hands on the people. The pastor laid hands on them, and from what we understand they laid hands on them. And this pastor came in (to the ETU), of course he was so sick and between the doctor and me and others we were asking who else was with you? And he was like, "no, no, no, this is just malaria or typhoid," up until like the last hour before he died and he said, "yes people came in (to the church)

and I laid hands on them,” and then he died very soon.... It was just denial, pure denial. I think it was tied to his faith that it wasn't Ebola. I think that for the general Pentecostal it was the perfect storm because you have that denial that everyone was believing in but then you also had this faith that 'I'm praying against this sickness, I'm protected from this sickness, I will lay hands on people in faith knowing that I will not be touched and the blood of Jesus' It was the perfect combination and that's why it spread through the Pentecostal or charismatic churches.

She commented on the hyper-faith of Pentecostals, combined with the belief in divine healing and protection, calling it the "perfect storm" and attributing these factors to the high mortality and morbidity among this Christian demographic.

After telling a story about the difficulties of engaging a Muslim community, Becky was asked to compare engagement between Christian and Muslim faiths. She said:

I think there was a similarity. One was more difficult because they felt they were untouchable, the Pentecostals. They were like "hey we're going by our belief in name it and claim it, we're going to be fine." When we're faced with something that is so alien to us, we all go to our default. For the Pentecostal church their default was the laying on of hands and almost being even more charismatic, feeding off of that and saying, "we will not be touched."

Alex, himself an NPC assistant pastor, said that when he began working with engaging church groups, he used other supportive pastors to be a part of meetings. However, some attendees (NPC pastors) would say, "...you guys are pastors. Why are you promoting this evil and not the name of Jesus?"

Bernadette had some insights into the culture and beliefs of NPCs. She also explained the different expressions of divine healing.

There are several different kinds of spiritual healers, from what I noticed. You have one group that believed strictly in prayers. That is, they do more prayers, and maybe laying of hands...they are charismatic. They also fall in line with the self-inclined churches as well. That is those that just decide to organize. Then you have churches that are quote/unquote, that have spiritual houses that do strong spiritual intervention. They are one group. You have prayer, you have study on Sunday classes, and other things, then you have another group that has spiritual healing houses. So, you have a church, and in the church is a compound or a separate house, and in the house you have sometimes up to 30 or more persons, based on the popularity of the church, you have several

persons that are living in the church compound and are giving spiritual treatment...divine healing and spiritual intervention. Also, for our Pentecostal churches, I have noticed that they have evolved. Instead of just prayer and laying hands, some people use water and salts and other spiritual items. But basically, those churches with many outbreaks were the ones that had the healing houses. They were difficult to engage, and some even believed that they had the ability to heal Ebola. Some will express divine knowledge that is something.... like think it's (Ebola) because of sin or Liberians are being punished.

Michael, a Liberian physician who worked at an ETU, observed these pastors and prayer teams, saying, "They would come to the ETU, and I heard them say things like, 'God has given me a dream and given me the cure for Ebola, if you let me I'm going to pray for all your patients and they will get well.'"

When asked if these churches eventually adopted the containment protocols, Michael said:

But at the same time there was still a few churches here and there who still firmly believed that it was some kind of divine illness, and they were still praying for people. And there were times that you saw a group of members from church, and their pastors, a prayer band, like we talked about, coming to the ETU to pray for people, the entire group would come. Those were mostly Pentecostal churches; they were the most resistant.

Eleanor was the only NGO interviewee who stated that she did not experience resistance, from any Christian group, during community engagement activities. A Liberian working with a local NGO, Eleanor felt that she had strong relationships and trust with the Christian churches where she operated. She stated that she did not experience any resistance from them. Like the others, Eleanor agreed that community engagement activities were slow to start, citing her involvement beginning around August 2014, after many communities had started experiencing high death counts.

5.4.2.3 Beliefs Contributed to Infections

Multiple NGO workers had stories of outbreaks occurring due to these beliefs and the activities that often accompanied them. Becky talked about one outbreak story she observed through her work with contact tracing. She described the prayer rooms and the conditions during prayer for a woman who was sick with Ebola.

But one specific lady, before she even got to town she went to another town, and there's a very charismatic, Pentecostal type of

church, and she went into their prayer room – and this is a very small room, like maybe 10X12 (feet) if even, it is really small. I can't even imagine, she was wet symptomatic because I talked to the pastor and he said that yes, she was vomiting, she was sweating, she's complaining of her stomach and having a runny tummy and they were helping to clean her up. So that pastor got sick and he infects his son. That whole community, just from that one act, there were 27 people who were infected, 15 died and 12 survived, they laid hands, from what I understand sometimes they get so emotional they're literally laying over the top of the body, praying, leaping over the body so you have all these liquids, it's a mess.

Becky's story described the small rooms used for these prayer meetings and the circumstances of high infection risk as multiple people crowded into these rooms, with sick individuals experiencing active symptoms. Through her NGO work with contact tracing, she determined that this one incident resulted in the infection of 27 individuals.

James was a healthcare professional who was initially working at a local hospital when Ebola manifested in Monrovia. After the hospital had to close down, he was hired by an NGO. He told the story of a hospital patient who died from Ebola. A nurse who cared for this patient became ill and refused to go to an ETU, insisting on going to her church for prayer. He said:

So, the church accepted her because her belief at that time was that what happened to her was not Ebola, but someone had bewitched her so with prayer she would be free from that. So, she went there, the pastor's wife, all the leaders in the church started to pray for her... So, because she had that disease all of those team, all the members of the team that were on that prayer team, came down with the disease.

Michael told a similar story:

I know in one community there's a church where the pastor and all the members got sick, not the members but the members of the prayer team got sick, and in fact that pastor died. I don't know if the members died or not, but that church right now has shut down because key members died. So, the key leaders of the church died, they are all gone. And there is one church in Central Monrovia where one of the young pastors, his wife died, and one of the team prayer members who are involved in some healing got sick, and they were taken to my ETU. There is also another church and the same thing. And the members visited my ETU. So, there were a couple of Pentecostal churches that did that. They didn't believe that there was a medical solution. They needed a supernatural, religious intervention.

5.4.2.4 Pastoral Influence

NGO staff also observed the power and influence of NPC pastors. Alex worked with an NGO during the outbreak but was also an NPC assistant pastor. Despite his role with an NPC, he noted:

What we have here, specifically in Africa and certainly in Liberia are church leaders. And especially Pentecostal church leaders are very powerful. Yes, they are very powerful in the sense of having so much authority...in the church and the community. People in the community are who go to the church.

Bernadette worked in community engagement during the outbreak. When asked if she had observed that NPC members followed the beliefs and responses of their pastor or not, she replied, "*Sometimes you have some religious groups that the members may have a contrary view but most of them listen directly to the religious leader.*"

Michael summed this up by saying:

I think pastors enjoy a special kind of influence on society... their pastors (NPC) are really influential, and their members, you find people who will take a significant portion of their savings, and even the poor, and give it to their churches. They really support their churches. Just a lot, because pastors really wield a lot of influence.

Victor noted the death of a pastor as a serious event in the community. Victor was an NPC member who also worked with an NGO. He said, "*And there were some cases where some pastors even died in the process. If kind of started to send down some very serious messages to those who were not complying.*"

5.4.3 Healthcare Workers

This section will discuss the results from the eleven healthcare workers interviewed for this research demographic. It will begin by describing their particular demographics and continue by identifying the primary themes that emerged from their interviews.

Eleven healthcare workers were interviewed. Three of the eleven stated that they were NPC members. Their interviews are discussed in both the healthcare and NPC member demographics when deemed appropriate by the PI. One healthcare provider, Michael, was a physician at a local hospital when the outbreak started. Ultimately this hospital closed, and he subsequently worked at an NGO-run ETU. Michael's observations are discussed from his position as a local medical doctor and from his NGO work. Except for

Michael, all the healthcare workers interviewed were registered nurses (RN) or nursing assistants. They all worked at local hospitals or clinics the New Kru Town and Caldwell neighbourhoods, and most referenced attending a church or residing in these areas.

Primary themes that emerged from these interviews were engagement and the impact of beliefs on engagement and Ebola infections.

5.4.3.1 Engagement

Almost all interviewees stated that specific Christian churches were more challenging to engage than others. Most of the interviewees were not familiar with the various types of churches and could not conclusively confirm whether or not a church was an NPC, according to the definition of this research. However, as they described these churches' behaviour and beliefs, their descriptions matched those of Liberian government, IG, and NGO comments when discussing NPC behaviour during the epidemic. Their perspectives were from the viewpoint of what they observed of these churches and not actually from trying to engage them, as the community health centres were not the primary conduit for eliciting community engagement.

Joy was an RN at a local government hospital. She described some of the Pentecostal church responses that she observed:

Pentecostal Churches, they don't have the believe that there is a crisis going on. Their belief is witch, prayers. They want to get into prayers...that witch so they got to...they will pray for that person to come up. They will not want to go to the hospital for them to seek medical advice or medical treatment. They will want to do some prayers at home or to the church, fast and pray so their person can get well. So, it, it's a bad notion on the Pentecostal side, the churches. Bad notion, they had a bad notion that "oh I'm sick so that witch". Even some of them when they carry them to the hospital they will be crying "carry me to the church I want to go to the church for prayer. That not, that not medical sickness that spiritual sickness. So, I'm going to the church.

Joy's story centres on a Pentecostal church member rather than a leader. Her comments contribute to the bulk of individuals who observed the belief that Ebola had a spiritual cause, which necessitated a spiritual response, therefore bypassing a medical response. As an RN, she identified this as a "bad notion." She described an individual who was so passionate about this belief that, as he/she was being carried to the hospital, itself a

risky behaviour during an Ebola outbreak, the patient would be resisting, insisting that the illness was spiritual and that the cure was to go to church.

Enoch, also an RN, worked in a community medical clinic. He stated:

Yes, some churches will tell you, or some pastor will tell you when you go to do deliverance on the field, or the health centre do not touch. Just stand and just preach and you go. But some pastors refused. Some of them refused. They will go, they will touch, they will anoint. And the rule says once the person is ill do not touch with your bare hands. But being a man of God who so believe that there is nothing impossible without God, they began to touch.

Mary told a similar story. An RN at the local, government hospital, she stated:

So, some of them have their own belief that it was not true, but yet them still they were still spreading the message around. Yet them still some of the pastors were still coming wanting to touch patient their own belief they said, "Ebola was not going to kill them," in fact, Ebola was not true, they didn't believe in Ebola at all. Some of them, yeah some of our pastors did that. Several times they came here we told them not to do it. They want to be touching patient, to be praying, we say, "no do not touch the patient," they didn't believe so they had their own belief that yes maybe their belief saves them, but some of them died also in that process.

Mary's comments support Enoch's observation of a belief system that pushed believers to go against the guidelines. It also demonstrates that there were pastors who appeared compliant but refused to apply the information to themselves.

While acknowledging that some churches were resistant to protocols, Mary was generally quite positive on the general church response and even alluded to the churches being a reason the outbreak ended, by saying:

They, they used to spread the message through their sermons which helped people that and you know, wash your hands, when somebody is sick do not touch them, call this so, so and so number that this person is sick, let the people be responsible to take them, so I guess they have major role in that...in bringing the Ebola to an end.

Gloria and Elizabeth were the only individuals who did not state that some churches were resistant to the outbreak containment protocols. Elizabeth worked at a local clinic while Gloria was an RN who worked at the government hospital. Gloria stated:

...my area I saw they (churches) were responding at the same time because even the, the churches that were around my area the same precaution we were taking they were also taking that same precaution. You could see the handwashing, measure was there where in especially for my church we sit on benches the benches were sometimes we can be four, five. During the Ebola they make, they make them three. Three persons sit on a bench.

Gloria did not mention the name or genre of her church or that of the churches in her area, making it difficult to assess whether this was a denominationally driven reaction or if she just happened to be surrounded by more compliant churches.

All interviewees stated that ultimately most churches did adhere to the containment protocols, although some took longer than others to do so. The most frequently mentioned reason for ultimately accepting the protocols was the death of a family member or close friend. Once compliance occurred, responses were described as handwashing stations, discussing Ebola containment during church services, social distancing in church, and encouraging members to call the Ebola hotline number if there was a suspected case.

Most respondents noted that while most churches ultimately did engage with the containment protocols, their engagement was purely in terms of educating their church membership. Most stated that they did not observe or were not aware of churches partnering with the broader governmental and NGO responses. Most stated that they did not see church leaders or members helping to educate the broader community. However, Michael, who ultimately ended up working with an NGO when his hospital closed during the outbreak, noted in Monrovia, that widespread community engagement was not well coordinated until sometime in August 2014.

The exception to this observation was Elizabeth. She felt that churches were involved in the broader response saying, *“The churches have leaders. So, people have like, like within the Ministry of Health, even if they gather information there, they can go to the church. Every one of them can meet and discussed before they can come up with solution. They worked together.”*

5.4.3.2 *Beliefs Contributed to Infections*

While discussing beliefs that seemed to contribute to a rejection of Ebola protocols, several interviewees mentioned that some of these behaviours and beliefs seemed to spawn more Ebola cases.

Teta, another RN from the government hospital, said:

... (some churches) tried to overlook things and say, "maybe this thing that spiritual thing your let's pray for the person," they started praying, laying hands on the person, coming in close contact with the person, and they die. ...this person here sick, and then they never told them to carry the person to the hospital and the pastor decide to pray and members of the church decide to come in close contact with the patient to pray for the person, all of them got affected and they died. I know in one community there's a church where the pastor and all the members got sick, not the members but the members of the prayer team got sick and in fact that pastor died. I don't know if the members died or not, but that church right now has shut down because key members died. So, the key leaders of the church died, they are all gone. And there is one church in Central Monrovia where one of the young pastors, his wife died and one of the team prayer members who are involved in some healing got sick and they were taken to my ETU. There is also another church and the same thing.

Joy concurred with Teta's observation, stating:

....they themselves later on they start responding that how even most of them, most of them even died from it because when they go they say that witch they will go pray "let's pray, let's pray" touching one another but when they got to know that most of them were dying that how they believe, they got to know yes it was Ebola because they believe that it was Ebola. So, they started taking precaution.

Enoch told the following story:

...a man of God left from here and went to do a little deliverance to one of the church members. Unfortunately, he came down with the Ebola virus. And when he got back people began to say it was not Ebola virus. It was this, this...this in fact was not Ebola it was a curse and this that until he died. And when he died, some of his members also the followers of his now, they were also backing saying it was not Ebola. At the end of the day, that church became vulnerable and lost more than ten members.

5.4.4 Objective #3: Summary Findings

Across all interviewees, across all interviewed demographics for this objective, almost all agreed as to the prevalence of NPCs in Monrovia. There was also widespread agreement regarding the initial generalized denial in regard to the Ebola outbreak. This denial was described as affecting most demographics, including all religious groups, during the early stages of the outbreak.

As the outbreak progressed, however, NPCs were characterized as the most resistant Christian group, particularly by those who responded to the Ebola outbreak at a macro level, working with diverse programs across multiple communities. This would include the Liberian public health sector, IG agencies, and NGOs. Interviewees whose perspectives were primarily limited to the community level generally supported this observation, however, not as unanimously or strongly. When discussed, this resistance was described similarly across demographics. It was characterized as refusing to believe in Ebola or believing that Ebola was a punishment from God, believing that as Pentecostals, they could not be affected by Ebola or the belief that Ebola could be healed through prayer and the laying on of hands.

All demographics interviewed told multiple stories of how these beliefs seemed to contribute to Ebola infections and deaths. Stories generally centred around the belief in divine healing, which required prayer accompanied by the laying on of hands. Those who were frequently mentioned as being infected with Ebola or dying were pastors, pastor's wives, and prayer team members. Several stories described the infection and deaths of individuals even further distanced from the prayer event.

Almost all interviewees stated that a vast majority of NPCs ultimately engaged with the Ebola containment protocols, citing the deaths of pastors and church members as the primary reason for this compliance. Once these churches engaged, all described the same engagement activities that they observed happening in NPCs, including Ebola education by the church or pastor, handwashing stations at the church, and a policy of no touching during church services, supporting the descriptions of NPC pastors and members. Most interviewees also described increased times of prayer as a common NPC response.

Almost all interviewed, across all demographics, stated that NPC engagement focused on their own church members and that they saw no NPC engagement in collaboration with formal community engagement responders. A couple of community members described a few local churches helping with the Ebola response in their neighbourhood, but they could not confirm that these were or were not NPCs. One community member did state that an NPC located by his home opened up their facility for community meetings and the storage of Ebola supplies.

Multiple comments, across all demographics, referred to the influence that pastors had over their membership. Interestingly, these comments did not come from NPC community members or healthcare providers, whose perspectives seemed to be derived from a strictly community level. These interview demographics did not deny or agree that pastors had this influence; they simply did not allude to it. However, many interviewees who responded to the outbreak on a larger scale, those associated with the government, IGOs, and NGOs, alluded to it. One healthcare interviewee also contributed to this discussion, and that was Michael. Michael was an outlier in the healthcare interviewee pool as he was highly educated, a physician who started out working in the government hospital and ultimately worked in an NGO-run ETU. These individuals noted the influence that pastors had over the decisions and opinions of their members. Most stories were told within the context of members insisting on following the advice and adopting the beliefs of their pastors vis-à-vis the Ebola outbreak response, despite the advice from outbreak experts. These observations align with comments from NPC pastors and members.

Overall, all interviewee demographics discussed in objective 3, strongly aligned with one another in terms of observed resistance from NPCs, beliefs that contributed to this resistance, and stories of how these beliefs possibly created chains of Ebola transmission. All agreed that NPCs were generally late to engage, but ultimately most did, and all described similar engagement activities.

Most of these observations also strongly aligned with the NPC leader and member comments. NPC leaders and members admitted to a generalized, initial denial of Ebola, but stated that they ultimately recognized the reality of Ebola and embraced the protocols. They described handwashing stations at church, giving Ebola information during services, increasing prayer meetings for the country, and changing elements of

their meetings to prevent touching. These are the same engagement behaviours described by the other interview demographics. The NPC leaders and members discussed a primary focus being on their own membership. A few NPC leaders and members stated that some members were a part of the formal community engagement teams. This participation was usually NPC members who were healthcare providers.

NPC members and pastors also agreed on the element of pastoral influence. While this was discussed from a different perspective, all described the same phenomenon. NPC members described their trust and adoration for the pastor and the importance of his prayers. NPC pastors also discussed the confidence that their membership had in church leadership, and several commented with confidence that their members followed pastoral recommendations.

The one area where there was not general alignment was in the area of NPC beliefs and how they did or did not contribute to resistance to protocols and possibly contribute to Ebola transmission. NPC leaders and members quickly discussed their beliefs in divine healing, the power of prayer, and the laying on of hands during prayer. However, they were less inclined to discuss a personal belief in divine protection. Some NPC leaders discussed the Ebola deaths of their colleagues with apparent sadness and confusion about why they died. However, they did not attempt to connect any NPC belief with possibly contributing to these deaths and infections. There were also a few NPC members who discussed the deaths of some NPC pastors. The members who discussed this tended to describe the events a bit more clearly, alluding to a disbelief that those sick pastors had Ebola and general confusion and fear when they ultimately did die.

5.5 Research Objective #4: Compare NPC Ebola Responses with Responses of Another Christian Denomination

This section aims to explore the response of another Christian church group to determine if other Christian groups had similar beliefs and reactions to the outbreak, or if NPC reactions and beliefs were relatively unique. Leaders, members, and community members from two different Christian church groups, Catholic and UMC, were interviewed.

This section will discuss the prominent themes that emerged from the data, as they pertain to the research objective and questions, first for the Catholic group and then for the UMC. Themes and comments from these groups' leaders, members, and community

members will be discussed. The section will conclude with a summary of the results and a comparison of the responses to NPC responses, described in the results of research objectives 1-3.

5.5.1 Catholic Church

Three Catholic church members were interviewed for this demographic. Additionally, one healthcare provider, one NGO interviewee, and one individual who worked for an IG stated that they were members of the Catholic church. Their interviews, as they pertained to their first-hand observations of the church, will be included in this section, bringing the total interviews of Catholic church members to six. Five individuals who lived near a Catholic church were also interviewed as Catholic church community members. Of these five, four self-identified as NPC members. Themes identified were the Catholic church's role in the community, primarily via health centres that were in existence before the outbreak, and the Catholic church response to the outbreak. It is of note that no interviewees discussed Catholic beliefs as they would pertain to health decision making.

5.5.1.1 Catholic Church Members

All Catholic church members interviewed stated that before the Ebola outbreak, the church was active in the community and was involved in the health sector. Members discussed a Catholic hospital as well as multiple church-run health centres. All members stated that when sick, they went to the hospital and that this was encouraged by the church.

When asked if other churches in the area were involved in the community, Tuli, an RN, stated:

Well, I don't know for other churches but for my church, the Catholic Church that I'm in... we play a major role when it comes to health. That is, we have a health initiative group within our parish, before even Ebola but it really got effective during Ebola but before Ebola, we had our church health team right outdoor. Every Sunday morning, they change, another group will come and do blood pressure, blood sugar yeah for the, the members in the church every Sunday and if somebody has fever, we will attend to them...

Winnie, who worked with an intergovernmental organization during the outbreak, was asked to describe her church's involvement in the community, vis-à-vis NPCs. Stating that she was a Catholic, she said:

...I'm from the Catholic church, so very different. It was very different because even in Monrovia we have our secretariat, we have the whole health system. They do health education ... Before Ebola, they were already involved in health education through the radio station...

Tuli and Winnie both referred to church-run health initiatives that were in place before the Ebola outbreak. This distinction is notable in comparison with NPCs, as no NPC leader, member, or community member discussed any regular health initiatives by their church.

Most Catholic church members spoke with pride about the active role that their church had in the community. Patrick stated:

But then I really admire the way they handle charity, yes carrying on charity process for the needy and the sick. And this is what really can give me joy and make me happy. I like to see my church helping disable people.

All Catholic church members described a church that was not only active in physical health education and response, but one that carried this activity beyond their church walls and out into the community, and all interviewees gave their church high marks for their Ebola response. Sarah stated, *"...during the outbreak the church was able to visit...the church did extremely well...the victims the Ebola victims; the church was able to take food to take clothes to them. They did extremely well; food, clothes, and medication."*

Isaac, another Catholic church member, said that his church was very proactive in Ebola education, *"Education, educating us...education oh as I tell you the team that team they come from Kenya if I'm not mistaken. On Sundays some Sundays they can come, and they tell us this is what we do, this is what we do."*

Winnie noted that her Catholic church was quick to follow the outbreak containment recommendations, which included a curfew and prohibited no large public gatherings. She compared that to the responses of several NPCs, stating:

So, there were a lot of (Pentecostal) pastors from them that were accepting sick people in the church. They were praying for people and still having tarried all night, even after the government announced a curfew and no gathering. They were stillI know from my own background we stopped touching, we stopped attending the meetings, the regular women's meeting in the heat of the outbreak.

Patrick had an opinion as to why the Catholic church was quick to enact Ebola containment measures. He said, *"Ebola was not spiritual aspect. It was physical. So, we (Catholic church) were taking his preventive measures (health minister). We had trust in him. We were looking up to the medical team from the health ministry."*

5.5.1.2 Catholic Church Community Members

Interviews were conducted with five individuals who lived or worked in the vicinity of a Catholic church. When asked what churches in his area did in the community, Jeremiah, himself an NPC member, said, *"Well, there are a number of these churches helping the community like the Catholic Church, the Catholic church is one of those churches that is helping the community."*

Jeremiah was an NPC member who lived close to a Catholic church. When asked about general church involvement in the community, he did not discuss his own church; however, he did mention that the Catholic church was involved in the community.

Most community members either talked exclusively about their respective churches (non-Catholic) or stated that churches, in general, did little in terms of actively helping the community. Interviewees also noted that they did not know how these churches responded to the Ebola outbreak, except to fast and pray.

5.5.1.3 Summary

Prayer and faith beliefs were not discussed by Catholic members and community members, as they related to general illness perception or as they related to Ebola outbreak perceptions.

All Catholic church members discussed the church's involvement in the community, mainly in the form of health education and church-run health centres. All also felt that their church had a valid and community-based response to Ebola.

Most Catholic church community members did not discuss the Catholic church in terms of community involvement or the Ebola response. While this perception is in contrast to

the opinions of Catholic church members, it does not necessarily directly contradict member descriptions of their church's response to health and Ebola. Most community members preferred to discuss their respective churches or spoke so generally about all churches in the community that it was difficult to link their descriptions to the Catholic church.

5.5.2 United Methodist Church

Four UMC leaders were interviewed, including two lay leaders, one assistant pastor, and one board chairman. Interviews were conducted with three UMC members and five UMC community members, among which one self-identified as an NPC member.

5.5.2.1 UMC Leaders

UMC leaders did not elaborate on the regular community involvement of their churches, except for Esther. The chairwoman for her UMC, Esther, stated that the church's motto was, "*The church in mission with the community at heart.*" She described the church's role in the community as follows:

Well, the role of the church should be the light. People should see positive things positive things that we do so that they will know that we are we are different from the world. So, the role of the church is to preach positive messages and to touch the lives of people in the community.

However, UMC leaders felt that their churches responded well to the Ebola outbreak.

Nixon said:

As a pastor I mobilized my members, and we used to have health talk yes creating awareness. We go in the community and you know, tell the people about cleanliness, personal hygiene and you know. And then to look out for signs and symptoms of would be Ebola patients yeah.

Esther also felt that her church had an excellent response to the Ebola outbreak.

When Ebola first started, we came out with our training. We came out with the handwashing stuff and we did our first-hand education. We did it down. We did it one on one. We did it from the pulpit. And not just that we, we verbally said it, but we practically demonstrated it by having the handwashing tools. We bought some supplies and we gave it to members of the community. The radio had this program and our Global church the United Methodist Church also had programs and activities on this Ebola, spreading awareness messages and all of that. So, we had

a global surrounding of messages that helped us in that light.... as the outbreak progressed, we did not only go to our members again, but we went beyond the local church to other members of the community trying to meet their need of the hygiene aspect of it, chlorine, the bucket and teaching handwashing and other things.

Jonathan explained how the UMC network passed the information:

Well as far as my memory can serve me partners did not come to us here, but they did it to our headquarters on twelve street. Yeah, they did it through our headquarters. When they knew that this virus was very deadly, they organized themselves to educate members of the local churches what to do and what not to do. So, these people came down to us. They brought some should I say solvents. Well I don't know, chloride, soap the rest of it. They brought some food stuffs as well. And they distributed it and lecture us.

Jonathan's description demonstrates a communication strategy where Ebola educators and responders started by going to the church denominational headquarters. Through that process, that not only information but also supplies were passed down to the local churches.

5.5.2.2 UMC Members

All UMC members mentioned their church's role in the community. Most described church outreaches, visiting the sick, and at times taking offerings to assist in health expenses for nonchurch members. Adam described this by explaining:

Yes, for example, when you're sick, you're not forced to be part of our church...when we get to know that you're sick in the community, the church pays visit. And in that visit, they carry things that you need for your illness. Like for example, sugar, tea, small, small things them that you need. If they feel that your sickness still going on, they give you small thing and take you to the hospital.

This broader community outreach was also evident during the Ebola outbreak. When asked how his church responded during the outbreak, Zachary said, "*The church itself went and bought some tie soap. Chloride, things and things them and gave it to Redemption hospital.*"

In describing his church's response, Adam stated:

.... Well for my church I will say they did well. The pastor was here he was like preaching on Ebola. The whole church was like scary.

We did Ebola awareness and we brought buckets. We shared it with the people that in the community that needed. We brought food. People that needed it in the community we gave it to them. People that were victims we supported them... The church did well. I must commend the church. The church did well.

Laura explained her church's response saying:

They always used to educate us when we go to church. When we used to go to church, they will say two persons on a bench. We shouldn't be three to four on one bench because that benches we got in the church. So that two persons that two persons used to be on the bench. And they used to tell us always we must be in long sleeves. So, we always used to be in our long sleeves whenever we go to church. We went around in the community. And we began to educate people how to get around people for Ebola. We should be very careful, for the Ebola sickness is real.

Jonathan described a similar community-oriented response, saying, *"We went around in the community. And we began to educate people how to get around people for Ebola."*

5.5.2.3 UMC Community Members

UMC community members were divided in terms of how they perceived UMC church roles in the community. Some community members wanted to discuss their own churches (not UMCs) and did not have information on UMC activities. However, several interviewees discussed their views of UMC involvement in the greater community.

Cecile stated that she went to a prominent member of the local UMC when she needed health advice. Cecile was not a UMC member but stated that this woman was always willing to help her. Cecile also commented on church-run schools as a way these churches contributed to community life. She stated, *"The churches here, some churches get school, like the Methodist got the school."*

Jonas also felt that the UMCs helped in the community. He stated, *"We have the Trinity United Methodist Church... always helping with some medical relief items and things whenever it comes."*

Able, interviewed as a UMC community member, actually mentioned the Catholic church when asked how churches in his community responded to Ebola. He had this to say about the Catholic response, *"Yeah, we have the Catholic institution also involved in such acts and other churches in the community also help less fortunate people in the community."* Able did not mention any UMC response to Ebola.

Some community members interviewed discussed the UMC Ebola response. Cecile stated, *“Yes the Baptist did it. The Methodist (UMC) did it. They did...they gave us Ebola bucket with chloride, tie soap and they even gave chlorine. The churches gave it. The churches divided Ebola materials.”*

Seth could not describe a UMC community-oriented response but did note that he had seen NGO workers at a UMC church near his home. He stated that the church had invited these workers to come and talk about Ebola.

Several others mentioned an adequate response by all the churches in their neighbourhood. They usually described this response as an increase in prayers. The majority of UMC community members interviewed could not give specific examples of UMC involvement.

5.5.2.4 Summary

As they pertained to illness perception and outbreak perception, faith beliefs were not discussed by UMC member or by UMC community members. Prayer was mentioned as a broad response by most churches but was not described as a primary UMC response.

A majority of UMC leaders and members discussed the church's' community programs in terms of health education and church-run health centres. They also expressed satisfaction with the UMC Ebola response.

UMC community members were divided on the visibility of the UMC presence in the community and during the Ebola outbreak. A few commented on the UMC presence in the community and were aware of Ebola responses. However, an equal amount stated that they were not aware of any community program or Ebola responses, other than to mention that all churches, in general, were praying during the outbreak.

5.5.3 Other Demographics

During all other interviews, some individuals spontaneously referred to reactions and responses by the Catholic church and the UMC. These comments fell mainly in two categories, with the first being community level observations of Catholic or UMC involvement in the health of the community and the Ebola outbreak, and the second being outbreak responder observations regarding what types of churches were or were not easy to engage.

5.5.3.1 Community Level Observations

Several individuals who were interviewed under different targeted research demographics voluntarily mentioned the Catholic and/or UMC church's involvement in their community's health.

Eleanor worked for a local faith-based NGO. When asked about churches that had specific health, she described the hospitals and health centres, run by the Catholic and UMC churches.

Felix was an NPC member. He compared NPCs and their responses to health issues with that of the Catholics, saying:

If anybody is sick, they (the Catholics) will say, 'oh let take this person to the clinic.' For now, only the Catholic churches, the, the Inline churches are doing it, but the Pentecostal churches they are not doing it especially the Kru churches that surrounded us, the, the Charismatic churches they are not thinking on it.

While Felix was a member of an NPC, he noted that NPCs did not typically access health facilities but instead relied on spiritual responses to health problems. He compared this to the Catholics and other "inline" (mainline) churches that would take their members to clinics or hospitals.

Joy, an RN who did not state any church affiliation, felt that NPCs should be encouraged to participate more in the medical aspect of community life, following the Catholic's example. She stated:

I would like to recommend those that getting in closer, getting closer to the Pentecostal Churches at least they should give them medical advice, medical education, they should educate them on the medical side. They should even select people to be... to select team within the church to give them that medical eh...advice and you know to teach them to give them the knowledge like to, to tell them they should get medical team in the church. Let them get medical team. Like Catholic Church they get their medical team. So, in case anything they can go and give awareness on, on illnesses even in crisis.

Tuli, who self-identified as a Catholic church member, was another RN who worked at a local health facility. When asked to describe local church roles in community health, she said, "Some other churches can take the initiative like uh...how you called it the Catholic

Churches, the Methodist (UMC), I have seen them doing a donation before, come around to pray for patients.”

Tuli mentioned both the Catholics and UMC in terms of being involved in illness by sending individuals to health centres and helping with healthcare finances. She was also one of very few who mentioned prayer as a Catholic or UMC response to illness.

In terms of the Catholic church or UMC and Ebola responses, several community-level interviewees discussed these churches. Eli was interviewed as an NPC community member who did not state any specific church affiliation. He said that the only church activity he observed during the outbreak was that of the Catholic church handing out supplies.

When asked about churches and Ebola, Joy, an RN, said:

...yes, because the Catholic Church, the Catholic Church, the pastor, their priest, their priest reported I can remember mm hmm. A member sick the priest will go and report. Sometimes they themselves used to carry their patient.

Louise was an RN who worked at a local health centre. An NPC member she was asked about local church responses during the outbreak. Rather than talk about her NPC she described the actions of a Catholic priest saying;

This Catholic Church, the father that was here was one of the strong persons helping in that direction. Whenever he hears say so, so and so even if you are not in his church and you are old, and he find that you are in that situation. There is lots of other risk he took because he had his pickup. He will help family.

Karen was another NPC member who discussed the help she received from the UMC during the outbreak.

We went to Methodists, they gave us gloves, they gave us different, different things. I still get my chlorine. As I say I get my chlorine.... That Methodists' Church but it was like certain NGO went there, brought the food but they were using the centre because when the Block Leaders thing was going on, they used to share food. Methodists was our Centre, Centre New Kru Town that Methodists we used to go received food

Karen described a local UMC that apparently partnered with an NGO for community supply and food distribution. While very few interviewees, across all community-level demographics, mentioned directly working with an NGO, the few times that it was

mentioned, it always referred to NGOs partnering with the Catholic or Methodist church. It was never mentioned regarding NPCs.

Two NPC affiliates alluded to the fact that mainline churches such as the Catholics and UMC had more resources, due to their links with a broader network. NPC member, William, described how his church was not able to do much on a community level, during the outbreak, due to a lack of resources. He compared this lack to other mainline churches who seemed to have more means for a broader response, "*...other churches like the Catholic, the Latter-Day Saint, they have support and they able to share to their members them these things them but for us we do not have it in our church.*"

NPC Pastor D echoed William's thoughts when talking about his church's response. He stated:

We were not financially strong like other mainland churches that like, like the Episcopalians, like the Catholic that has strong financial you know backing so these people and you know they had some other...their support from all around the world sent in materials for their members. But for us as Pentecostal churches we don't have these people outside there, so we ourselves was raising our own money to see how well we could buy these materials to use but it was our everyday thing and we were not really financially strong to even go you know all around in the community to spread this uh message around.

5.5.3.2 Outbreak Responder Observations

Several individuals, who were a part of the Liberia government or the international community response, commented on the ease of engaging certain Christian faith groups over others. They often mentioned the Catholic church and the UMC, while sometimes contrasting this with the difficulty in engaging NPCs.

Johnson, an NPC member who worked for the Liberian government health sector, was asked if some Christian churches were easier to engage than others. He said:

Oh yes, because what happened was that the information as passed on to all of them, so for example if you contacted the Catholic bishop for example. You will write a communication and it will be read to all the Catholic churches in Liberia. Yes, there were some churches like those established churches. Established like, you have the Pentecostal, you have the AG, you have the Baptist, the Catholics, the Methodist... Those churches, the pastors of the churches they easily understood. I believe that the orientation of the pastors makes it easier. Orientation in terms of

their, perhaps their education and a long standing of those churches in the community.

Johnson used the Catholic church as an example of a mainline church whose structure made it easy to engage. He broadened this observation to other mainline churches. He also commented on the “orientation” of individual pastors, explaining that not only was he referring to their education, but to how long the churches had been in the community.

Leila, herself an NPC member, had the same observation in terms of the ease of engaging churches who shared the same denominational structure. Working with the Liberia government Ebola response, she was asked if some churches were easily engaged and how they were approached for engagement. She used the Catholic church as her example, saying:

Yes, because what really make the churches to come, we would call the bishop to come in, the bishop for the catholic church and we would tell him to tell the churches and they needed to know that this Ebola is a real thing. And when the pastor (bishop) talked they (Catholic priests) started agreeing with him. They would come into the office; we saw priests asking for promotional materials.

As an NPC member, she was asked how NPCs received this messaging since they did not have a centralized authority structure, like the Catholic bishop. She responded, “*Those (churches) that have no leadership they listen to the radio to say, “let’s see what messages we get from the radio” and maybe they listen.*”

Victor, when asked if particular Christian churches were more easily engaged and why, replied, “*So what I would call “mainline” churches ...Methodist, Baptists, Lutheran.*” Seeking clarification, the interviewer asked if he meant denominational churches with an authority structure, to which he replied, “*Exactly, they have a faster response to the issues. They sought the knowledge they sought the understanding and there was a faster response.*”

Kate worked for the Liberian government and helped with community engagement. When asked if certain Christian groups were less resistant than others, she listed the Baptists, Catholics, and Methodists.

5.5.3.3 Summary

Throughout the interviews, various demographics mentioned the Catholic and UMC churches' responses, and the ease of engaging these two church groups. One central theme from these interviews was the already practicing health initiatives of both church groups. These churches already had health programs and church-run health centres. These churches were already reaching out to their communities; therefore, when the Ebola outbreak began, it seemed natural for their Ebola responses to reach out into the community.

International responders that mentioned these churches, commented that they were more easily engaged than NPCs, mainly due to their centralized authority structures. They noted that by starting with church headquarters, Ebola messages were passed down more quickly and accepted more readily by affiliate local churches.

5.5.4 Objective #4: Summary Findings

Catholic and UMC leaders and members were consistent in describing their churches as actively involved in the community's health through health education and church-run health centres. They also unanimously described well-executed, community-based responses to the Ebola outbreak.

Catholic and UMC community members were similar in providing vague responses regarding these church's roles in the community and their Ebola responses. It is difficult to interpret this vagueness as many community members were members of other churches and preferred to discuss their own church's response. They often generalized church responses, not specifying, or not knowing what specific churches were doing certain activities. These responses are similar to healthcare workers' responses. It appeared that many healthcare workers were not familiar with the specific genre of churches, so their responses were generalized, or their perspectives were very limited to churches near where they lived/worked.

Ebola responders were as specific about their perceptions of Catholic and UMC involvement, as they were when discussing NPCs. This demographic responded to the outbreak on a macro level and had a broader viewpoint of church engagement. When asked to describe churches that were easily engaged, all mentioned mainline churches, often spontaneously using the Catholic church and the UMC as examples.

Several Ebola responders discussed the nuance of mainline churches that had a centralized authority structure. They felt that this structure was an asset in engaging the broader denomination, as the denominational headquarters were quickly targeted and then took responsibility for disseminating the information among their local churches.

This contrasts with statements about NPCs. In interviews analysed for research objectives 1-3, numerous interviewees commented on the difficulty in knowing who some of these churches were and where they were located. There were comments on the lack of a centralized authority structure and the necessity of taking the time to seek out these churches, one by one. NPC affiliates themselves discussed making their own decisions or seeking out Ebola information for themselves, alluding to a possible culture of faith isolation.

All interviews across all demographics that were analysed for this research objective did not mention faith beliefs as they pertain to healthcare and Ebola responses vis-à-vis the Catholic church and the UMC. A few mentioned prayer as a Catholic or UMC response to Ebola. This is not to suggest that they did not pray, but prayer was rarely mentioned, implying that it was not an obstacle, or that other responses were considered more prominent. In contrast, interviews analysed for research objectives 1-3 were full of references to NPC faith in divine healing, a spiritual cause for the outbreak, divine protection, and a commitment to prayer. Many interviewees attributed these beliefs to the delayed response by NPCs and even to virus transmission.

While the sample pool for the comparison group of Catholics and UMC was noticeably smaller than that of NPCs, this pool's results suggest a difference in response to Ebola between the two groups. The Catholics and UMCs were universally described as easier to engage, due to their authority structures, and as having a broader community response to Ebola. In research objective results 1-3, NPCs were consistently described as the Christian group the most difficult to engage.

The comparison group was not described as having beliefs that conflicted with Ebola engagement and the outbreak containment protocols. However, NPC beliefs were consistently discussed as possibly contributing to difficult and delayed and to possible Ebola infection.

5.6 Chapter Summary

There was broad consensus across interview demographics and the literature on the large NPC presence in Monrovia. With this presence were generalized observations of the influence and power accorded to these NPC pastors. Comparison group presence (Catholics and UMC) was generally acknowledged but not discussed in terms of being a relatively newer presence in Monrovia or in terms of rapid expansion.

All interview demographics were unanimous in their observations on NPC spiritual responses. Responses described included increased prayer meetings, praying for the sick, and believing that Ebola was a punishment from God or the result of witchcraft. These responses were also mentioned in the literature on faith and Ebola, however, outside of a few remarks, the literature discussed faith in broad, generalized terms, making it difficult to breakdown responses according to faith subgroups. On the part of NPCs, these same responses were well-documented in the literature on faith responses to HIV/AIDS. Prayer, beliefs, and an overall spiritual response was rarely mentioned by any demographic when discussing the comparison groups.

All interview demographics mentioned a general delayed faith response, with NPC responses described as even further delayed. When extremely resistant churches were discussed, or stories were told about church-centred Ebola outbreaks, they always involved NPCs. These delays and church-centred outbreaks were generally tied to NPC beliefs on divine healing. Once again, the literature was not specific as to faith affiliation when describing resistance and beliefs.

Catholics and UMC churches were widely described as easy to engage and locate via their church headquarters. On the other hand, NPCs were challenging to engage, and difficult to find as their lack of a centralized authority and communication structure required a one on one approach.

While NPC pastors generally acknowledged a delay in responding, all pastors interviewed for this study described relatively timely reactions once they understood the situation. No NPC pastor interviewed for this study admitted to any responses or beliefs that created chains of infection. However, several discussed NPC colleagues who died from Ebola, stopping short of citing specific beliefs and actions that could have contributed to these infections.

Several demographics recounted stories of pastors who seemed to be amenable to outbreak protocols, but in reality, they did not implement these protocols. Some of these pastors taught Ebola containment measures in their churches but did not adhere to them personally. This appeared to demonstrate an entirely different type of resistance that would be difficult to track.

Community-level, non-NPC affiliates had vague observations on church involvement, as they tended to generalize all church responses or understandably could only comment on churches that were near where they lived. Many had pertinent observations but were unable to specify the genre of the church they were describing.

Ultimately all demographics stated that most NPCs did adopt the containment measures, but only after they witnessed widespread death in their neighbourhoods. Many NPC pastors agreed, stating that as they began to hear more sirens (ambulances) in their communities and people that they knew died, they were more motivated to comply with Ebola prevention measures.

Chapter 6: Discussion

6.1 Introduction

This research sought to examine the possible effect that Christian faith beliefs have on health decisions. This was studied within the context of NPCs in Monrovia, Liberia, and their responses to the Ebola outbreak and the subsequent Ebola containment measures. By examining these responses and the stated reasons, or explanations, that guided NPC responses, the study has highlighted various barriers and facilitators to NPC engagement, during the Ebola outbreak. It is hoped that these findings will not only add to the existing research on the faith/health relationship but that it will be useful in the development of community engagement protocols and will serve to highlight the importance of engaging specific subsets of Christian faith. Efforts to engage local communities in disease mitigation and response could be considerably more effective by giving serious consideration to NPCs' widespread existence and NPC communities of faith throughout Africa.

The necessity of engaging community stakeholders in public health initiatives is well documented [1, 3, 6, 7, 9]. While faith stakeholders have long been recognized as essential entities within a community, having an impact on how faith adherents view illness, there is scant literature explicitly on this faith/health interaction and how to specifically engage these stakeholders. When the stakeholder literature addresses faith, it is often discussed in general terms, sometimes differentiating between well-known faiths such as Islam and Christianity, but rarely discussing faith community subsets that exist within these larger belief systems. Christianity has many forms of expression. NPCs are one of these subsets that are proliferating on the African continent, including in Liberia. NPC growth and presence in SSA are well-documented in the scholarship, and there is ample literature on their beliefs and responses vis-à-vis HIV/AIDS (see section [3.1.1](#)). However, little has been written on specifically examining their beliefs and worldview vis-à-vis other health responses, and given this worldview, how to successfully engage them in health initiatives. This research aims to fill that void.

This chapter will discuss research objective #5, which addresses analysis and results of the data. This data analysis aims to identify relationships and patterns where they exist and conceptualize what can be implied from these relationships and patterns. This chapter aims to take the results and the information gathered from the interviews and

literature review to develop a theoretical narrative of how NPC beliefs affected their Ebola responses, and to discover faith-related barriers and facilitators to NPC engagement during the outbreak in Monrovia, Liberia. The implications of these findings will be discussed in comparison to standard community engagement protocols. This is the final step of the grounded theory approach, which entails examining the data and developing theories that emanate from it [212]. The grounded theory approach ultimately aims to derive theoretical assumptions and key themes from the data. This study did not aim to prove or disprove already existing theories but to make analytical inferences based on the data to identify deeper meaning and insight that could improve faith inclusivity in community engagement strategies.

This chapter discusses the key themes identified across the data from the semi-structured interviews, grey literature, and the scholarship. From these key themes, three theoretical propositions are discussed. The implications of these themes and propositions will be considered, not only in terms of how they possibly impacted Ebola containment efforts during the Liberia outbreak but also in terms of the broader ramifications for public health initiatives across the continent where there is a prominent NPC presence. In light of these themes, successful NPC engagement strategies will be outlined to complete research objective #5. Recommendations and implications for future practice and research will be detailed.

6.2 Key Themes

Multiple data sources provided information on NPC beliefs and distinctives that impacted their perceptions of and responses to the Ebola outbreak and containment measures. These themes shed light on the barriers and facilitators to NPC engagement, the importance of ensuring inclusivity during religious community engagement, and the critical need to periodically re-evaluate standard community engagement methodologies. As the religious landscape changes in Africa, a 'one size fits all' approach to engagement risks omitting or neglecting potential faith sub-groups that are encompassed within the larger faith, as is the case with NPCs.

6.2.1 Beliefs

While NPCs are a subset of protestant Christianity, they are not associated with a mainline denomination, nor are they structurally or formally linked to one another (see section [1.8](#) for literature-based faith definitions). However, despite their individuality,

there is a shared set of beliefs to which most NPCs adhere. These shared beliefs encompass illness perception, primarily in terms of illness causation and responses, impacting the narratives that NPCs create and communicate to their members during times of poor health. See section [1.9.2.1](#) for a literature review and discussion on these prevalent NPC beliefs. These beliefs proved to be particularly relevant during the Ebola outbreak.

Multiple data sources from the interviews and the scholarship discussed the widespread NPC belief that the root of illness was spiritual, therefore requiring a spiritual response [26, 63, 71, 74, 77, 79, 85, 86, 94, 111, 185, 190-192]. This spiritual response included the belief in divine healing, expressed through fervent prayer and the laying on of hands. These beliefs and praxes have been described as crucial for framing NPC responses to various illnesses, such as HIV/AIDS. See section [3.1.1.1](#) for the literature-based discussion on NPC beliefs in illness causation and responses as it pertained to HIV/AIDS.

Other faiths have similar tenets, particularly in SSA, where poor health infrastructure and a generalized lack of access to adequate healthcare are a daily reality. However, while acknowledging these beliefs, other Christian faith groups seem more at ease combining them with biomedical interventions. For example, the Catholic and UMC churches, who served as the comparison groups for this study, rarely mentioned prayer as a response to Ebola. Community members and Ebola responders also described Catholic and UMC responses as more 'clinical.' Other than the universally rejected cremation protocol, there was no mention of their religious beliefs conflicting with containment measures.

However, virtually every interviewee that discussed NPC responses, including NPC affiliates, began by mentioning their commitment to prayer and the belief in divine healing. This strongly aligns with the literature on Pentecostal beliefs and mirrors the initial responses of many NPCs to HIV/AIDS (section [3.1.1.1](#)). Monrovia-based Pentecostals were unanimously described as increasing prayer times during the outbreak as they prayed against the demon of Ebola and sought divine healing for those who were infected. Several interviewees told stories of sick individuals, begging to be taken to the church instead of a health facility or ETU. It would be reasonable to assume that those taking a sick individual to a health facility would be family members or close friends, trusted people who had a relationship with them. To refuse to listen to the

recommendations of people with whom one had a relationship and to insist on going to the church demonstrates the influence that the church had on health decisions. An influence that at times superseded family.

Many religions in Africa allow for a syncretic response to illness, promoting scientific responses, prayer, and sometimes even traditional beliefs [67]. While other faith systems might embrace similar tenets, it is the depth and scope of these beliefs, among NPCs, that is important.

Several healthcare workers who were interviewed for this study, ultimately defaulted to faith, when discussing the balance between these beliefs and scientific interventions. Louise, an interviewee who was a health worker and an NPC member described her beliefs, saying that faith ultimately played a vital role in the medicine's effectiveness. Despite her medical training, she stated that an individual's faith could either potentiate or inhibit biomedical interventions. Another interviewee, Mark, was a Liberian physician. He described the tension between faith and science that existed for many Africans. He stated that when an African cannot understand or explain the science behind an event, he/she defaults to a faith worldview. A highly educated Liberian himself, Mark also said that this way of thinking and processing far outweighed the level of education of the person holding this worldview. While he was one person speaking generally about a larger population, his remarks revealed the commitment to faith, even by a highly educated, science-oriented individual. Mark's comments implied that ultimately, when there is tension between faith concepts and science, faith wins. This is a crucial worldview to consider, not only in villages or poverty-stricken areas where educational levels tend to be lower and traditional beliefs are more prevalent, but among the urbanized and educated as well.

Interviewee Becky had lived in Liberia for many years, working with an FBO. An anthropologist, she noted that during times of increased stress and fear, many people cling to their default responses. During the Ebola outbreak, she observed that Pentecostals became even more Pentecostal, more fervent in prayer, and more insistent on divine healing.

While beliefs on illness perception possibly created scenarios of harm during everyday life as Liberians navigated malaria, typhoid, and other endemic illnesses, these beliefs, when acted upon, often had fatal results during the Ebola outbreak. A focus on seeking

a spiritual answer to Ebola resulted in delayed medical treatment. Prayer for divine healing was usually performed through the laying on of hands, creating chains of infection, which in turn created an increased need for prayer. Despite the high mortality and morbidity from Ebola, some NPCs were described as becoming even more aggressive in their approaches as they began to seek out the sick in the community, even approaching ETUs and asking to lay hands on the sick.

It is important to note that not all NPCs responded in the same manner. However, when resistance was described, it always revolved around an NPC. Given the infectiousness of Ebola and the praxes that accompany NPC beliefs, one can easily imagine how just a few resistant NPCs in a crowded urban area could dramatically impact an infectious disease outbreak.

6.2.2 Perceptions of Leadership

Another key theme that emerged from the data was the perception that NPC members had of their pastors, and how the pastors valued and portrayed their roles in the community. These perceptions aligned with the theory of charismatic leadership [214], which guided participant selection and the development of the interview questionnaires.

While this theme was prominent in the interview data, it was not broadly addressed in the literature. Robbins [55] and Wariboko [25, 65] discuss it in their writings on Pentecostalism in Africa and Gifford cites similar observations in his research on Pentecostals in Liberia [83]. Gillespie [62] and Bangura [77] also note the powerful influence of these leaders and how this impacted public perception during the Ebola outbreak. While the literature on HIV/AIDS discusses church leaders' reactions and subsequently follower reactions, it does not specifically examine this leader/follower dynamic ([section 3.1.1](#)).

However, NPC leader's authoritative nature and the reverence and respect they received from their adherents impacted how NPC members responded and was a common subject in the interviews. NPC adherents discussed their faith in and love for their pastor, often describing him in terms which put him below God, but above themselves. They described beliefs implying that his prayers were more effective than

their own, alluding to him being their spiritual advocate. Their faith in and respect for their pastor gave him considerable influence in their lives, including in health decisions.

Pastors have incredible influence over their members, and this power can have positive or negative outcomes. The scholarship supported this relationship, describing pastors as being considered godlike and indispensable [25, 71], freely dispensing information and advice that was unquestionably believed and followed [65]. These results not only contribute to the veracity of the theory of charismatic leadership, they also encourage a broader application of its use, possibly in studies that examine the impact of religious leaders and religious affiliation.

MOH interviewee, Johnson, had a very personal story on pastoral influence when he discussed his wife's refusal to believe that Ebola was real and that she should adopt the prevention measures. An NPC member, Johnson's wife consistently referred to her pastor's advice rather than her husband's. For almost two months, her pastor did not acknowledge Ebola to his church members. Even though her husband was an employee of the MOH and therefore had access to pertinent information on the outbreak, his wife insisted that since her pastor had not acknowledged Ebola, that there was nothing to worry about. Johnson's story illustrates that this absolute trust in the pastor can even supersede marital trust.

NPC leaders seemed to embrace this role. All NPC pastors interviewed for this study described their influential relationship with their members. All felt confident that their church members followed their advice.

NPC pastors also seemed to care about how the community perceived them. All NPC pastors interviewed for this study described their responses to the outbreak as relatively timely and accepting of all containment measures. They were, however, willing to discuss the often-fatal refusal of their colleagues to accept the protocols. It is difficult to determine whether this research randomly interviewed only NPC pastors who responded appropriately, or whether these leaders learned from experience and, possibly feeling shame or regret, chose to describe their responses more positively.

Several pastors recounted stories of their colleagues who had died exhibiting symptoms of Ebola. However, their churches and family members insisted that they had died of a curse brought on them by witchcraft. In the midst of an Ebola outbreak, the explanation

of witchcraft demonstrates the strength of the denial mechanism that was in place. It could also indicate a more profound emotion of shame, possibly because the deaths resulted from protocols not being implemented or perhaps admitting that a pastor died of Ebola reflected poorly on his faith. It is paradoxical that churches and families would rather portray a pastor's death as an act of witchcraft, an ungodly and evil force in NPC belief, rather than admitting that it was due to Ebola. One would assume that a pastor with firm faith would overcome witchcraft in the battle of good vs. evil, while death from Ebola, a physical illness, would be more acceptable. However, at some point in their resistance against Ebola, it appears that losing that battle was an issue of honour, something that the pastor's entourage did not want to acknowledge. Somehow death by witchcraft was more palatable than death by Ebola.

This pressure to demonstrate a faith that could overcome Ebola was illustrated in the story told by NPC Pastor B. He discussed a colleague pastor who had been publicly resistant to the Ebola containment measures, insisting that his faith was strong enough to ward off infection. While Pastor B was at this man's house, unsuccessfully attempting to reason with this resistant pastor, he overheard the pastor telling his wife not to buy bushmeat during her weekly outing to the market, apparently alluding to Ebola information that speculated its transmission via bushmeat. Evidently, while this pastor was publicly promoting his faith and resisting Ebola protocols, he was privately implementing some prevention behaviours. It seems that this pastor had a private fear that motivated him to protect himself and his family. However, something propelled him to publicly display a faith that superseded physical prevention measures.

What caused this hyper-faith response on the part of some NPC pastors? They lived in a country with endemic tropical illnesses, yet it would appear that they drew the proverbial 'line in the sand' over Ebola. When asked about illness response, before the Ebola outbreak, all NPC pastors interviewed for this study described combined responses, emphasizing prayer and divine healing, but ultimately recommending medical care when needed. Did the Ebola biomedical interventions, communicated incessantly in a top-down authoritative fashion, provoke defiance? Alternatively, perhaps pastors felt a degree of pressure from their colleagues and their followers, to demonstrate a hyper-faith during a frightening time. With communities looking to them

for hope and reassurance, perhaps they could only give the type of reassurance that they were familiar with, spiritual reassurance of protection and healing.

Whatever the reason, it appears that some NPC pastors were afraid of being viewed as weak in the faith if they accepted scientifically proven protocols. Some of these pastors likely contributed to this societal pressure when they declared that Ebola was God's judgment on sin and preached that God would divinely heal those with faith.

While the realization of the leader/member dynamic contributed to the use of the theory of charismatic leadership for participant selection, how this authority and trust dynamic played out during the outbreak was unexpected as it went beyond the pastor/member relationship and spilled out into the community. The persona, assumed faith, and charisma of many NPC pastors gave them a level of respect, even among non-NPC adherents, inciting certain expectations on the part of the broader community.

There were several stories where pastors were chastised for recommending the adoption of the containment measures. Some individuals seemed to perceive pastoral support of the protocols as a lack of faith and expressed surprise that a pastor who preached divine healing would support biomedical recommendations.

The deaths of NPC pastors were reported as particularly shocking to NPC members and community members alike. Seeing a pastor who fervently preached faith and divine healing die of Ebola caused fear and concern, above and beyond others' deaths. Pastors seemed to be held to a higher standard when it came to Ebola.

Many pastors would not admit to personal or church-related deaths from Ebola. This stood in contrast to the openness of other Liberians interviewed. Healthcare workers, government officials, and all community members appeared willing to tell their stories. They discussed the illness and deaths of family members and how Ebola impacted their immediate communities. Several openly discussed their own Ebola infection. These demographics did not exhibit any feelings of shame or embarrassment that Ebola had impacted their families. However, pastors appeared to minimize Ebola's impact as it related to themselves and their churches. This could represent a degree of regret, in hindsight, or a sensitivity to how others might view their faith if these perceived 'failures' were admitted. Throughout the interviews with NPC pastors, it was observed that they

valued their position as a 'man of God' and the importance of being regarded as having a powerful, unwavering faith.

Ebola responders told multiple stories of resistant NPC pastors. They described an attitude that seemed to suggest that adherence to the containment protocols implied a weakness in faith, threatening their spiritual position and authority. Conversely, publicly rejecting the measures seemed to demonstrate a depth and strength of faith. Among some NPC pastors, there appeared to be a belief that having a strong faith in God and implementing the containment protocols were mutually exclusive.

While many African contexts ascribe status to their authority figures, particularly religious leaders, the implications of this were strikingly apparent among the NPC community during the Ebola outbreak. When receiving a variety of messages from different sources, NPC adherents usually adopted their pastor's beliefs and recommendations, behaviour that aligned with the literature [25, 65, 71]. This underscores the impact that NPC leaders have on their membership and the importance of their engagement. Given the prominent role that religion played in ending the relatively recent war and the documented impact that Pentecostals had on the peace and reconciliation process [138, 143, 144, 151], it is understandable that many communities had more trust in religious leaders than in the government and outbreak responders (see sections [2.3](#) and [2.4](#)). Several interviewees commented on the numbers of people that sought comfort and hope within churches. Even those who had not been faithful church attendees before Ebola began to attend prayer services. Religious influence on community engagement cannot be over emphasized.

6.2.3 Independence

The independent nature of NPCs was not broadly addressed in the literature on NPCs and HIV/AIDS (see section [3.1.1](#)), and it was only briefly alluded to in the literature on Ebola [119, 126]. However, it was frequently mentioned in the interviews with Ebola responders. A lack of linkages to a broader denomination or centralized authority structure was a distinction of NPCs that seemed to impact NPC Ebola responses and their accessibility to responders. As previously discussed, most NPCs operate individually, outside of mainline denominations. Each church is its own authority, its own accountability structure, and has its own regulatory system. Piot described them as, “*radically autonomous* ([67], p. 118),” stating that Pentecostals often rejected or

distanced themselves from mainline denominations and that, *“God, church, and pastor serve as authority figures in the regulation of everyday life([67], p.119).”*

It should be noted that there are some Pentecostal churches who are not affiliated with mainline denominations, yet do not fall within this description. As mentioned earlier, in section [1.8.3](#), there are African initiated Pentecostal churches that do not neatly fit within this typology. Examples of this are the Winner’s Chapel and the Redeemed Christian Church of Christ, both of which originated in Nigeria. These church movements were independently initiated and are not tied to any formal denomination. However, they have grown rapidly and extensively. Both churches have satellite churches across Africa and beyond. While it appears that the satellite churches remain affiliated to the ‘mother’ church, each church has its own pastor and board of directors, therefore, somewhat replicating the mainline denominational structure.

However, the churches included in this study were stand-alone, independent churches. A few had a ‘daughter’ congregation elsewhere in Monrovia, which was directly attached to the ‘mother’ church but were not international in scope. Some of the NPC pastors, interviewed for this study, had graduate degrees in theology from established theological seminaries while others had not finished high school. This aspect of no centralized authority that monitored pastoral requirements, training, theology, and practices possibly influenced NPC responses. There were no denominational headquarters distributing information, and no perceived authority prescribing specific responses. Each NPC was responsible for deciding what their Ebola response would, or would not entail, with no default authority figure speaking into these decisions. This aligns with descriptions in the literature of churches having no regulatory system, no higher authority speaking into doctrine and praxis, and the potential to formulate harmful, unchallenged doctrine [50, 55, 83].

This lack of centralization and connectedness also affected engagement efforts. Responders discussed the ease of engaging mainline denominations, specifically mentioning the Catholic and UMC churches, by approaching their denominational headquarters. Information was quickly delivered through these centralized authority structures and disseminated down to local churches. These denominational headquarters followed up on their churches, providing an accountability structure for implementing Ebola protocols. While there were a handful of ecumenical organizations

and Pentecostal associations in Monrovia, membership was voluntary, and these organizations lacked any authoritative clout. Some responders mentioned relying on these ecumenical organizations for faith inclusivity for community engagement. However, historically churches that are not associated with Western mainline denominations, such as NPCs, distance themselves from these groups to keep their beliefs and doctrines pure [39, 138]. Therefore, the assumption of ecumenicalism would create a serious gap in inclusive faith engagement.

Some responders discussed the difficulty in actually locating NPCs, as the lack of denominational headquarters required responders to use mass communication methods or the time consuming, labour-intensive one on one approach. As independent entities, it was noted that many were not registered with these faith associations or with the government. They were described as 'pop up' churches, randomly appearing in communities. After decades of war, religious structures and governmental authorities had not conducted a thorough religious census. Therefore, there was a lack of information on the presence and location of many NPCs. Pfeiffer mentions a similar scenario when discussing the lack of NPC presence in the development of a CSM campaign in Mozambique [78].

Outbreak responders described community engagement methods as radio announcements and sending letters of invitation or text messages to community stakeholders. These methods of communication, while historically deemed effective, risked excluding many NPCs. While a few of the larger NPCs were ultimately targeted, many smaller NPCs that did not have personal contact with responders. While New Kru Town and Caldwell had the highest deaths, from Ebola, in Monrovia, very few of the NPCs interviewed for the study reported having had direct contact with responders. Given the infectious nature of Ebola and the already described NPC beliefs, one can imagine how even a small, neighbourhood church could spark a cluster of outbreaks.

This provokes reflection of a possible religious 'blind spot' for many international organizations and in the stakeholder literature. Karam noted that there was a presumed "*secular predominance*" mentality in many international aid organizations, starting at the initial level of the stakeholder analysis, which could cause the exclusion of some religious leaders ([241], p. 14). Ter Haar stated that in SSA, the most active religious groups in the socio-political context were the mainline denominations, noting that they

were also the primary beneficiaries of aid organizations [152]. She commented on the tendency of these organizations to focus on established, institutionalized religious groups who had recognizable structures and directorates as well as denominational ties with Europe. These denominational associations with the West and their experience in navigating socio-political situations give these churches an ability to articulate vision and speak a similar language as the secular development world, thus enhancing their relationship, involvement, and funding opportunities [152]. Within this context, one could imagine how NPCs, who generally do not operate on a social or political level and are independent of any mainline denomination, could be overlooked in outbreak responses.

While many of the initial engagement strategies described are the standard methods discussed in the literature, there is ample scholarship on the need for relief and development interventions to operate within the local context. In areas of high religiosity, acknowledging and specifically addressing prominent religious beliefs would be critical to success. However, despite this acknowledgment, much of the literature continues to employ the concept of 'faith' in broad, general terms, not acknowledging the belief and practice differences that can exist within seemingly homogenous faith groups.

Part of this blind spot could be attributed to not knowing what one does not know. Several responders discussed confidence in having cast a wide net of faith engagement as they worked through the LCC. The LCC refers to the Liberian chapter of the global World Council of Churches, an ecumenical, Christian organization. However, according to the LCC website, only one NPC is a member of this organization [242]. Understandably, an organization with limited local faith literacy would assume that the LCC served as an umbrella association for all Christian churches, and was, therefore, an appropriate conduit for inclusive faith engagement. Many mainline denominations historically have embraced ecumenicalism and the World Council of Churches. However, as previously discussed, NPCs tend to not only be independent from one another but from other Christian faiths as well, indicating a resistance towards ecumenical gatherings and leading to a conscious disassociation from other Christian groups [39]. Wilkinson et al. alluded to this, stating that the assumption that various community

leaders, including religious leaders, would seamlessly work together and readily cross religious lines during an epidemic was unfounded[166].

6.3 Theoretical Propositions

In analysing the data and reflecting on its deeper meaning, several theoretical propositions were identified. These concepts build a bridge between the data revealed and the 'why' behind the described actions. They aid in framing the realities of working with and engaging NPCs, explaining the relationship between specific faith dynamics, reactions to Ebola containment measures, and engagement strategies.

6.3.1 Not all Christianity is the Same

This thesis has demonstrated that while there are considerable similarities between faiths that share the same centrality of beliefs, there are also considerable differences. While many faiths have similar beliefs regarding illness perception, the depth of these beliefs, and how they are actually applied to illness can vary greatly. An example of this in the literature are the variations in responses to HIV/AIDS (section [3.1.1](#)).

During the Ebola outbreak, NPC beliefs on illness perception were dogmatic and tenacious. The strength of these beliefs often superseded expert opinion, family advice, and safety. As the Ebola crisis grew, it seemed that the praxis of these beliefs became even more rigid and evangelistic, at times manifesting in outward expressions of high-risk behaviour, in terms of Ebola infection, and public defiance of containment protocols.

While many humanitarian aid organizations acknowledge the importance of faith engagement and claim faith inclusivity, it is necessary to understand the differences in various faith subgroups or inclusivity will not be achieved. To function effectively as an agent of change in communities of high religiosity, it is necessary to uncover the subtleties of various Christian subgroups and understand their key differences.

While this proposition may seem elementary, one only has to read the literature on faith responses during the West Africa Ebola outbreak to see that 'faith' and 'Christianity' are applied globally in most of the literature ([section 3.3](#)). In contrast there is an abundance of research that specifically addresses Pentecostalism, and even neo-Pentecostalism, and HIV/AIDS responses ([section 3.1](#)). However, when examining faith and Ebola

responses in West Africa most scholarship reverts to using broad terms when discussing varied and complex faith groups.

NPC beliefs are deeply held and valued, and the Ebola crisis seemed to intensify their outward manifestations. NPC engagement would require a faith lens to understand how EVD was conceptualized by NPC adherents and to address this conceptualization appropriately.

6.3.2 NPC Pastors have far-reaching Impact due to their Ascribed Status

This thesis highlights the socio-cultural phenomenon of NPC pastors and their relationship with adherents. NPC leaders possess a broad sphere of influence over their members, which accords them input into many aspects of life. Pastors seem to enjoy this position while adherents encourage and willingly submit to it, aligning with the theory of charismatic leadership in both leader and follower characteristics [215-217].

While pastoral influence and trust is mentioned in the literature, this dynamic was not specifically discussed in the literature resourced for this research. It was primarily mentioned by theologians or social scientists/anthropologists while describing the phenomenon of NPCs in Africa [25, 55, 65, 71, 83]. It was not, however, examined in the scholarship on faith responses to Ebola ([section 3.2](#)).

NPC pastors are assumed to have divine knowledge on various life issues, despite a lack of qualifications. Those ascribing status to these leaders often consider them as an authority or expert on a broad range of topics. During the Ebola outbreak, a time of generalized fear, this sphere of influence seemed to broaden and go beyond NPC church membership as community members also looked to them for guidance and support, while simultaneously having expectations as to their responses.

The depth and scope of this belief and trust in church leadership and its effect on communities and on NPC pastors themselves, is an important dynamic to recognize. During the Ebola outbreak, community expectations on NPC leaders intensified. Some pastors were mocked for embracing containment measures. Others publicly expressed a hyper-faith, while privately trying to protect themselves and their families from infection. In this case, engagement protocols would need to acknowledge this tension. Pastors would need the support and communication tools necessary to promote a response that deviates from their standard illness responses. They would require

strategies that would acknowledge and support their pastoral position of influence in the community, while simultaneously equipping them to use that influence to support the biomedical responses. These are deeply held societal and spiritual roles that would most likely not be adequately addressed by generalized, standard engagement protocols implemented by a secular aid organization. Engagement would need to begin with a cultural and spiritual dialogue, not a biomedical one.

6.3.3 NPC Independence is a Deeply Held Value

This is a research result that deviates from the literature on NPCs and outbreak responses. While it does not contradict current scholarship, this theoretical supposition is simply not addressed from a public health and development/community engagement perspective. Theological and religious literature on NPCs discusses the characteristic of independence from a mainline denomination and the lack of centralized governance as this is a distinctive that qualifies NPC classification [39, 55-57, 59, 65]. However, the literature on HIV/AIDS does not discuss how the independent nature of these churches possibly impacted their responses to and engagement with HIV/AIDS responses (see section [3.1.1](#)), and it is only briefly mentioned in the literature on the Ebola outbreak [119, 126]. However, the independent nature of these Monrovia-based NPCs was frequently mentioned in the interviews, by outbreak responders, as a difficult dynamic for NPC engagement.

NPC's independent status goes beyond a structural independence to a deeply held value that impacts their view of other faiths and secular entities. Their perceptions of those who do not share the same beliefs create mistrust and obstacles for partnership. It also impacts their ability to accept advice or information from other entities as they prefer to remain aloof from perceived secularity.

This relational distance created an apparent tension between NPCs and Ebola responders. NPC trust of Ebola information was filtered through their perceptions of the government and secular humanitarian workers, while Ebola responders did not intentionally target NPCs for engagement. There seemed to be a diminished social contract between both groups, possibly from ignorance of one another or from historical perceptions of conflict and difficulties during the early years of HIV/AIDS responses.

Understanding the value that NPCs place on their independence should impact the starting point for their engagement. There is an already established degree of suspicion towards those who share some of their core beliefs. Approaching them from a secular or biomedical standpoint with no faith literacy and no previous relational collateral would likely fail.

6.4 Implications for Practice

This research has discussed NPC beliefs and distinctives as they specifically related to their perception of the Ebola outbreak and the recommended containment protocols. It has revealed several distinct strategies for enhancing the success of ensuring broad faith inclusivity in community engagement and specifically NPC engagement.

6.4.1 Religious Mapping

It is recommended to periodically conduct a religious mapping in pertinent urban areas. Religious mapping has frequently been recommended in the literature on community engagement and health responses in Africa [78, 80, 118, 243] as any successful faith engagement strategy requires a knowledge of the faith landscape. For decades, in countries with a dominant Christian presence, faith stakeholder engagement was somewhat easily accomplished by working with respective denominational headquarters. When the representatives of these mainline denominations participated, inclusivity of faith in community engagement strategies was often justifiably assumed. However, with the rapid and growing emergence of NPCs, this assumption is no longer valid. Considering the high prevalence of NPCs in most SSA countries and the large segments of populations adhering to this faith, the engagement of NPC pastors should be considered crucial for successful community engagement strategies. This is alluded to in the literature on NPCs and HIV/AIDS as it was frequently mentioned that NPCs are a new and emerging faith group in SSA that needs to be recognized and understood [26, 52, 63, 71, 74, 76-81, 87, 93, 101, 106, 109-111, 184, 186, 187, 189-193].

Interviewee Bernadette, a Liberian who worked for an international NGO during the outbreak, aptly described the crucial need for inclusive community involvement when she stated:

I think one of the things that Ebola taught us is that the health promotion aspect, or the prevention aspect is even more important than the curative aspect. The community involvement is very, very

key when it comes to healthcare in country...I think the Ebola outbreak was terrible but, in the end... it shows us that having the community involved in the health sector is important. Acknowledging the structures in the community working along with them had a great impact and the fight against Ebola wouldn't have been won without the reinforcement of the community.

To adequately involve the community requires knowledge of the various sub-communities that exist with the broader geographical community. Religious mapping should not only identify where these churches are geographically but should consider their stakeholders as well. While more easily accomplished with mainline dominations through their centralized authority structures, this is not as easily or quickly achieved with the independent NPCs. Although it could be reasonably assumed that most NPCs adhere to the prominent beliefs in the spiritual causality of illness and divine healing through laying on of hands, they cannot be considered a homogenous group in terms of authority and influence. Once this NPC distinctive was acknowledged and understood by Ebola responders, engagement efforts were modified, resulting in increased success. However, during a rapidly changing infectious disease outbreak, finding the time and resources to identify the informal networks and approach these churches one by one was a challenge. Therefore, a priority recommendation would be the semi-regular, thorough religious mapping of any country that is considered at high risk for disease outbreaks.

For the past several decades, much of the literature that discussed faith vis-à-vis public health initiatives and disease outbreaks recognized the importance of increasing faith literacy through religious mapping. However, 'faith' or 'Christianity' was often presented in a global, all-encompassing manner. This research recommends more detailed faith mapping, such as specifically mapping NPCs given their stand-alone independence, beliefs, widespread presence, and far-reaching influence. This would be best accomplished during a time of peace or non-crisis. This would allow for ample opportunity to thoroughly explore not only where specific places of worship are located, but to develop relationships and seek to understand their beliefs and practices as they could relate to an infectious disease outbreak.

6.4.2 Intentional Relationship Building with NPCs

It is recommended that aid organizations aim to partner regularly with all faith groups, being aware of faith sub-groups, such as NPCs. A compelling instigator of NPC responses,

whether compliant or resistant, could be summed up in one word – relationship. A lack of relationship with responders was frequently cited as a barrier to NPC engagement while capitalizing on prior relationships was acknowledged as a facilitator to positive NPC response.

Intentionally seeking out and including NPCs in community health and development programs could foster a positive working relationship and build a foundation that would facilitate partnership more quickly, should a crisis arise. Outbreak responders from most sectors had little relationship with a majority of NPCs before the outbreak. This could have been complicated by the secular orientation of many international aid organizations. It has already been noted that NPCs stand relatively independent of one another and even more so from other Christian faiths. Given this trend, it is not illogical to conclude that a secular organization could provoke increased mistrust, especially when there is no history of partnership between the organization and the NPC. Several interviewees noted that NPC leaders were more open to dialogue on Ebola if approached by another NPC believer, ideally an NPC pastor or member. Others remarked that being a member of any Christian faith was advantageous, although there were several comments on NPC aloofness towards non-Pentecostal Christian groups. The literature on NPCs supports this, noting a general NPC reaction towards other Christian faith groups as one of reservation and, at times, even judgment [138, 139]. Therefore, an unsolicited approach by a secular organization where there was no prior partnership, encouraging culturally challenging recommendations was not well accepted. Ebola containment protocols were communicated in a factual, scientific manner. While these were accurate in content, they did not acknowledge deeply rooted beliefs. Facts and science rarely win the war against faith, especially when communicated by strangers who were often not of NPC faith. This lack of relationship capital impacted what NPCs heard and how they reacted to the information.

Ter Haar discussed the gap between areas of high religiosity and the westernized mentality of many development agencies, noting that often development workers are focused on the final goal rather than the journey to that goal [152]. The journey can take time, with many twists and turns. During an infectious disease outbreak, time is precious. Therefore, it is recommended to begin the journey during a non-crisis time.

Relationship development would require intentional organizational will on the part of nonfaith based international aid organizations. Built on secular methodology and often managed by individuals from highly secularized countries, in Liberia these organizations appeared to have a somewhat healthy relationship with mainline denominations. They had worked together in the past and easily approached these churches through denominational headquarters.

However, what makes an NPC, an NPC, puts them outside of the mainline denominations, and therefore, an entity that is less understood by international aid organizations. They cannot be approached by one visit to a national headquarters, and they likely do not have experience working with government and international aid entities. Engaging NPCs will require relationship, time, and a well-crafted strategy.

Along these lines, it would also be recommended that larger funding organizations identify smaller FBOs that are already active in the country. FBOs have more faith literacy and, while not necessarily Pentecostal, many are Christian and work within the broader faith networks in the field. In Liberia, there were several of these FBOs, already present and integrated in multiple faith communities. While it was not within the scope of this research to examine funding recipients during the outbreak, in future outbreaks, it would be recommended to consider the comparative advantage of increasing the capacity of these already established FBOs vis-à-vis partnering with large, outside organizations who have no established networks in communities.

6.4.3 Organizational Reflection

It is recommended that international aid organizations review their community engagement strategies through the lens of faith inclusivity and the possibility that some faith groups are excluded by the strategies. As was already discussed, most international aid organizations are secular in methodology and culture. These organizations hire local employees in various countries, and while some of these local employees could be adherents to dominant faiths in those countries, they are absorbed into the broader organizational culture and work within already established strategies and methods.

Pfeiffer (2011) researched HIV education in Mozambique and noted the high prevalence of NPCs, yet discovered that most NGOs sought partnerships with already known mainline denominations [80]. He discussed a negative preconception of some NGOs

towards these churches, stating that, “...public health and medical services have been dominated by foreign aid workers and local elites who by and large do not belong to the new churches (NPCs) and view them with dismissiveness or great suspicion ([80], p. 167).”

If aid organizations are committed to broad faith inclusion in community engagement strategies, then care should be taken to include all forms of Christianity. In today’s religious landscape in SSA, the most prevalent forms of Christianity would self-describe as ‘fundamentalist’ or ‘evangelical’ [39]. These genres of Christianity tend to have a separatist position that keeps them from participating in broader Christian associations [39]. Most mainline denominations have a history of working with governmental and aid organizations. In Liberia, many of these denominations were already engaged in some political and social activities and networking. The Pentecostals, on the other hand, according to Heaner, were, “*totally untouched by secular organizations ([138], p. 299).*” Therefore, organizational reflection is encouraged to identify if there are default faiths that are automatically sought out for partnership. While certainly no faith group should be excluded, if religious mapping demonstrates a strong NPC presence, responding organizations need to ensure that they have the organizational will, faith literacy, and strategies for their engagement. The need for organizational reflection and intentional targeting of NPCs for community engagement was also noted in the literature on NPCs and HIV/AIDS (see section [3.1.2](#)).

6.4.4 Engage Early

It is recommended that community engagement strategies, with an emphasis on broad faith inclusion, begin concurrently with biomedical responses. It was widely reported in the literature on the West Africa Ebola outbreak and acknowledged in some of the responder interviews that community engagement was not aggressively addressed until months after the outbreak began. These same sources also stated that faith stakeholder engagement was even further delayed.

6.4.5 Update Engagement Strategies

The literature on community engagement often reiterates standard community engagement strategies. Religious stakeholders are frequently described simply as ‘religious stakeholders’ with no discussion on the broad range of beliefs that often exist

within a broader religious group, such as the case of NPCs within Christianity. Considering the rapidly changing religious demographics in SSA, stakeholder descriptions and engagement methodologies need to be examined in light of these changes.

6.4.5.1 Personalized Contact Through the Identification of Informal Networks

It is recommended to create strategies that support a personalized method of contact and that identify and capitalize on influential informal networks. Recognizing the lack of NPC engagement via traditional mass media channels, some study interviewees resorted to a one-on-one strategy, particularly with resistant NPCs.

Several responders reiterated that given the lack of an NPC denominational headquarters, it was critical to find the informal networks of influence for individual NPC leaders. Typically, these leaders did not readily respond to a general summons. However, approaching them individually, particularly through, or with, a known and respected colleague proved to be more successful. Several interviewees emphasized that everyone has someone that they go to for advice. Whether a colleague pastor, a former teacher, or a healthcare provider, the goal was to identify the influential individual(s) for each NPC pastor.

This personalized contact could take place via church members. Many churches have adherents who work in the health field or who are employed by an NGO. Resourcing individuals known by an NPC, due to their membership, but who work within the broader development or healthcare community are strategic assets for relaying information.

6.4.5.2 Theologically Sensitive Communication

Many interviewees found that engaging NPC leaders from the starting point of their faith facilitated a more open and honest dialogue. Discussing the realities of Ebola and examining these realities through the lens of NPC faith and practices allowed NPC leaders to problem solve areas where faith practices and Ebola containment measures conflicted. It was noted that for this strategy to be effective, it required a safe space where NPC pastors would not feel outnumbered by international responders insisting only on scientific facts and scientific responses.

It is recommended that responders find NPC pastors who have already navigated the delicate balance between their faith and Ebola responses that seem to conflict with beliefs and scripture. This would not only add to the relationship factor of Ebola communication, but these pastors could help develop a template for these meetings. The gatherings should be considered a place of religious dialogue where worship, prayer, and other vital religious practices are included, putting pastors at ease and creating an atmosphere where they would be comfortable discussing the issues and finding ways to compromise.

Koko, an interviewee from the MOH, described the need to tailor the message for the targeted population. He said, *“During Ebola people saw for themselves that when you engage the community with the right message people change their attitudes.”*

6.5 Future Research

Past research on faith and health largely discusses faith groups in broad terms, not detailing the specific differences on faith group subsets and how these differences impact health. However, as the HIV/AIDS pandemic progressed there was an increasing awareness of the specific beliefs and influences of NPCs and a considerable amount of literature emerged that specifically discusses NPC responses and beliefs towards HIV/AIDS, not grouping all Christian beliefs into one broad category (see section [3.1.1](#)). However, the literature on Ebola faith responses reverts to primarily discussing the ‘Christian’ response, combining the vast array of Christian churches under one large faith umbrella, while not discussing the pertinent subsets of Christianity separately (see section [3.2.1](#)). While there is some literature, mainly from anthropologists, discussing the societal Pentecostal impact in SSA, this has not been expanded to a rigorous examination of their impacts on health, practical responses, and engagement strategies.

As the scholarship continues to examine outbreak responses, it is encouraged to be more faith specific; not combining all Christian faiths into one group but taking the time to specifically examine the rapidly growing faiths, such as NPCs, as subsets of Christianity.

The overall contribution of faith to relief and development efforts is under-researched as well. One possible reason for this is that, while faith groups have knowingly been involved in addressing community health for decades, they, themselves, often do not document and publish their efforts and results. Larger mainline denominations that

have historically operated clinics and hospitals are sometimes the subject of research or possibly have the capacity to document their efforts. However, much of the faith work in communities is done on an informal level in the form of churches addressing health issues during worship services or informal visitation to members. Often these churches do not have the capacity to quantify and publish their efforts, so their actions go unrecognized and unexamined. Nevertheless, the Ebola outbreak in West Africa demonstrated that these unofficial actions carried out on a micro-level had an important impact on outbreak containment. It is therefore recommended that institutions with higher research capacity intentionally examine the specific health impacts of NPCs.

However, there remains the obstacle of the access and uptake of research by aid organizations. Existing research needs to be easily accessed, actionable, and practical for these organizations. The necessity of community engagement is not new. In Gillespie et al.'s study on social mobilization and community engagement during the outbreak, a study participant stated:

Why is the debate being reopened on engagement? It is not new and has worked in many contexts over years...[but still] we failed to solve the local conflict because the solutions were not coming from the community itself ([62], p. 11).

6.6 Conclusion

Given the prevalence of NPCs in Liberia, their beliefs in regard to illness, the influence that the NPC pastor has over his adherents, and the lack of central authority, their presence and prevalence is critical information for outbreak responders, as these distinctions seemed to affect their engagement during the Ebola outbreak. An abundance of scholarship states that NPCs are rapidly emerging and changing the religious landscape in Africa. This change, what it entails, and how it impacts community engagement strategies demands consideration by outbreak responders when developing community engagement protocols.

This study has shown that NPC beliefs were linked to resistance towards Ebola containment protocols and to initiating chains of Ebola infection. It has also highlighted the importance of their engagement and recommended unique strategies for their support of and participation in outbreak responses. Successful NPC engagement strategies were those that recognized NPC beliefs and distinctives and worked within

them, rather than around them. While more time consuming, they achieved better results in engaging even resistant NPCs.

Standard community engagement protocols often discuss faith in broad categories without acknowledging the diverse faith communities that exist within these categories. NPCs and their responses to the Ebola outbreak have demonstrated the importance of recognizing all faith communities and the critical need to develop engagement strategies that focus on faith inclusivity.

There is broad consensus in the literature and in anecdotal reports on the sociological phenomenon of NPC's rapidly increasing presence across SSA. NPCs are quickly overtaking many Christian mainline denominations as the most prevalent form of Christianity on the African continent. As a growing subset of Christianity with specific praxis and beliefs that can conflict with infectious disease outbreak measures, their presence has highlighted a weakness in community engagement strategies.

It is hoped that the lessons learned through this study can be applied to faith engagement in a broader context. Effective and inclusive faith engagement would contribute to mitigating the consequences of disease outbreaks.

During the writing of this thesis, Africa battled another protracted Ebola outbreak, this time in the DRC. As I conclude the writing, Africa, along with the rest of the world, is struggling with even bigger challenges in the face of the COVID-19 pandemic, which has been front and centre on the world stage, making the findings of this research particularly poignant.

Africa has been greatly affected by COVID and given the high degree of religiosity across the continent; this once again highlights the importance of faith-inclusive engagement strategies. The importance of identifying key stakeholders and creating outbreak response messages that are palatable and coherent to these stakeholders will be critical to COVID responses. It is hoped that the findings of this study can play a relevant role in current and future infectious disease outbreaks.

References

1. Brugha, R. and Z. Varvasovszky, *Stakeholder analysis: a review*. Health policy and planning, 2000. **15**(3): p. 239-246.
2. Bompani, B. *Religion and faith-based organisations in Africa: the forgotten actors*. 2011 [cited 2019 01 February]; Available from: <https://www.e-ir.info/2011/09/27/religion-and-faith-based-organisations-in-africa-the-forgotten-actors/>.
3. Marshall, K. and S. Smith, *Religion and Ebola: learning from experience*. The Lancet, 2015.
4. Trinitapoli, J. and A. Weinreb, *Religion and AIDS in Africa*. 2012: Oxford University Press.
5. Casale, M., et al., *Dilemmas and tensions facing a faith-based organisation promoting HIV prevention among young people in South Africa*. African journal of AIDS research, 2010. **9**(2): p. 135-145.
6. Bannister-Tyrrell, M., et al., *Blood as medicine: Social meanings of blood and the success of Ebola trials*. The Lancet, 2015. **385**(9966): p. 420.
7. Dhillon, R.S. and J. Daniel Kelly, *Community trust and the ebola endgame*. New England Journal of Medicine, 2015. **373**(9): p. 787-789.
8. Institute of Development Studies, *Ebola and Lessons for Development*, S.E.-B. Policy, Editor. 2015, IDS: Brighton.
9. Obilade, T.T., *Ebola virus disease stigmatization; The role of societal attributes*. International Archives of Medicine, 2015. **8**(1).
10. World Health Organization, *Field Situation: How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola virus disease*, EVD/Guidance, Editor. 2014, World Health Organization.
11. Thompson, S. and M. Das, *Helpdesk Report: Ebola - Traditional healers, witch doctors, burial attendants*. 2015, HEART Helpdesk.
12. Thompson, S. and L. Bolton, *Helpdesk Report: Ebola Regional Lesson Learning*. 2014, HEART Helpdesk.

13. Grant, C., *Helpdesk Report: Ebola-local beliefs and behaviour change*. 2014, HEART Helpdesk.
14. Fleck, F., *The human factor*. Bulletin of the World Health Organization, 2015. **93**(2): p. 72-73.
15. Oosterhoff, P., *Local Engagement in Ebola Outbreaks and Beyond in Sierra Leone*, S.E.-B.P. Programme, Editor. 2015, IDS: Brighton.
16. Ssali, S., *Managing the Ebola Epidemic in Uganda in 2000-2001*, R. Consortium, Editor. 2014.
17. Hewlett, B.S., et al., *Medical anthropology and Ebola in Congo: cultural models and humanistic care*. Bulletin de la Societe de Pathologie Exotique, 2005. **98**(3): p. 230-6.
18. Omidian, P., K. Tehoungue, and J. Monger, *Medical Anthropology Study of the Ebola Virus Disease (EVD) Outbreak in Liberia/West Africa*. WHO Field Report. Monrovia Liberia, 2014.
19. Berliner, D., *Perception of haemorrhagic fevers of Ebola virus on the Congo-Gabon border*. Civilisations, 2004. **LII**(1): p. 117-120.
20. International Federation of Red Cross for Psychosocial Support, *Psychosocial support during an outbreak of Ebola virus disease*. 2014, International Federation of the Red Cross.
21. Fairhead, J., *The significance of death, funerals and after-life in Ebola-hit Sierra Leone, Guinea and Liberia: Anthropological insights into infection and social resistance*. 2014.
22. Duff, J.F. and W.W. Buckingham, *Strengthening of partnerships between the public sector and faith-based groups*. The Lancet, 2015.
23. De Roo, A., et al., *Survey among survivors of the 1995 Ebola epidemic in Kikwit, Democratic Republic of Congo: Their feelings and experiences*. Tropical Medicine and International Health, 1998. **3**(11): p. 883-885.
24. Pew Research Center. *Overview: Pentecostalism in Africa*. Religion & Public Life 2006 [cited 2016 03 February 2016]; Available from:

<http://www.pewforum.org/2006/10/05/overview-pentecostalism-in-africa/>.

25. Wariboko, N., *West African Pentecostalism: A survey of everyday theology*, in *Global Renewal Christianity; Spirit-empowered movements past, present, and future*, V. Synan, A. Yong, and J.K. Asamoah-Gyadu, Editors. 2016, Charisma House: Florida, USA.
26. Gusman, A., *HIV/AIDS, Pentecostal churches, and the "Joseph Generation" in Uganda. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.)*. *Africa Today*, 2009. **56**(1): p. 67-86.
27. Tumpey, A.J., D. Daigle, and G. Nowak, *Communicating During an Outbreak or Public Health Investigation*, C.f.D.C.a. Prevention, Editor. 2018, CDC.
28. *Sub-Saharan Africa. The future of world religions: population growth projections, 2010-2050* 2015 [cited 2019 24 June]; Available from: <https://www.pewforum.org/2015/04/02/sub-saharan-africa/>.
29. Norris, P. and R. Inglehart, *Sacred and Secular; Religion and politics worldwide*. 2006, NY: Cambridge University Press.
30. Chaves, M., *secularization as declining religious authority*. *Social Forces*, 1994. **72**(3): p. 749-774.
31. Berger, P.L., *The Desecularization of the World; Resurgent religion and World Politics*. 1999, Grand Rapids, Michigan: Ethics and Public Policy Center and Wm. B. Eerdmans Publishing Co.
32. Stark, R. and R. Finke, *Acts of Faith: Explaining the human side of religion*. 1 ed. 2000, Oakland, CA: University of California Press.
33. Swatos, W.J. and K. Christiano, *Secularization Theory: The course of a concept*. *Sociology of Religion*, 1999. **60**(3): p. 209-228.
34. Hadden, J., *Toward Desacralizing Secularization Theory*. *Social Forces*, 1987. **65**(3): p. 587-611.

35. *Faith Partnership Principles: Working effective with faith groups to fight global poverty*, D.f.I. Development, Editor. 2012, Department of International Development: UK.
36. *World Religion Database*. 2008 [cited 2019 27 June].
37. Bodakwoski, M., *Faith-Inspired Development Work: Lessons Learned and Next Steps*. 2012, Georgetown University.
38. Dickinson, E., *Faith in Africa*, in *Foreign Policy*. 2010, Foreign Policy.
39. Wrogermann, H., *Intercultural Hermeneutics*. Vol. One. 2012, Illinois, USA: IVP Academic.
40. Luga, L. and A. Cooperman. *Tolerance and Tension: Islam and Christianity in sub-Saharan Africa*. Religion & Public Life 2010 [cited 2016 13 October]; Available from: <http://www.pewforum.org/2010/04/15/executive-summary-islam-and-christianity-in-sub-saharan-africa/>.
41. Kalu, O., *African Christianity; An African Story*. Vol. 1. 2007, Trenton, New Jersey: Africa World Press, Inc.
42. Hall, B.L., G.J.S. Dei, and D.G. Rosenberg, *Indigenous knowledges in global contexts: Multiple readings of our world*. 2000: University of Toronto Press.
43. *World Population Review*. Continents 2018 [cited 2019 06 April 2019]; Available from: <http://worldpopulationreview.com/continents/africa-population/>.
44. *Under-five mortality*. UNICEF Data: Monitoring the situation of children and women 2018 March 2018 [cited 2019 26 June]; Available from: <https://data.unicef.org/topic/child-survival/under-five-mortality/>.
45. Ortiz-Ospina, E. and M. Roser. *Our world in data*. Global Health 2019 [cited 2019 26 June]; Available from: <https://ourworldindata.org/health-meta>.
46. *Plagues*. 1st ed. 2017, UK: Cambridge University Press.
47. WHO, *Factors that contributed to undetected spread of the Ebola virus and impeded rapid containment*. 2015, WHO: Geneva.

48. World Health Organization. Key facts on HIV epidemic and progress in regions and countries in 2010 2011 [cited 2020 11 May 2020]; Available from: https://www.who.int/hiv/pub/progress_report2011/regional_facts/en/.
49. Fatokun, S., *Christianity in Africa: a historical appraisal*. Verbum et Ecclesia, 2005. **26**(2).
50. Asamoah-Gyadu, J.K., *Current developments within independent indigenous Pentecostalism in Ghana*. Journal of Religion in Africa, 2005. **27**.
51. Mead, F., S. Hill, and C. Atwood, *The Handbook of Denominations in the United States*. 2010, Nashville, TN: Abingdon Press.
52. Gyimah, S.O., et al., *Religion, religiosity and premarital sexual attitudes of young people in the informal settlements of Nairobi, Kenya*. J Biosoc Sci, 2013. **45**(1): p. 13-29.
53. Ann Neville, M., et al., *Kenyan pastors' perspectives on communicating about sexual behaviour and HIV*. African Journal of AIDS Research, 2011. **10**(3): p. 271-280.
54. Farhadian, C., *Introducing world religions; a Christian engagement*. 2015, Michigan, USA: Baker Academic.
55. Robbins, J., *The Globalization of Pentecostal and Charismatic Christianity*. Annual Review of Anthropology, 2004. **33**: p. 117-143.
56. Jenkins, P., *The Next Christendom; The coming of global Christianity*. 2002, New Hork: Oxford University Press.
57. Asamoah-Gyadu, K., *African Pentecostal/Charismatic Christianity: An Overview*. Lausanne World Pulse Archives, 2006(08).
58. Kärkkäinen, V.-M., *An Introduction to Ecclesiology: Ecumenical, Historical & Global Perspectives*. 2009, Downers Grove, Illinois: Inter-Varsity Press.
59. Burgess, S. and E. Van der Maas, *The New International Dictionary of Pentecostal Charismatic Movements*. 2002, Grand Rapids, Michigan: Zondervan.
60. *Assemblies of God; Protestant denomination*, in *Encyclopaedia Britannica*, G. Aakanksha, Editor. 2018.

61. *Church of God in Christ*, in *Encyclopedia.com*. 2020.
62. Gillepsie, A., et al., *Social mobilization and community engagement central to the Ebola response in West Africa: Lessons for future public health emergencies*. *Global Health Science and Practice*, 2016. 4(4): p. 626-646.
63. Gusman, A., *The abstinence campaign and the construction of the Balokole identity in the Ugandan Pentecostal movement*. *Canadian Journal of African Studies / Revue canadienne des études africaines*, 2013. 47(2): p. 273-292.
64. Cox, H., *Fire From Heaven; The rise of Pentecostal spirituality and the reshaping of religion in the twenty-first century*. 1995, Cambridge, MA: Da Capo Press.
65. Wariboko, N., *Pentecostalism in Africa*, in *Oxford Research Encyclopedias*. 2017, Oxford University Press: USA.
66. Ayegboyin, D. and A. Ishola, *African Indigenous Churches*. 2011: Institute for Religious Research.
67. Piot, C., *Pentecostal and Development Imageries in West Africa*, in *Pentecostalism and development; churches, NGOs and social change in Africa*, D. Freeman, Editor. 2012, Palgrave Macmillan: Hampshire, England.
68. Anderson, A., *The Newer Pentecostal and Charismatic Churches: The Shape of Future Christianity in Africa*. *Pneuma*, 2002. 24(2): p. 167-184.
69. Myers, B., *Engaging Globalization; The poor, Christian mission, and our hyperconnected world*. 2017, Grand Rapids, MI: Baker Academic.
70. *The Redeemed Christian Church of God*. 2020 [cited 2020 03 December]; Available from: <https://www.rccg.org>.
71. Gifford, P., *Healing in African Pentecostalism: The "victorious Living" of David Oyedepo*, in *Global Pentecostal and Charismatic Healing*, C.G. Brown, Editor. 2011, Oxford University Press: USA.
72. *Historical Overview of Pentecostalism in Nigeria; Origins and Growth*. *Religion & Public Life* 2006 [cited 2020 10 August 2020]; Available from: <https://www.pewforum.org/2006/10/05/historical-overview-of-pentecostalism-in-nigeria/>.

73. Parsitau, D.S., *From the periphery to the centre: the Pentecostalisation of mainline Christianity in Kenya*. *Missionalia*, 2007. **35**(3): p. 83-111.
74. Parsitau, D.S., "Keep holy distance and abstain till he comes": interrogating a Pentecostal church's engagements with HIV/AIDS and the youth in Kenya. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.). *Africa Today*, 2009. **56**(1): p. 45-64.
75. Asamoah-Gyadu, K., *Pentecostalism in Africa and the changing face of Christian mission*. *Mission Studies*, 2002. **19**: p. 14-38.
76. Attanasi, K., *Pentecostal theologies of healing, HIV/AIDS, and women's agency in South Africa*. *Pneuma*, 2015. **37**(1): p. 7-20.
77. Bangura, J.B., *Hope in the midst of Death: Charismatic Spirituality, Healing Evangelists and the Ebola Crises in Sierra Leone*. *Missionalia*, 2016. **44**(1).
78. Pfeiffer, J., *Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: a clash of AIDS prevention messages*. *Med Anthropol Q*, 2004. **18**(1): p. 77-103.
79. Pfeiffer, J., *Commodity fetichismo, the Holy Spirit, and the turn to Pentecostal and African Independent Churches in Central Mozambique*. *Cult Med Psychiatry*, 2005. **29**(3): p. 255-83.
80. Pfeiffer, J., *Pentecostalism and AIDS treatment in Mozambique: creating new approaches to HIV prevention through anti-retroviral therapy. (Special Issue: Religious responses to HIV and AIDS.)*. *Global Public Health*, 2011. **6**(Suppl. 2): p. S163-S173.
81. Pfeiffer, J., K. Gimbel-Sherr, and O.J. Augusto, *The Holy Spirit in the household: Pentecostalism, gender, and neoliberalism in Mozambique*. *American Anthropologist*, 2007. **109**(4): p. 688-700.
82. *Under the radar: Pentecostalism in South Africa and its potential social and economic role, in Pentecostalism and prosperity; The socioeconomics of the global charismatic*

- movement*, K. Attanasi and A. Yong, Editors. 2012, Palgrave MacMillan: New York.
83. Gifford, P., *Christianity and politics in Doe's Liberia*. 1993, NY: Univeristy Press, Cambridge.
 84. Freeman, D., *Pentecostalism and econimic development in sub-Saharan Africa*, in *The Routledge Handbook of Religions and Global Development*, E. Tomalin, Editor. 2015, LSE: UK.
 85. Omenyo, C.N., *New wine in an old wine bottle? Charismatic healing in the mainline churches in Ghana*, in *Global Pentecostal and Charismatic Healing*, C.G. Brown, Editor. 2011, Oxford University Press: USA.
 86. Adogame, A., *HIV/AIDS support and African Pentecostalism: the case of the Redeemed Christian Church of God (RCCG)*. *Journal of Health Psychology*, 2007. **12**(3): p. 475-484.
 87. Garner, R.C., *Safe sects? Dynamic religion and AIDS in South Africa*. *Journal of Modern African Studies*, 2000. **38**(1): p. 41-69.
 88. Kagee, A. and T. Delpont, *Barriers to adherence to antiretroviral treatment: the perspectives of patient advocates*. *J Health Psychol*, 2010. **15**(7): p. 1001-11.
 89. Lartey, E.Y., *HEALING: TRADITION AND PENTECOSTALISM IN AFRICA TODAY*. *International Review of Mission*, 1986. **75**(297): p. 75-81.
 90. Manglos, N.D. and J. Trinitapoli, *The third therapeutic system: faith healing strategies in the context of a generalized AIDS epidemic*. *J Health Soc Behav*, 2011. **52**(1): p. 107-22.
 91. Bochow, A. and R. Van Dijk, *Christian creations of new spaces of sexuality, reproduction, and relationships in Africa: Exploring faith and religious heterotopia: A Special Issue of the Journal of Religion in Africa*. *Journal of Religion in Africa*, 2012. **42**(4): p. 325-344.
 92. Seeling, S., et al., *Barriers to access to antiretroviral treatment for HIV-positive tuberculosis patients in Windhoek, Namibia*. *International Journal of Mycobacteriology*, 2014. **3**(4): p. 268-275.

93. Kisenyi, R.N., J.K. Muliira, and E. Ayebare, *Religiosity and adherence to antiretroviral therapy among patients attending a public hospital-based HIV/AIDS clinic in Uganda*. *Journal of Religion & Health*, 2013. **52**(1): p. 307-17.
94. Adogame, A., *'A walk for Africa': combating the demon of HIV / AIDS in an African Pentecostal Church - the case of the Redeemed Christian Church of God: the challenge of HIV / AIDS to Christian theology*. *Scriptura*, 2005. **89**(2): p. 396-405.
95. Asare, M. and S. Danquah, *The African Belief System and the Patient's Choice of Treatment from Existing Health Models: The Case of Ghana*. *Acta Psychopathologica*, 2017. **3**(4:40).
96. White, P., *The concept of diseases and health care in African traditional religion in Ghana*. *HTS Theologiese Studies / Theological Studies*, 2015. **71**(3).
97. Kangwa, J., *Pentecostalisation of Mainline Churches in Africa: The Case Of The United Church of Zambia*. *The Expository Times*, 2016: p. 0014524616646677.
98. Kangwa, J., *The role of the theology of retribution in the growth of Pentecostal-Charismatic churches in Africa*. *Verbum et Ecclesia*, 2016. **37**(1).
99. Manguvo, A. and B. Mafuvadze, *The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift*. *Pan African Medical Journal*, 2015. **22**(Suppl 1).
100. Falade, B. and C. Coultas, *Scientific and non-scientific information in the uptake of health information: The case of Ebola*. *South African Journal of Science*, 2017. **113**(7/8).
101. Ucheaga, D.N. and K.A. Hartwig, *Religious Leaders Response to AIDS in Nigeria*. *Global Public Health*, 2010. **5**(6): p. 611-625.
102. Bertozzi, S., T. Martz, and P. Piot, *The evolving HIV/AIDS response and the urgent task ahead*, in *Fighting HIV/AIDS*. 2009, Project HOP-The People to People Health Foundation, Inc.

103. Kharsany, A. and Q. Karim, *HIV Infection and AIDS in sub-Saharan Africa: Current status, challenges and opportunities*. Open AIDS Journal, 2016. **10**: p. 34-38.
104. Mulwo, A.K., K.G. Tomaselli, and M.D. Francis, *HIV/AIDS and discourses of denial in sub-Saharan Africa: An Afro-optimist response?* International Journal of Cultural Studies, 2012. **15**(6): p. 567-582.
105. Trinitapoli, J., *Religious responses to AIDS in sub-Saharan Africa: an examination of religious congregations in rural Malawi*. Review of Religious Research, 2006. **47**(3): p. 253-270.
106. Winskell, K., E. Hill, and O. Obyerodhyambo, *Comparing HIV-related symbolic stigma in six African countries: Social representations in young people's narratives*. Social Science and Medicine, 2011. **73**(8): p. 1257-1265.
107. Anderson, A.H., *To the Ends of the Earth: Pentecostalism and the Transformation of World Christianity*. To the Ends of the Earth: Pentecostalism and the Transformation of World Christianity. 2013. 1-336.
108. Featherstone, A., *Keeping the Faith the Role of Faith Leaders in the Ebola Response*. 2015, Christian Aid, Tearfund, Islamic Relief Worldwide. p. 11.
109. Mpofu, E., et al., *Faith and HIV prevention: the conceptual framing of HIV prevention among Pentecostal Batswana teenagers*. BMC Public Health, 2014. **14**: p. 225.
110. Smith, D.J., *Youth, sin and sex in Nigeria: Christianity and HIV/AIDS-related beliefs and behaviour among rural-urban migrants*. Culture, Health & Sexuality, 2004. **6**(5): p. 425-437.
111. Zou, J., et al., *Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes*. BMC Public Health, 2009. **9**: p. 75.
112. Fenollar, F. and O. Mediannikov, *Emerging infectious diseases in Africa in the 21st century*. New Microbes and New Infections, 2018. **26**: p. S10 - S18.
113. Radhakrishnan, A., et al., *Introductory article on global burden and epidemiology of typhoid fever*. American

- Journal of Tropical Medicine and Hygiene, 2018. **99**(3 suppl): p. 4-9.
114. WHO, *Malaria*. 2019, World Health Organization.
 115. Colvin, C., et al., *Understanding careseeking for child illness in sub-Saharan Africa: A systematic review and conceptual framework based on qualitative research of household recognition and response to child diarrhoea, pneumonia and malaria*. *Social Science & Medicine*, 2013. **86**: p. 66-78.
 116. Pryce, J., M. Richardson, and C. Lengeler, *Insecticide-treated nets for preventing malaria (review)*. 2018: Cochrane Database of Systematic Reviews.
 117. *Frequently asked questions on Ebola virus disease*. Emergencies Preparedness, response 2017 [cited 2019 28 June]; Available from: <https://www.who.int/csr/disease/ebola/faq-ebola/en/>.
 118. *The AAA/Wenner-Gren Ebola Emergency Response Workshop Preliminary Guidances and Recommendations*, in *Ebola Anthropology Guidances and Recommendations*. 2014, American Anthropological Association.
 119. Marshall, K. and C. Corman, *Responding to the Ebola epidemic in West Africa: What role does religion play?* 2016, Berkley Center for Religion, Peace, and World Affairs: Georgetown University.
 120. Blevins, J., M. Jalloh, and D. Robinson, *Faith and global health practice in Ebola and HIV emergencies*. *American Journal of Public Health*, 2019. **109**(3): p. e1-36.
 121. Asamoah-Gyadu, J.K., "We are on the internet": *Contemporary pentecostalism in Africa and the new culture of online religion*, in *New Media and Religious Transformations in Africa*. 2015. p. 157-170.
 122. Wake, C. *The role of fear in the Ebola response*. 2015 [cited 2019 28 June]; Available from: <https://www.odi.org/blogs/9968-role-fear-ebola-response>.
 123. Maganga, G.D., et al., *Ebola virus disease in the Democratic Republic of Congo*. *New England Journal of Medicine*, 2014. **371**(22): p. 2083-2091.

124. *2014-2016 Ebola outbreak in West Africa*. Ebola (Ebola Virus Disease) 2019 [cited 2019 28 June]; Available from: <https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html>.
125. *A fast-moving Ebola epidemic full of tragic surprises*. Emergencies preparedness, response 2014 [cited 2019 28 June]; Available from: <https://www.who.int/csr/disease/ebola/ebola-6-months/surprises/en/>.
126. Marshall, K., *Roles of religious actors in the West African Ebola response*. *Development in Practice*, 2017. **27**(5): p. 622-633.
127. *Ebola virus disease*. 2019 [cited 2019 29 June]; Available from: <https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease>.
128. *Global religious futures*. Pew-Templeton global religious futures project [cited 2019 29 June]; Available from: <http://www.globalreligiousfutures.org/countries>.
129. Hoffman, D., *Monrovia Modern: urban form and political imagination in Liberia*. 2017, Durham and London: Duke University Press.
130. Holsoe, S., D. Petterson, and A. Jones. *Encyclopaedia Britannica*. Liberia 2005 [cited 2019 26 February]; Available from: <https://www.britannica.com/place/Liberia/Government-and-society>.
131. Barbu, J., *Liberia's religious democracy and hidden conflicts*, in *The nineteenth annual international law and religion symposium*. 2012, Brigham Young University: Provo-Utah.
132. CILSS, *Country Profiles, Land Use and Land Cover, and Trends; Liberia*, in *Landscapes of West Africa; A Window on a Changing World*. 2016, U.S. Geological Surveys EROS: Garretson, SD 57030. p. 148-156.
133. Dunn-Marcos, R., et al., *Liberians an introduction to their history and culture*, C.f.A. Linguistics, Editor. 2005, Center for Applied Linguistics: Washington, DC.

134. Ellis, S., *Mystical weapons: Some evidence from the Liberian war*. *Journal of Religion in Africa*, 2001. **31**(2): p. 222-236.
135. IEG, *Liberia Country Program evaluation: 2004-2011*. 2013, World Bank: Washington, D.C.
136. *Liberia society and culture*. 2011, Best Country Reports: Petaluma, California.
137. *Index mundi*. Liberia Religions 2018 [cited 2019 27 February]; Available from: <https://www.indexmundi.com/liberia/religions.html>.
138. Heaner, G., *Destroying the destroyer of your destiny*, in *Department of the Study of Religions*. 2011, The School of Oriental and African Studies.
139. Marshall, R., *Political spiritualities. The Pentecostal revoution in Nigeria*. 2009, Chicago, IL: University of Chicago Press.
140. Dennis, P., *A Brief History of Liberia*. 2006, International Center for Transitional Justice.
141. Ellis, S., *The mask of anarchy* 1999, London: Hurst & Company.
142. Fulton, R.M., *The Kpelle Traditional Political System*, in *Liberian Studies Journal*, S. Holsoe and D.M. Foley, Editors. 1968, African Studies Center: DePauw Univeristy.
143. Kieh, G., *Liberia: Religious Leaders, Peacemaking, and the First Liberian Civil War*, in *Religion and Conflict Case Study Series*. 2013, Berkley Center for Religion, Peace & World Affairs: Georgetown University.
144. Press, R.M., "Guided by the hand of God": *Liberian women peacemakers and civil war*. *The Review of Faith & International Affairs*, 2010: p. 23-29.
145. *Liberia: Churches call for peace support*. *Africa Action Africa Policy E-Journal*, 2003.
146. Kieh, G., *Ending Liberia's second civil war: Religious women as peacemakers*, in *Religion and Conflict Case Study Series*. 2013, Berkley Center for Religion, Peace and World Affairs: Georgetown University.

147. Ouellit, J.X., *Women and Religion in Liberia's Peace and REconciliation*. Critical INTERsections in Education: An OISE/UT Students' Journal, 2013. **1**(1): p. 12-20.
148. Alber, E., T. Häberlein, and J. Martin, *Changing webs of kinship: Spotlights on West Africa webs of kinship*. Afrika Spectrum, 2010. **45**(3).
149. Mukpo, A., *Surviving Ebola; public perceptions of governance and the outbreak response in Liberia*. 2015, International Alert.
150. Greyling, C., et al., *Lessons from the faith-drive response to the West Africa Ebola epidemic*. The Review of Faith & International Affairs, 2016. **14**(3): p. 118-123.
151. Ecke, J.P., *Continuity and discontinuity: Pentecostalism and cultural change in a Liberian refugee camp in Ghana*. PentecoStudies 2015. **14**(1): p. 42-71.
152. Ter Haar, G., *Religion and development what's in two names*, in *Symposium on the 10th anniversary of the chair of religion and development, 11 June 2009*. 2009: The Hague - The Netherlands.
153. Shaw, R., *Displacing Violence: Making Pentecostal memory in postwar Sierra Leone*. Cultural Anthropology, 2007. **22**(1): p. 66-93.
154. *Liberia: Poverty Reduction Strategy Paper*, I.M. Fund, Editor. 2008, IMF Publication Services: Washington, DC.
155. Quinn, M., *Governance and health in post-conflict countries: The Ebola outbreak in Liberia and Sierra Leone*. 2016, International Peace Institute: New York.
156. Derderian, K., H. Lorinquer, and S. Goetghebuer, *Post-war Liberia: Healthcare in the balance*. Forced Migration, 2007. **28**.
157. *Government of Liberia national health policy*, M.o.H.a.S. Welfare, Editor. 2007, Government of Liberia: Liberia.
158. Cheng, M., *Reviving health care in Liberia*. The Lancet, 2009. **373**: p. 1239-1240.
159. Kamal-Yanni, M., *Never Again building resilient health systems and learning from the Ebola crisis*. 2015, OXFAM: Oxford.

160. *World Health Organization. One year into the Ebola epidemic: a deadly, tenacious and unforgiving virus 2015* [cited 2019 26 February]; Available from: <https://www.who.int/csr/disease/ebola/one-year-report/introduction/en/>.
161. Chan, M., *Ebola Virus Disease in West Africa - No early end to the outbreak*. The New England Journal of Medicine, 2014. **371**.
162. Varpilah, S.T., et al., *Rebuilding human resources for health: a case study from Liberia*. Human Resources for Health, 2011. **9**(11).
163. Shultz, J., et al., *The role of fear-related behaviors in the 2013-2016 West Africa Ebola virus disease outbreak*. Current Psychiatry Reports, 2016. **18**(11).
164. Chandler, C., et al., *Ebola: limitations of correcting misinformation*. The Lancet, 2015. **385**: p. 1275-1276.
165. Allen, D. and R. Lacson, *Understanding why Ebola deaths occur at home in urban Montserrado County, Liberia*. 2015, CDC, Liberia Ministry of Health.
166. A., W., et al., *Engaging 'communities': anthropological insights from the West African Ebola epidemic*. Philosophical Transactions of the Royal Society B: Biological Sciences, 2016. **372**(1721).
167. Abramowitz, S.A., et al., *The opposite of denial: Social learning at the onset of the Ebola emergency in Liberia*. Journal of health communication, 2017. **22**: p. 59-65.
168. Allgaier, J. and A. Svalastog, *The communication aspects of the Ebola virus disease outbreak in Western Africa - do we need to counter one, two or many epidemics/*. Croatian Medical Journal, 2015. **56**(5): p. 496-499.
169. Modino, C. and A. Street, *The pivotal role of faith leaders in the Ebola Virus Disease outbreak in West Africa*. 2014, CAFOD: London.
170. Sirleaf, E., *Statement on the declaration of a state of emergency by President Ellen Johnson Sirleaf*. 2014, Government of Liberia.
171. Fairhead, J., *The significance of death, funerals and the after-life in Ebola-hit Sierra Leone, Guinea and Liberia*:

- Anthropological insights into infection and social resistance.* 2014.
172. Faye, S., *How anthropologists help medics fight Ebola in Guinea.* 2014, Sci Dev Net.
 173. Kinsman, J., et al., *Development of a set of community-informed Ebola messages for Sierra Leone.* PLoS Negl Trop Dis, 2017. **11**(8).
 174. *Latest Ebola outbreak over in Liberia; West Africa is at zero, but new flare-ups are likely to occur.* 2016, World Health Organization.
 175. Saul, H., *Ebola virus: Liberia church leaders claim deadly outbreak is 'plague' sent by God for 'homosexuality' and 'immoral acts',* in *The Independent.* 2014, The Independent: UK.
 176. Onishi, N., *Liberia conquers Ebola, but faces a crisis of faith,* in *The New York Times.* 2015, The New York Times: NYC.
 177. *Liberia: A country - and its capital - are overwhelmed with Ebola cases,* in *Emergencies preparedness, Response.* 2015, WHO.
 178. Sarukhan, A., *Ebola: Two years and 11,300 deaths later.* 2016, IS Global; Barcelona Institute for Global Health.
 179. Marshall, K. *Ebola: Ten proposals to engage religious actors more proactively.* Faith in Action 2014 [cited 2019 12 June 2019]; Available from: <https://berkleycenter.georgetown.edu/posts/ebola-ten-proposals-to-engage-religious-actors-more-proactively>.
 180. Denis, P., *HIV/AIDS and religion in sub-Saharan Africa: an emerging field of enquiry.* Archives de sciences sociales des religions, 2013. **164**: p. 43-58.
 181. Green, E., *The impact of religious organizations in promoting HIV/AIDS prevention,* in *Challenges for the Church: AIDS, Malaria & TB.* 2001: Arlington, VA.
 182. Mantell, J., et al., *Conflicts between conservative Christian institutions and secular groups in sub-Saharan Africa: Ideological discourses on sexualities, reproduction, and HIV/AIDS.* Global Public Health, 2011. **6**: p. S192-S209.

183. Miller, A.N., et al., *Kenyan pastors' perspectives on communicating about sexual behaviour and HIV*. African Journal of AIDS Research, 2011. **10**(3): p. 271-280.
184. Miller, A.N. and K.W. Ngula, *The impact of church contextual factors on church-going youth's HIV prevention behaviour in Nairobi, Kenya: A cross-denominational study*. African Journal of AIDS Research, 2013. **12**(3): p. 131-140.
185. Prince, R., P. Denis, and R.v. Dijk, *Special Issue: Christianity and HIV/AIDS in East and Southern Africa. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.)*. 2009: Africa Today; 2009. 56(1):v-xviii + 3-120.
186. Rigillo, N., *Faith in God, But Not in Condoms: Churches and Competing Visions of HIV Prevention in Namibia*. Canadian Journal of African Studies / Revue canadienne des études africaines, 2011. **43**(1): p. 34-59.
187. Trinitapoli, J. and M.D. Regnerus, *Religion and HIV risk behaviors among married men: Initial results from a study in rural sub-Saharan Africa*. Journal for the Scientific Study of Religion, 2006. **45**(4): p. 505-528.
188. van Dijk, R., *Counselling and Pentecostal modalities of social engineering of relationships in Botswana*. Cult Health Sex, 2013. **15 Suppl 4**: p. S509-22.
189. Miller, A.N., K.W. Ngula, and G. Musambira, *Predictors of sexual behaviour among church-going youths in Nairobi, Kenya: A cross-denominational study*. African Journal of AIDS Research, 2012. **11**(1): p. 57-64.
190. Mhizha, S., *Religious self-beliefs and coping among vending adolescent in harare*. J Relig Health, 2014. **53**(5): p. 1487-97.
191. Adogame, A., *Africa Christianities and the politics of development from below*. HTS Theological Studies, 2016. **72**(4).
192. Togarasei, L., *The Pentecostal gospel of prosperity in African contexts of poverty: an appraisal*. Exchange, 2011. **40**(4): p. 336-350.

193. van Dijk, R., *Counselling and Pentecostal modalities of social engineering of relationships in Botswana*. Culture, Health and Sexuality, 2013. **15**(4).
194. *Lessons from Ebola Affected communities: Being prepared for future health crises*, T. Hird and S. Linton, Editors. 2016, Polygeia.
195. Homer, K., *Still surviving Ebola; Emergency and recovery response in Sierra Leone*, E. Valdez, Editor. 2016, World Vision.
196. Modarres, N., *Community perspectives about Ebola in Bong, Lofa and Montserrado counties of Liberia: Results of a qualitative study*, J.H.C.f.C. Programs, Editor. 2015, USAID.
197. Oosterhoff, P. and A. Wilkinson, *Local Engagement in Ebola Outbreaks and Beyond in Sierra Leone*. 2015.
198. Thompson, S. and L. Bolton, *Ebola Regional Lesson Learning*. 2014, HEART; Health & Education Advice & Resource Team: UK.
199. Hammarberg, K., M. Kirkman, and S.d. Lacey, *Qualitative research methods: when to use them and how to judge them*. Human Reproduction, 2016. **31**(3): p. 498-501.
200. Padgett, D.K., *Qualitative methods in social work research*. 2nd ed. 2008, New York, NY: SAGE Publications Inc.
201. Ritchie, J., *The applications of qualitative research methods*, in *Qualitative research practice; a guide for social science students and researchers*, J. Ritchie and J. Lewis, Editors. 2003, SAGE Publications Inc.
202. Glanz, K. and D.B. Bishop, *The Role of Behavioral Science Theory in development and Implementation of Public Health Interventions*. Annual Review of Public Health, 2010. **31**: p. 399-418.
203. Prochaska, J.O. and W.F. Velicer, *The Transtheoretical Model of Health Behavior Change*. American Journal of Health Promotion, 1997. **12**(1): p. 38-48.
204. LaMorte, W. *The Transtheoretical Model (Stages of Change)*. Behavioral Change Models 2019 [21 February 2020]; Available from: <http://sphweb.bumc.bu.edu/otlt/MPH->

[Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html](#).

205. LaMorte, W. *The Health Belief Model*. 2019 [cited 2020 21 February 2020]; Available from: <http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html>.
206. Stokols, D., *Translating social ecological theory into guidelines for community health promotion*. American journal of health promotion, 1996. **10**(4): p. 282-298.
207. Golden, S.D. and J.L. Earp, *Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education & Behavior Health Promotion Interventions*. Health Education & Behavior, 2012. **39**(3): p. 364-372.
208. Bandura, A., *Social Cognitive Theory in Cultural Context*. Applied Psychology: An International Review, 2002. **51**(2).
209. Harding, T. and D. Whitehead, *Analysing data in qualitative research, in Nursing & midwifery research: methods and appraisal for evidence-based practice*. 2013, Elsevier-Mosby, Marrickville, Sydney. p. 141-160.
210. Avis, M., *Do we need methodological theory to do qualitative research?* Qualitative Health Research, 2003. **13**(7): p. 99501004.
211. Lawrence, J.a.T., U., *The use of Grounded Theory Technique as a Practical Tool for Qualitative Data Collection and Analysis*. The Electronic Journal of Business Research Methods, 2013. **11**(1): p. 29-40.
212. Lingard, L., M. Albert, and W. Levinson, *Grounded theory, mixed methods, and action research*. Bmj, 2008. **337**.
213. Welch, P., et al., *Clinical assessment and reasoning it iterative, un-blinded and inductive*. 2017: MedEdPublish.
214. Antonakis, J., *Transformational and charismatic leadership, in The nature of leadership*, D. Day and J. Antonakis, Editors. 2012, SAGE Publications Inc.
215. House, R.J. and J. Howell, *Personality and charismatic leadership*. Leadership Quarterly, 1992. **3**(2): p. 81-108.

216. House, R.J., *A 1976 theory of charismatic leadership*, in *Leadership: The cutting edge*, J.G. Hunt and L.L. Larson, Editors. 1977, Southern Illinois University Press: Carbondale, IL.
217. Northouse, P.G., *Leadership Theory and Practice*. 6th ed. ed. 2013, Los Angeles: Sage.
218. Heuser, R. and K. Byron, *Charismatic Leadership Theory: A shadow Side Confessed*. *Pneuma: The Journal of the Society for pentecostal Studies*, 1998. **20**(2): p. 161-174.
219. Barnes, D.F., *Charisma and Religious Leadership: An Historical Analysis*. *Society for the Scientific Study of Religion*, 1978. **17**(1): p. 1-18.
220. Jacobsen, C. and R.J. House, *Dynamics of charismatic leadership A process theory, simulation model, and tests*. *The Leadership Quarterly*, 2001. **12**: p. 75-112.
221. Sy, T., C. Horton, and R. Riggio, *Charismatic leadership: Eliciting and channeling follower emotions*. *The Leadership Quarterly*, 2018. **29**: p. 58-69.
222. Grabo, A., B.R. Spisak, and M. van Vugt, *Chrisma as signal: An evolutionary perspective on charismatic leadership*. *The Leadership Quarterly*, 2017. **28**: p. 473-485.
223. <*Special Issue.Engaging Christianities.HIV.pdf*>.
224. *2014-2016 Ebola outbreak in West Africa*. Ebola (Ebola Virus Disease) 2019 [cited 2019 23 July 2019]; Available from: <https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html>.
225. *Index Mundi*. Liberia 2018 [14 January 2019]; Available from: <https://www.indexmundi.com/liberia/#Introduction>.
226. Heaner, G., *Religion, law and human rights in post-conflict Liberia*. *African Human Rights Law Journal*, 2008. **8**(2): p. 458-485.
227. Liberia, i., *Liberia: Cumulative incidence of Ebola per 10,000 population by zone, Greater Monrovia*. 2014, iLab Liberia: Liberia.
228. Glaser, B. and A. Strauss, *The discovery of grounded theory: strategies for qualitative resaerch*. 1967, Chicago, IL: Aldine.

229. Charmaz, K., *Constructing grounded theory: a practical guide through qualitative analysis*. 2006, London: Sage.
230. Fusch, P. and L. Ness, *Are we there yet? Data saturation in qualitative research*. Walden University School of Management Publications, 2015. **20**(9).
231. Guest, G., A. Bunce, and L. Johnson, *How many interviews are enough?: An experiment with data saturation and variability*. *Field Methods*, 2006. **18**(59).
232. Bowen, G., *Naturalistic inquiry and the saturation concept: a research note*. *Qualitative Research*, 2008. **8**(1): p. 137-152.
233. Caelli, K., L. Ray, and J. Mill, *'Clear as mud'; Toward greater clarity in generic qualitative research*. *International Journal of Qualitative Methods*, 2003. **2**(2).
234. Francis, J., et al., *What is an adequate sample size? Operationalising data saturation for theory-based interview studies*. *Psychology & Health*, 2010. **25**(10): p. 1229-1245.
235. Vasileiou, K., et al., *Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period*. *BioMed Central Medical Research Methodology*, 2018. **18**(148).
236. Hennink, M., B. Kaiser, and V. Marconi, *Code saturation versus meaning saturation: How many interviews are enough?* *Qualitative Health Research*, 2016: p. 1-18.
237. Tucker, B., *A context and stakeholder focused exploration of the sustainability of local organizations in development*, in *Brown School of Social Work*. 2017, Washington University in St. Louis.
238. Kumar, R., *Research methodology a step-by-step guide for beginners*. 3rd ed. 2011: Sage Publications Ltd.
239. Charmaz, K., *Constructing Grounded Theory*. 2nd ed. 2014, Los Angeles, CA: Sage Publications, Inc.
240. Kuehne, A., et al., *Mortality, morbidity and health-seeking behaviour during the Ebola epidemic 2014-2015 in Monrovia results from a mobile phone survey*, in *Neglected Tropical Diseases*. 2016, PLOS.

241. UNFPA, *Religion and Development post - 2015*, in *Consultation among donor organizations, United Nations Development Agencies and faith-based organizations*, A. Karam, Editor. 2014, United Nations: New York.
242. *Liberian Council of Churches*. 2020 [cited 2020 25 March 2020]; Available from: <https://www.oikoumene.org/en/member-churches/africa/liberia/lcc>.
243. Thompson, S. and L. Bolton, *Ebola Regional Lesson Learning*, H.E.A.R. Team, Editor. 2014.

Appendix A: Literature Review Tables

Table 1 – Results of Initial Literature Review

Study Reference	Study Location	Study Objectives	Conclusions
ADOGAME, A. 2005. A Walk for Africa: Combatting the Demon of HIV/AIDS in an African Pentecostal Church – the case of the Redeemed Christian Church of God: the challenge of HIV/AIDS to Christian Theology. <i>Scriptura</i> , 89(2): pp. 396-405	Nigeria	To show examine the responses of African NPCs to HIV/AIDS, using the Redeemed Christian Church of God in Nigeria as a case study.	The paper discusses the silence in research on local church responses to HIV/AIDS. It discusses what the RCCG has done to impact the HIV/AIDS crisis, concluding that most of their response has been in the spiritual realm, to pray against the demon of HIV, but notes that they have also responded medically and in HIV education, including advocating for messages of abstinence and fidelity.
ADOGAME, A. 2007. HIV/AIDS support and African Pentecostalism: the case of the Redeemed Christian Church of God (RCCG). <i>Journal of Health Psychology</i> , 12, 475-484.	Nigeria	To show methods and extent of engagement in HIV/AIDS of African Pentecostal churches. To look at church beliefs vis-à-vis HIV/AIDS and examine how the RCCG church responds, in light of these beliefs.	The paper discusses the rapid rise and spread of NPCs in Africa. The RCCG Church is discussed as an example of Pentecostal reactions to HIV/AIDS. This church believes that demons are one cause of HIV/AIDS, thus eliciting a spiritual response of prayer against these demons. However, there is also a more pragmatic response of involvement in ARV provision and HIV/AIDS education. While some of their practices are controversial (no condom promotion, abstinence-only sex education and the belief that some members have been divinely healed of HIV), the paper postulates that the church provides an element of social, spiritual and emotional support for those with HIV as well as contributing to community HIV

Study Reference	Study Location	Study Objectives	Conclusions
			education, highlighting the role that faith can play, on their level, in HIV/AIDS.
Adogame, A., <i>Africa Christianities and the politics of development from below</i> . HTS Theological Studies, 2016. 72(4).	Africa	Aims to examine development from the grassroots, rather than from the macro-level of large NGOs.	Discusses the examination of development through the lens of religion and spirituality. The author states that most development reports and research do not consider development that is occurring in the religious sector, specifically in grassroots faith institutions. He argues that religion has been involved in positive development activities and uses the RCCG church as an example.
ATTANASI, K. 2015. Pentecostal theologies of healing, HIV/AIDS, and women's agency in South Africa. <i>Pneuma</i> , 37, 7-20.	South Africa	To examine gender implications that arise from the healing theologies of black, Pentecostal churches.	Pentecostal theologies of healing can impact women's ability to flourish both positively and negatively. Women benefit psychologically from prayer, which also impacts their physical health. Women also benefit from the variety of social outlets that Pentecostal churches provide for their members. This study also showed that the churches interviewed had a respect for medical science, which is surprising given their beliefs on healing. Women are also negatively affected by these beliefs as the burden of not being healed falls on the individual. Women also bear a burden when prayer is viewed as a valid strategy for HIV prevention.
BANGURA, J. B. 2016. Hope in the midst of death: Charismatic spirituality, healing evangelists and the Ebola crisis in Sierra Leone.	Sierra Leone	To understand NPC approaches to outbreaks and the belief in healing.	NPCs are a rapidly growing church movement in SL. SL had a poor health infrastructure before the outbreak, which played into the severity of the outbreak as well as into the culture of seeking

Study Reference	Study Location	Study Objectives	Conclusions
<i>Missionalia</i> , 44, 2-18.		<p>To look at the healthcare infrastructure before Ebola.</p> <p>To examine SL's culture and values to understand how they view illness and death.</p> <p>To look at how NPCs use the bible to explain illness and suffering.</p> <p>To examine NPC spirituality in dealing with Ebola.</p>	<p>healing from traditional healers or churches that believed in divine healing.</p> <p>The belief in a spiritual cause and effect for illness, as well as the importance of burial rituals to ensure someone passes into the afterlife, made many SL's resistant to Ebola containment measures.</p> <p>Containment measures affected church life and rituals. Many pastors were initially resistant, promoting false information and encouraging stigma. The outbreak brought fear and a search for reasons, which created much belief in the denial of scientific facts.</p> <p>The church needs to have a biblically sound response to outbreaks before the outbreak occurs so that these messages are not exaggerated in the face of a crisis. Biblical messages need to be applied within the context of science.</p>
Blevins, J., M. Jalloh, and D. Robinson, <i>Faith and global health practice in Ebola and HIV emergencies</i> .	Sub-Saharan Africa	To examine the relationship between religion and health by looking at religious	Religion facilitated and obstructed responses to HIV/AIDS and Ebola. Faith beliefs played a role in both outbreaks, influencing how people with faith viewed the diseases and the appropriate containment

Study Reference	Study Location	Study Objectives	Conclusions
American Journal of Public Health, 2019. 109(3): p. e1-36.		responses to the West Africa Ebola outbreak and comparing those with the response to HIV/AIDS.	measures. The authors noted that while there was literature on Christianity and Islam, local healers were often not included in the discussion or research focus. They concluded that religion played a role in increasing stigma in both crises but was a vital worldview to acknowledge but effective responses.
Denis, P., <i>HIV/AIDS and religion in sub-Saharan Africa: an emerging field of enquiry</i> . Archives de sciences sociales des religions, 2013. 164: p. 43-58.	Sub-Saharan Africa	To examine what he calls the newly emerging scholarship on the religious impact of HIV/AIDS and aims to give an overview.	Religion's impact on HIV/AIDS was not aggressively studied until the early 2000s. As the crisis is now several decades old, there is growing acknowledgment that it is not merely a biomedical crisis, but rather one that impacts all aspects of life, including religion. States that now there is more research on HIV and religions and recognition of religion's contribution to the pandemic.
GARNER, R. C. 2000. Safe sects? Dynamic religion and AIDS in South Africa. <i>Journal of Modern African Studies</i> , 38, 41-69.	South Africa	To look at the amount of pre and extra-marital sex among different religious groups in light of the increasing AIDS epidemic in South Africa	Of the churches examined, only Pentecostalism undoubtedly impacts sexual behaviour and decision-making.
GIFFORD, P., <i>Healing in African Pentecostalism: The "victorious Living" of David Oyedepo, in Global Pentecostal and Charismatic Healing</i> , C.G. Brown, Editor. 2011, Oxford	Nigeria	To address the place in of healing in African Pentecostalism by examining Winner's Chapel and their pastor, David Oyedepo,	In studying African Pentecostalism, the author identified six areas that African Pentecostalism identifies with success; motivation, entrepreneurship, skills, faith, prophetic words, and purification or exorcism. He then demonstrated how these six are manifested through the ministry of Oyedepo. This emphasis on success and a future encourage

Study Reference	Study Location	Study Objectives	Conclusions
University Press: USA.		in Lagos, Nigeria.	the following to let go of the past and focus on this future.
GREEN, E. <i>The impact of religious organizations in promoting HIV/AIDS prevention</i> , in Challenges for the Church: AIDS, Malaria & TB. 2001: Arlington, VA	Global with an emphasis on SSA	To examine the role of religious groups in HIV prevention and primary sexual behaviour change.	More research is concluding that encouraging primary behaviour change (i.e., changing sexual behaviour) is showing effectiveness in HIV protection and reduction. Therefore, religious organizations should be studied and receive more funding and support.
GUSMAN, A. 2009. HIV/AIDS, Pentecostal churches, and the "Joseph Generation" in Uganda. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.). <i>Africa Today</i> , 56, 67-86.	Uganda	To discuss the social changes and HIV/AIDS strategy changes that happened in Uganda due to the rapid growth and expansion of Pentecostal churches and their impact upon society.	NPC involvement in HIV/AIDS programs has led to a national approach that promotes abstinence over condom use. The term "salvation" in this context has evolved to not only mean spiritual salvation but physical salvation as well, in the sense of being safe. Therefore, salvation is not an individual affair but a community one, leading to the desire to have a moral, Christian country. This strategy is not always realistic when dealing with daily life.
GUSMAN, A. 2013. The abstinence campaign and the construction of the Balokole identity in the Ugandan Pentecostal movement. (Special Issue: The politics and anti-politics of social movements: religion and HIV/AIDS in Africa.). <i>Canadian</i>	Uganda	The study looked at young Pentecostals who were involved in abstinence-based HIV campaigns and the construction of identity within the Pentecostal movement.	The country's HIV epidemic has helped to drive the Pentecostal movement. This movement has interpreted the presence of HIV as being associated with demonic forces exhibited by widespread moral failure. The collective identity encouraged by Pentecostalism and involvement in HIV/AIDS programs (helped by PEPFAR) has created a lot of HIV/AIDS activity on the part of Pentecostals. The religious frame that Pentecostalism provides for HIV/AIDS seems effective at

Study Reference	Study Location	Study Objectives	Conclusions
<i>Journal of African Studies</i> , 47, 273-292.			mobilizing volunteers. Pentecostalism encourages its adherents to put up obstacles towards “others” who are not of the same belief, often as evidenced through moral choices. This can contribute to HIV stigmatization.
GYIMAH, S. O., KODZI, I., EMINA, J., COFIE, N. & EZEH, A. 2013. Religion, religiosity and premarital sexual attitudes of young people in the informal settlements of Nairobi, Kenya. <i>J Biosoc Sci</i> , 45, 13-29.	Kenya	To investigate religious dimensions vis-à-vis sexual attitudes.	NPCs and Evangelicals were found to have the most conservative views towards premarital sex among the Christian churches in the study. Religion plays an essential role in attitudes towards sexual activity, and these attitudes could correspond with behaviour, indicating less high-risk sexual behaviour.
KAGEE, A. & DELPORT, T. 2010. Barriers to adherence to antiretroviral treatment: the perspectives of patient advocates. <i>J Health Psychol</i> , 15, 1001-11.	South Africa	To examine the structural barriers of ARV adherence from the perspective of patient advocates.	Identified barriers were poverty-related (transportation and food insecurity), negative experiences with clinic staff, health literacy, lack of access to substance abuse treatment, traditional health practices and perceived stigmatization from charismatic churches
KISENYI, R. N., MULIIRA, J. K. & AYEBARE, E. 2013. Religiosity and adherence to antiretroviral therapy among patients attending a public hospital-based HIV/AIDS clinic in Uganda. <i>Journal of Religion</i>	Uganda	To examine the relationship between religiosity and ARV adherence.	Confirms a relationship between religiosity and ARV adherence as well as the importance of addressing religious beliefs in HIV care. Recommends collaboration with religious leaders in order to ensure correct HIV and ARV information as well as to provide holistically, religious and spiritual needs for HIV patients. States that resourcing religious leaders is under-utilized in ARV treatment.

Study Reference	Study Location	Study Objectives	Conclusions
& Health, 52, 307-17.			
LARTEY, E. Y. 1986. Healing: Tradition and Pentecostalism in Africa Today. <i>International Review of Mission</i> , 75, 75-81.	Africa	To discuss the origins of the NPC movement in Africa and why divine healing has become such a popular and widespread belief.	Divine healing rituals have many similarities to traditional African healing rituals; therefore, they are readily accepted and integrated into various forms of worship.
MANGLOS, N. D. & TRINITAPOLI, J. 2011. The third therapeutic system: faith healing strategies in the context of a generalized AIDS epidemic. <i>J Health Soc Behav</i> , 52, 107-22.	Malawi	To look at faith healing across various churches to identify the impact that this belief has on those living in a high HIV/AIDS environment.	Faith healing belief is associated with fewer worries related to HIV/AIDS, and it is argued that faith healing should be considered a third therapeutic system. Faith healing, as a system, is different from the biomedical and traditional forms of healing because it is holistic, looking at communities and seeking harmony socially and spiritually.
MANTELL, J., et al., <i>Conflicts between conservative Christian institutions and secular groups in sub-Saharan Africa: Ideological discourses on sexualities, reproduction, and HIV/AIDS</i> . <i>Global Public Health</i> , 2011. 6: p. S192-S209.	Sub-Saharan Africa	To identify areas where secular organizations and conservative Christian groups can collaborate on HIV responses.	Conservative Christian groups (Pentecostals are specifically mentioned), and secular aid organizations do not agree on the definition of sexual and reproductive rights. Conservative Christian groups widely believe that the message of HIV prevention (as it pertains to sexual transmission) is to keep sexual activity exclusively between husband and wife. There is a need to develop an understanding of each position, find the points that they can both agree on, and possibly find moderators who could help reach a compromise in areas where there is no agreement.

Study Reference	Study Location	Study Objectives	Conclusions
MHIZHA, S. 2014. Religious self-beliefs and coping among vending adolescent in Harare. <i>J Relig Health</i> , 53, 1487-97.	Zimbabwe	To investigate the nature of religious self-beliefs and religion's role in coping among street children.	Many of the street kids in the study regularly attended Pentecostal churches and saw themselves as active members. Street children attributed Pentecostal involvement and beliefs to help them cope with the stress associated with living on the street.
MILLER, A. N., KIZITO, M. N., MWITHIA, J. K., NJOROGE, L., NGULA, K. W. & DAVIS, K. 2011. Kenyan pastors' perspectives on communicating about sexual behaviour and HIV. <i>Afr J AIDS Res</i> , 10, 271-80.	Kenya	To analyse the messages that Christian religious leaders give, or do not give, in regard to HIV/AIDS and to identify the obstacles that they express as to why the discussion about HIV, in church, is problematic.	Every pastor interviewed was consistent in what was taught about sex; that it is a gift of God to be used within marriage. No pastor in the study was willing to compromise on this conviction in light of HIV/AIDS. The study concluded that while religious taught on sexual morality, some of these same leaders were very involved in offering HIV/AIDS services, causing the researchers to question whether or not they were contributing to HIV stigmatization (as many researchers say).
MILLER, A. N., WA NGULA, K. & MUSAMBIRA, G. 2012. Predictors of sexual behaviour among church-going youths in Nairobi, Kenya: a cross-denominational study. <i>Afr J AIDS Res</i> , 11, 57-64.	Kenya	Research has shown that high religiosity in youth serves as a protection against HIV as these youth tend to have less risky sexual behaviours. Pentecostal/Evangelical (P/E) churches are known for having high religiosity. The paper seeks to see what aspects of P/E churches	The study supports previous findings that P/E youth are less likely to engage in sexual behaviour than youth of mainline denominations. It also concludes that Pentecostal youth attend more religious functions and talk about spiritual issues more frequently than youth of mainline churches. Gender, age, and educational level were predictors of sexual behaviour. Pentecostal males were less likely to engage in sexual activity than males of other churches. The findings support the idea that individual religiosity is an indicator of safe sexual behaviours as well as the increased religious socialization

Study Reference	Study Location	Study Objectives	Conclusions
		contribute most to the influence that these churches have on the lives of adherents and the sexual behaviour of youth adherents.	that occurs in Pentecostal settings.
MILLER, A. N. & NGULA, K. W. 2013. The impact of church contextual factors on church-going youth's HIV prevention behaviour in Nairobi, Kenya: a cross-denominational study. <i>African Journal of AIDS Research</i> , 12, 131-140.	Kenya	To look at the impact of church denomination on the sexual behaviour of youth, as well as to try to identify what aspects of the church have the most impact on a youth's sexual choices.	Pentecostal/Evangelical (P/E) youth do not tend to stray from church teachings on abstinence, as do youth from mainline Christian denominations. P/E youths cited exclusion and socialization as aspects of their churches that aided them in their sexual behaviour choices.
MPOFU, E., NKOMAZANA, F., MUCHADO, J. A., TOGARASEI, L. & BINGENHEIMER, J. B. 2014. Faith and HIV prevention: the conceptual framing of HIV prevention among Pentecostal Batswana teenagers. <i>BMC Public Health</i> , 14, 225.	Botswana	To examine how Pentecostal church-going youth in Botswana conceptualize HIV.	Youth have several beliefs that are protective against HIV, but the most important to them is their faith. If they follow their church teachings, they have a lower risk of HIV infection. However, these beliefs can also alienate the youth from access to public health suggestions.
Omenyo, C.N., <i>New wine in an old wine bottle? Charismatic healing in the mainline churches</i>	Global Part III focuses on	In light of the increasing NPCs worldwide, which has brought the	Divine healing, though introduced by NPCs, is becoming an increasingly popular belief among many churches. One reason postulated for this is that

Study Reference	Study Location	Study Objectives	Conclusions
<p><i>in Ghana</i>, in <i>Global Pentecostal and Charismatic Healing</i>, C.G. Brown, Editor. 2011, Oxford University Press: USA.</p>	<p>Africa and Asia</p>	<p>belief of divine healing, traditionally an NPC belief, into many different churches, the book aims to examine how people's perceptions and desires for divine healing affect their moral choices and cultural practices.</p>	<p>with poor health infrastructures and increasing poverty, the idea of help or relief via a spiritual resource is appealing.</p>
<p>PARSITAU, D. S. 2009. "Keep holy distance and abstain till he comes": interrogating a Pentecostal church's engagements with HIV/AIDS and the youth in Kenya. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.). <i>Africa Today</i>, 56, 45-64.</p>	<p>Kenya</p>	<p>A look at the Pentecostal response to HIV/AIDS by looking at one particular Pentecostal church, the Deliverance Church.</p>	<p>The Deliverance Church has targeted youth in its HIV/AIDS message, encouraging them to participate in multiple weekly activities and encouraging a spiritual commitment of being "born again." In this context, abstinence before marriage and fidelity after marriage is promoted. However, the church will not admit to any degree of failure in their strategy. The simplistic message does not align with the complexities of daily life and the pressures and lifestyles of today's youth. Focusing on what they should be doing instead of the reality of their actions causes the church to miss out on essential teaching opportunities.</p>
<p>PFEIFFER, J. 2004. Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: a clash of AIDS</p>	<p>Mozambique</p>	<p>To discuss condom social marketing (CSM) in a highly religious area of Mozambique and the effect</p>	<p>There is a need for evaluating CSM that takes into consideration community perceptions and concerns. HIV prevention often targets poor communities, but often these same communities have Pentecostal churches in them with strong beliefs about</p>

Study Reference	Study Location	Study Objectives	Conclusions
prevention messages. <i>Med Anthropol Q</i> , 18, 77-103.		that this had on the community and the religious group's willingness to then engage in HIV/AIDS prevention.	condom distribution. Therefore, the CSM campaign alienates the community it hopes to target. These communities are often not part of the conversation before the CSM begins, causing resistance to the message. While public health organizations do not have to embrace the church's messages, they cannot ignore the presence of these churches and need to try to engage them on their level and bring them into the conversation. The conclusions also question the efficacy of CSM in this context.
PFEIFFER, J. 2005. Commodity fetichismo, the Holy Spirit, and the turn to Pentecostal and African Independent Churches in Central Mozambique. <i>Cult Med Psychiatry</i> , 29, 255-83.	Mozambique	To examine the societal shift from a reliance on traditional healers to more people seeking divine healing from Pentecostal churches.	Traditional healing has been a part of this culture for many years. However, with globalization and migration, the growth of Pentecostal churches has caused a shift away from traditional healers to faith healing. Traditional healers are charging more money for their services, while faith healing is typically free and more accommodating of women.
Pfeiffer, J., K. Gimbel-Sherr, and O.J. Augusto, <i>The Holy Spirit in the household: Pentecostalism, gender, and neoliberalism in Mozambique</i> . American Anthropologist, 2007. 109(4): p. 688-700.	Mozambique	To examine how genders react differently to economic stress, in terms of spirituality.	During the economic downturn, this research found that women turned to the increasingly popular Pentecostal churches for encouragement and prayer for divine healing, particularly as it relates to reproductive health. Men, on the other hand, were more likely to turn to traditional healers and to use more occult like practices to deal with issues of finance and employment, affecting household money and health-seeking decision making.
PFEIFFER, J. 2011. Pentecostalism and AIDS treatment in	Mozambique	To discuss the prominence of Pentecostal	There is almost no relationship between the national health services and Pentecostal

Study Reference	Study Location	Study Objectives	Conclusions
Mozambique: creating new approaches to HIV prevention through anti-retroviral therapy. <i>Glob Public Health</i> , 6 Suppl 2, S163-73.		churches in areas of Mozambique and the necessity of including them in ART education programs.	churches, despite these churches having influence and access to a large portion of the population. Many health service employees professed to be Catholic and had little to no awareness of these churches and their beliefs. Therefore, health service messaging has not been very successful due to the lack of engagement of these churches.
PRINCE, R., DENIS, P. & DIJK, R. V. 2009. <i>Special Issue: Christianity and HIV/AIDS in East and Southern Africa. (Special Issue: Christianity and HIV/AIDS in East and Southern Africa.)</i> , Africa Today; 2009. 56(1):v-xviii + 3-120.	Botswana, Kenya, Uganda, Tanzania	To analyse and explore how Christianity is becoming prominent in HIV/AIDS responses in some African countries and the consequences of increased Christian engagement.	This is an introductory piece to several articles, in this journal, on Christianity and HIV/AIDS. This paper discusses the trend for Christian faiths to become more prominent in the HIV response, attributing some of this response to a desire to access the funding made available by PEPFAR as well as out of a sense of "brotherly love" and a need to show compassion to the suffering. It also discusses the political agenda of fundamental Christianity and its desire to spread beliefs to Africa.
RIGILLO, N. 2009. Faith in God, but not in condoms: churches and competing visions of HIV prevention in Namibia. (Special Issue: New perspectives on sexualities in Africa.). <i>Canadian Journal of African Studies</i> , 43, 34-59.	Namibia	The paper aims to look at how Pentecostal religious leaders challenge the promotion of condoms in HIV prevention.	Religious leaders used uncertainty in science to promote abstinence and fidelity as "healthy choices" over condom promotion. Given already existing societal mistrust in condoms, this method has been effective in Namibia.
SEELING, S., MAVHUNGA, F., THOMAS, A., ADELBERGER, B. & ULRICHS, T. 2014.	Namibia	To examine barriers to ART access of HIV-positive TB patients from	The main barriers cited were health system inadequacies (inadequate staffing and poorly trained health workers) and fear of discrimination and

Study Reference	Study Location	Study Objectives	Conclusions
<p>Barriers to access to antiretroviral treatment for HIV-positive tuberculosis patients in Windhoek, Namibia. <i>International Journal of Mycobacteriology</i>, 3, 268-275.</p>		<p>the perspective of healthcare professionals.</p>	<p>stigmatization. NPCs were identified as providing barriers to adherence with fear of stigmatization and the encouragement to rely upon prayer and healing.</p>
<p>SMITH, D. J. 2004. Youth, sin and sex in Nigeria: Christianity and HIV/AIDS-related beliefs and behaviour among rural-urban migrants. <i>Culture, Health & Sexuality</i>, 6, 425-437.</p>	<p>Nigeria</p>	<p>To look at HIV/AIDS-related beliefs and behaviour among adolescents and young adults.</p>	<p>Almost all the study participants identified as Christian and, more specifically, Pentecostal. Sexually active young people who look at HIV/AIDS through a religious lens can be prone to making risky sexual decisions. It is important to acknowledge the presence and influence of these churches and try to construct ways to include them, and their beliefs, into HIV/AIDS responses.</p>
<p>TOGARASEI, L. 2010. Christian theology of life, death and healing in an era of antiretroviral therapy: reflections on the responses of some Botswana churches. <i>Afr J AIDS Res</i>, 9, 429-35.</p>	<p>Botswana</p>	<p>To discuss Christian understanding of life, death, and healing within the context of ARV treatment.</p>	<p>ARVs are seen as competing with God by some Pentecostal faith leaders. The paper argues for the development of a theology of ARVs to help with the confusion and resistance of some faiths (primarily Pentecostal) to ARVs.</p>
<p>TRINITAPOLI, J. & REGNERUS, M. D. 2006. Religion and HIV risk behaviours among married men: Initial results from a study in rural sub-Saharan Africa. <i>Journal for the Scientific Study</i></p>	<p>Malawi</p>	<p>To examine the impact that religious affiliation has on the HIV risk and perceived risk of married men.</p>	<p>Results varied across religious demographics. Pentecostal men had less risky behaviour and lowered perceived risk. Regular church attendance was linked to reduced odds of admitting to extra-marital affairs and reduced perceived risk.</p>

Study Reference	Study Location	Study Objectives	Conclusions
<i>of Religion</i> , 45, 505-528.			
UCHEAGA, D. N. & HARTWIG, K. A. 2010. Religious leaders' response to AIDS in Nigeria. <i>Global Public Health</i> , 5, 611-25.	Nigeria	To examine HIV-related messages and activities of six religious institutions.	All six had messages of abstinence outside of marriage. Pentecostals had a message of condemnation and judgment. Urban FBOs had more HIV programs than nonurban. Views on condoms varied across denominations. Overall religious groups played a role in HIV, but their responses were not uniform. Governments and aid agencies should be aware of religious groups and incorporate them into HIV responses.
VAN DIJK, R. 2013. Counselling and Pentecostal modalities of social engineering of relationships in Botswana. <i>Cult Health Sex</i> , 15 Suppl 4, S509-22.	Botswana –	To explore the importance of faith-based counselling's effect on personal behaviour and its increasing prevalence and influence.	As a response to HIV, counselling has become popular as a way to control or change behaviour. Religious counselling is becoming more and more sought out, with Pentecostals being very active. While this counselling acknowledges the scientific field, it uses it to strengthen their moral beliefs.
WINSKELL, K., HILL, E. & OBYERODHYAMBO, O. 2011. Comparing HIV-related symbolic stigma in six African countries: Social representations in young people's narratives. <i>Social Science and Medicine</i> , 73, 1257-1265.	Swaziland, Namibia, Kenya, SE Nigeria, Burkina Faso and Senegal	To compare stigmatization ratings of six African countries in order to inform stigma reduction efforts.	The countries with the highest rate of moralizing HIV with negative results were SE Nigeria and Kenya. These are countries with a large population of Evangelical/Pentecostal adherents.
ZOU, J., YAMANAKA, Y., JOHN, M., WATT,	Tanzania	To examine the possible relationship	HIV stigma was associated with religious beliefs that it is a punishment from God, however,

Study Reference	Study Location	Study Objectives	Conclusions
M., OSTERMANN, J. & THIELMAN, N. 2009. Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. <i>BMC Public Health</i> , 9, 75.		between religious beliefs and HIV stigma, disclosure, and ARV attitudes.	most respondents said that they would disclose their HIV status, should they become infected, to their pastor and congregation. ARV attitudes were associated with education level and knowledge of ARVs more than religious beliefs.

Table 2 - Results from the Follow up Literature Review

Study Reference	Study Location	Study Objectives	Conclusions
<i>TheAAA/Wenner-Gren Ebola Emergency Response Workshop Preliminary Guidance's and Recommendations, in Ebola Anthropology Guidance's and Recommendations.</i> 2014, American Anthropological Association.	West Africa	To assess the quality of the knowledge base in the West African countries affected by Ebola vis-à-vis Ebola response strategies. This was performed by a consortium of anthropologists who had studied and worked in West Africa.	Increased need to understand the local contexts, particularly local belief systems, as there were multiple healing strategies and beliefs already operating in these countries. Specifically mentioned that Pentecostal communities were some of the fastest growing in the faith sector but did not seem to be specifically sought out for engagement.
<i>Lessons from Ebola Affected communities: Being prepared for future health crises</i> , T. Hird and S. Linton, Editors. 2016, Polygeia.	West Africa	To present lessons learned from outbreak responses and how various groups were engaged. It aims to highlight the importance of trust between actors and	There should be more engagement on health issues at a community level. Communities should be involved in responses as early as possible. Religious leaders are relevant community influencers and need to be specifically targeted and included.

Study Reference	Study Location	Study Objectives	Conclusions
		knowledge of the local context.	
Allen, D. and R. Lacson, <i>Understanding why Ebola deaths occur at home in urban Montserrado County, Liberia</i> . 2015, CDC, Liberia Ministry of Health.	Liberia	A rapid anthropological assessment to better understand any there were so many Ebola deaths at home rather than seeking treatment at ETUs.	While believing that Ebola was due to a spiritual cause, many sought at home spiritual solutions. Many died at home due to resistance of the cremation policy.
BANGURA, J. B. 2016. Hope in the midst of death: Charismatic spirituality, healing evangelists and the Ebola crisis in Sierra Leone. <i>Missionalia</i> , 44, 2-18.	Sierra Leone	<p>To understand NPC approaches to outbreaks and the belief in healing.</p> <p>To look at the healthcare infrastructure before Ebola.</p> <p>To examine SL's culture and values to understand how they view illness and death.</p> <p>To look at how NPCs use the bible to explain illness and suffering.</p> <p>To examine NPC spirituality in dealing with Ebola.</p>	<p>NPCs are a rapidly growing church movement in SL.</p> <p>SL had a poor health infrastructure before the outbreak, which played into the severity of the outbreak as well as into the culture of seeking healing from traditional healers or churches that believed in divine healing.</p> <p>The belief in a spiritual cause and effect for illness, as well as the importance of burial rituals to ensure someone passes into the afterlife, made many SL's resistant to Ebola containment measures.</p> <p>Containment measures affected church life and rituals. Many pastors were initially resistant, promoting false information and encouraging stigma. The outbreak brought fear and a search for reasons, which created much belief in the denial of scientific facts.</p> <p>The church needs to have a biblically sound response to outbreaks before the outbreak occurs so that these messages are not exaggerated in the face of a crisis. Biblical messages need to</p>

Study Reference	Study Location	Study Objectives	Conclusions
			be applied within the context of science.
<p>Blevins, J., M. Jalloh, and D. Robinson, <i>Faith and global health practice in Ebola and HIV emergencies</i>. American Journal of Public Health, 2019. 109(3): p. e1-36.</p>	SSA	To examine the impact of religion on health via HIV/AIDS in SSA and Ebola in West Africa.	There were similarities and differences. Both disease outbreaks included rumours and misinformation, often spread by religious groups. Religious groups also contributed to stigma in both outbreaks. Some differences in the poor and marginalized carried the burden of HIV, while Ebola spread rapidly in all contexts. HIV can take years to manifest, and Ebola kills within days or weeks, leading to a different narrative. Ultimately religion can help or hurt outbreaks, but despite this, public health officials need to find common ground and include faith groups.
<p>Falade, B. and C. Coultas, <i>Scientific and non-scientific information in the uptake of health information: The case of Ebola</i>. South African Journal of Science, 2017. 113(7/8).</p>	West Africa	To examine media coverage of the outbreak in order to discuss scientific and non-scientific information that maybe have contributed to the public's understanding of Ebola.	Media coverage is a way to measure the public's perception and anxiety about Ebola. Religion played a role as a facilitator and an obstacle to the outbreak with widespread beliefs that Ebola was sorcery and some faith leaders telling their adherents that they could not be infected. Ultimately cannot only relay scientific facts but need to understand local beliefs and context.
<p>Featherstone, A., <i>Keeping the Faith the Role of Faith Leaders</i></p>	West Africa	Seeks to explore the relationship between faith and	Faith is important in the three affected countries and played an essential role in the outbreak.

Study Reference	Study Location	Study Objectives	Conclusions
<i>in the Ebola Response</i> . 2015, Christian Aid, Tearfund, Islamic Relief Worldwide. p. 11.		humanitarianism. To provide information on the role that faith groups played in the outbreak.	Faith leaders are trusted and respected. While faith leaders were some of the first responders, they lacked information and training, so at times their responses were mixed.
Gillepsie, A., et al., <i>Social mobilization and community engagement central to the Ebola response in West Africa: Lessons for future public health emergencies</i> . Global Health Science and Practice, 2016. 4 (4): p. 626-646.	West Africa	Lessons learned about community engagement during the Ebola outbreak.	Cannot only focus on treatment but also need to emphasize prevention. Need to know the context of communities for accurate and appropriate messaging.
Greyling, C., et al., <i>Lessons from the faith-driven response to the West Africa Ebola epidemic</i> . The Review of Faith & International Affairs, 2016. 14 (3): p. 118-123.	West Africa	To discuss the contribution that faith organizations had on the outbreak.	The faith response was an essential aspect of the Ebola response as they have a long-term presence in communities and receive a great deal of trust and respect. Faith should be engaged early in a crisis, and there should be an honest dialogue between crisis responders and faith groups.
Hewlett, B.S., et al., <i>Medical anthropology and Ebola in Congo: cultural models and humanistic care</i> . Bulletin de la Societé de Pathologie Exotique, 2005. 98 (3): p. 230-	Congo	To discuss the importance of medical anthropologists in outbreak responses.	It is crucial to understand feelings, beliefs, and perceptions around an outbreak.
Homer, K., <i>Still surviving Ebola; Emergency and recovery response in Sierra Leone</i> , E.	Sierra Leone	Examines the role of World Vision International in the Ebola	Community engagement is critical. Messaging should be done by trusted community influencers who were involved in message creation. The needs of

Study Reference	Study Location	Study Objectives	Conclusions
Valdez, Editor. 2016, World Vision.		outbreak in Sierra Leone.	children during a health crisis should be a priority.
Manguvo, A. and B. Mafuvadze, <i>The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift</i> . Pan African Medical Journal, 2015. 22 (Suppl 1).	West Africa	To explore ways that religious and traditional structures can impact the Ebola outbreak.	While Ebola requires specific medical intervention, responses cannot ignore local context and beliefs. Therefore, religious and traditional leaders should be involved in outbreak responses and communication.
Marshall, K. <i>Ebola: Ten proposals to engage religious actors more proactively</i> . Faith in Action 2014	West Africa	To discuss and analyse faith leader involvement in the Ebola outbreak.	In areas of high religiosity, such as West Africa, outbreak responses need to consider local beliefs. Religious leaders are strategic resources as they offer a variety of services and assets.
Marshall, K., <i>Roles of religious actors in the West African Ebola response</i> . Development in Practice, 2017. 27 (5): p. 622-633.	West Africa	To analyse the religious response to Ebola and implications for responders.	While religious leaders and faith groups offer extensive assets to outbreak responses, they are under-utilized. Many reports written after the outbreak do not adequately discuss the role of faith groups and how to strengthen partnerships with them.
Marshall, K. and C. Corman, <i>Responding to the Ebola epidemic in West Africa: What role does religion play?</i> 2016, Berkley Centre for Religion, Peace, and World Affairs: Georgetown University.	West Africa	To highlight roles that faith played in the outbreak, both positive and negative, and to discuss the lack of engagement of the faith community by outbreak responders.	Local faith groups played an early and vital role in the outbreak, yet responders were severely delayed in their engagement. Faith responses were initially mixed, but ultimately faith played an essential role in Ebola containment,
Marshall, K. and S. Smith, <i>Religion and Ebola: learning from</i>	West Africa	Discussion on what was learned through the Ebola outbreak vis-à-vis	The international community was late to engage religious actors, and there was a knowledge gap in understanding the presence and beliefs of various faith

Study Reference	Study Location	Study Objectives	Conclusions
<i>experience</i> . The Lancet, 2015.		religious engagement.	groups. This understanding would be valuable and help in future disease outbreaks.
Modarres, N., <i>Community perspectives about Ebola in Bong, Lofa and Montserrado counties of Liberia: Results of a qualitative study</i> , J.H.C.f.C. Programs, Editor. 2015, USAID.	Liberia	To understand community beliefs, norms, and practices as they related to the Ebola outbreak.	Community engagement was delayed and impacted community perception of Ebola and its containment. Involving religious leaders was an effective strategy, once engagement strategies were launched. Communities should be involved at multiple levels for an effective community engagement ownership.
Modino, C. and A. Street, <i>The pivotal role of faith leaders in the Ebola Virus Disease outbreak in West Africa</i> . 2014, CAFOD: London.	West Africa	To discuss the role that faith leaders can play in the outbreak.	Faith involvement is vital to defeat Ebola. The leaders should be involved at higher levels of discussion and have input into policies and messaging. Faith leaders have a unique role to play as they have the respect and trust of many in their communities. Through their faith services, they are in contact with large portions of the community regularly, playing a strategic role in Ebola education and prevention. Due to their widespread influence investing in faith leaders is good value for time and money.
Omidian, P., K. Tehoungue, and J. Monger, <i>Medical Anthropology Study of the Ebola Virus Disease (EVD) Outbreak in Liberia/West Africa</i> . WHO Field Report. Monrovia Liberia, 2014.	Liberia	To understand the impact of local beliefs and practices on the acceptance or refusal of Ebola responses.	The recent wars have affected how populations respond to government messages. Containment measures that include social distancing from those with symptoms and touch upon strong cultural and religious beliefs impact acceptance of containment protocols. It is necessary to have a multi-sectoral response that addresses more than the medical issue of

Study Reference	Study Location	Study Objectives	Conclusions
			Ebola, and that utilizes community stakeholders.
Oosterhoff, P. and A. Wilkinson, <i>Local Engagement in Ebola Outbreaks and Beyond in Sierra Leone</i> . 2015.	Sierra Leone	Discussion on the importance of local engagement in Ebola responses	Mistrust and exclusion have exacerbated the epidemic. It is important to resource local influencers and local knowledge to engage communities in Ebola and its containment measures.
Shultz, J., et al., <i>The role of fear-related behaviours in the 2013-2016 West Africa Ebola virus disease outbreak</i> . Current Psychiatry Reports, 2016. 18 (11).	West Africa	Fear-related behaviours played a role in how communities responded to the outbreak.	Fear-related behaviours fuelled the outbreak. If dealt with early in an outbreak, mortality and morbidity could be decreased, possibly shortening the outbreak. To deal with fear-related behaviours is to understand local cultures and beliefs and to engage influential community members in education and messaging.
Thompson, S. and L. Bolton, <i>Ebola Regional Lesson Learning</i> . 2014, HEART; Health & Education Advice & Resource Team: UK.	West Africa	What lessons can be learned about best practice in an Ebola outbreak as it relates to community mobilization and engagement	Local beliefs and cultures impacted how Ebola messages were received; however, many communities were able to learn new information and practice it relatively quickly. Community engagement is key to the response.
Wilkinson A. et al., <i>Engaging 'communities': anthropological insights from the West African Ebola epidemic</i> . Philosophical Transactions of the Royal Society B: Biological Sciences, 2016. 372 (1721).	West Africa	To encourage reflection on the definition of 'community' in order to assure that all communities are involved and engaged in responses.	Engaging communities in the Ebola outbreak was crucial for ending the epidemic. Community definitions need to take into account social and political relationships and interactions to ensure inclusivity.

Appendix B: Ethics Approval Letters

Initial LSHTM Approval Letter, October 2016

London School of Hygiene & Tropical Medicine

Keppel Street, London WC1E 7HT
United Kingdom
Switchboard: +44 (0)20 7636 8636

www.lshtm.ac.uk

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



Observational / Interventions Research Ethics Committee

Suzanne Hurst
LSHTM

25 October 2016

Dear Suzanne,

Study Title: A Study of the Role of local Independent Pentecostal/charismatic churches in the 2014/15 Ebola outbreaks in Liberia to Determine Community Engagement Barriers and Facilitators

LSHTM Ethics Ref: 11753

Thank you for responding to the Observational Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Covering Letter	Ethics Cover Letter.ii		
Protocol / Proposal	Study Protocol	24/07/2016	1
Protocol / Proposal	Questionnaire Community Members	24/07/2016	1
Protocol / Proposal	Questionnaire for independent Pentecostal	24/07/2016	1
Protocol / Proposal	Questionnaire for MOH	24/07/2016	1
Protocol / Proposal	Questionnaire for NGO's	24/07/2016	1
Protocol / Proposal	Questionnaire for Pentecostal Members	24/07/2016	1
Investigator CV	CV	24/07/2016	1
Information Sheet	Consent Form	24/07/2016	1
Information Sheet	Patient Information Sheet	12/09/2016	1
Information Sheet	Consent Form	12/09/2016	2
Covering Letter	Ethics Cover Letter	15/09/2016	1
Covering Letter	Advisory.Comm.Approval	20/10/2016	1

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

Initial Liberia NREB Approval Letter, November 2016



THE NATIONAL RESEARCH ETHICS BOARD (NREB)
21ST STREET, SINKOR, JFK COMPOUND
MONTSERRADO COUNTY
MONROVIA, LIBERIA



Ref: NREB-020-16

8 November 2016

Suzanne Hurst, Principal Investigator
DrPh Candidate
London School of Hygiene &
Tropical Medicine (LSHTM)
London, UK

Subj: Faith Community Engagement Research in Liberia

Dear Ms. Hurst,

In accordance with 45 CFR 46, the human subject protocol of the above-mentioned research study that you had submitted, based on comments from the National Research Ethics Board (NREB) through an online review of the application by its members, has been approved. The component reviewed included the Project Description, Informed Consent, Patient Information Sheet, and the Questionnaires for Community Members, NGOs and Pentecostal Members, among others. This approval covers the versions of the protocol submitted in August 2016. This approval expires on 8TH March 2017.

Should there be any protocol deviation, or Serious Adverse Events (SAEs), involving human subjects during the conduct of this research, they must be immediately reported to the NREB. Protocol deviations in research during the period for which ethical approval has been granted may not be implemented without prior NREB review and approval, except where necessary to protect human subjects. Proposed changes to the protocol must be reported promptly to the NREB for review using a continuation review format.

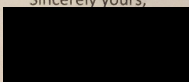
The NREB may conduct intermittent visits during the implementation of the qualitative research study to monitor its progress and adherence to ethical standards. You will be duly informed about the proposed visits, whenever the NREB deems it necessary.

The NREB requires progress report during the implementation of this study.

For your record, our Federal-wide Assurance number is 00021658; and our organization number (IORG) is 0008374.

Kindest regards.

Sincerely yours,


Rev. Jiji Tyge
Member, NREB

E-mail: lawsher@yahoo.com / director.libr@gmail.com Tel #: +231-886-578-615 or +231-886-513-040

Secondary LSHTM Approval Letter, January 2018

London School of Hygiene & Tropical Medicine

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Observational / Interventions Research Ethics Committee

Mrs. Suzanne Hurst
LSHTM

23 January 2018

Dear Suzanne,

Study Title: A Study of the Role of local Independent Pentecostal/charismatic churches in the 2014/15 Ebola outbreaks in Liberia to Determine Community Engagement Barriers and Facilitators

LSHTM Ethics Ref: 11753 - 1

Thank you for your letter responding to the Observational Committee's request for further information on the above amendment to research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above amendment to research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval for the amendment having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Other	Oct. 2017 Study Protocol with track changes	31/10/2017	2
Other	Research Assistant Confidentiality Agreement	31/10/2017	1
Covering Letter	Ethics Clarification.Jan.2018	13/01/2018	1

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

An annual report should be submitted to the committee using an Annual Report form on the anniversary of the approval of the study during the lifetime of the study.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

All aforementioned forms are available on the ethics online applications website and can only be submitted to the committee via the website at: <http://leo.lshtm.ac.uk>

Additional information is available at: www.lshtm.ac.uk/ethics

Yours sincerely,



Professor John DH Porter
Chair

ethics@lshtm.ac.uk
<http://www.lshtm.ac.uk/ethics/>

Secondary Liberia NREB Approval Letter, February 2018



THE NATIONAL RESEARCH ETHICS BOARD (NREB)
21st STREET, SINKOR, JFK COMPOUND
MONTERRADO COUNTY
MONROVIA, LIBERIA



Ref: NREB-008-18

28th February 2018

Suzanne Hurst, Principal Investigator
DrPh Candidate
London School of Higiene &
Tropical Medicine
(LSHTM)
London, UK

Subj: A Study on the Participation of Local Independent Pentecostal/Charismatic Churches During the 2014/2015 Ebola Outbreak in Monrovia, Liberia to Discover What Encouraged or Discouraged Their Involvement in the Ebola Response

Dear Ms. Hurst,

In accordance with 45 CFR 46, the human subject protocol of the above-mentioned research study submitted, based on the amended version of the protocol, has been approved. The component reviewed was the revised protocol with methodology changes, among others. This approval covers the version of the protocol submitted in February 2018. This approval expires on 1st June 2018.

Should there be any protocol deviation, or Serious Adverse Events (SAEs), involving human subjects during the conduct of this research, they must be immediately reported to the NREB. Protocol deviations in research during the period for which ethical approval has been granted may not be implemented without prior NREB review and approval, except where necessary to protect human subjects. Proposed changes to the protocol must be reported promptly to the NREB for review using a continuation review format.

The NREB may conduct intermittent visits during the implementation of the qualitative research study to monitor its progress and adherence to ethical standards. You will be duly informed about the proposed visits, whenever the NREB deems it necessary.

The NREB requires progress report during the implementation of this study.

For your record, our Federal-wide Assurance number is 00021658; and our organization number (IORG) is 0008374.

Kindest regards.

Sincerely yours,


Rev. Tijli Iyee
Member, NREB

E-mail: lhurster@unhcr.com / director_libr@gmail.com / Tel: +231-886-578-615 or +231-886-513-040

Appendix C: Study Participant Consent and Information

CONSENT FORM FOR PARTICIPANT AND REPRESENTATIVE



Title of Project: A Study on the Participation of Local Independent Pentecostal/Charismatic Churches During the 2014/15 Ebola Outbreaks in Monrovia, Liberia to Discover What Encouraged or Discouraged Their Involvement in the Ebola Response

Name of PI/Researcher responsible for project: Suzanne Hurst

Statement	Please initial or thumbprint* each box
I confirm that I have read and understood the information sheet dated, October 2016, for the above named study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
I understand that my consent is voluntary and that I am free to withdraw this consent at any time without giving any reason and without my legal rights being affected.	
I understand that relevant sections of my data collected during the study may be looked at by authorised individuals from the London School of Hygiene & Tropical Medicine, where it is relevant to my taking part in this research. I give permission for these individuals to have access to these records.	
I agree to me taking part in the above named study.	

Printed name of participant/Representative	Signature of participant/Representative (or thumbprint/mark if unable to sign)	Date
Printed name of person obtaining consent	Signature of person obtaining consent	Date

A copy of this informed consent document has been provided to the participant.

[Informed Consent for Participant and Representative_for incapacitated adults_19.02.15_v1]



Participant Information Sheet

March 2018

Title: A Study on the Participation of Local Independent Pentecostal/Charismatic Churches During the 2014/15 Ebola Outbreaks in Monrovia, Liberia to examine a possible faith/health interaction and determine what encouraged or discouraged involvement in the Ebola response

We would like to invite you to take part in this research study. You have been asked to be a part of this because we would like to hear your observations and opinions as you live in Monrovia and were present during the Ebola outbreak. Joining the study is entirely up to you, before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through this information sheet with you, to help you decide whether or not you would like to take part and answer any questions you may have. We'd suggest this should take about ten minutes. Please feel free to talk to others about the study if you wish.

The first part of this Participant Information Sheet tells you the purpose of the study and what your participation will involve, if you decide to take part.

Then we give you more detailed information about the conduct of the study. Please ask if anything is unclear.

Study Summary: This study will look at the level of involvement of local independent Pentecostal/charismatic churches during the Ebola outbreak. This is of interest because there has been an increase in the number and membership of this particular type of church. Because of this it is important to know how to encourage their involvement in health responses in ways that respect their beliefs while providing accurate health information. The 2014/15 Ebola outbreaks provide an opportunity to learn what was and was not successful in encouraging partnership with these churches, during the Ebola response.

Should you decide to participate this would mean consenting to an interview so that you could give your opinion on how the Ebola education was received by these churches in your community and how the churches responded to Ebola and the information given. The interview should last for approximately 30-60 minutes. At any time during the interview, if you feel uncomfortable you can request that the interview be stopped. Once you have been interviewed your participation in the study would be finished.

Purpose and Background of this Study

This study is to learn more about the beliefs of Pentecostal/charismatic churches so we can know how to partner with them on health issues. The Ebola outbreak is used as a way look at how health professionals and churches worked together. This is important, as the number of these churches and their members has risen significantly, making it necessary for health



professionals to understand what encourages or discourages their involvement in health responses.

Studies have shown that it is important to identify and involve community leaders in health issues and education. Religious leaders are known to be important community leaders. Different religions have their own sets of beliefs that need to be understood so that health messages respect these beliefs and are done in a way that helps religious leaders to feel comfortable being a part of health education. This study will help to understand how to properly work with these specific churches and their leaders so that future health messages will be spread more rapidly because of their involvement.

You are invited to take part in this study because you live in Monrovia, were there during the Ebola outbreak and are either a member of one of these churches, live close to a church or participated in the Ebola outbreak response. Because of this your opinion and observations are valuable as to what you experienced or observed that helped or discouraged church involvement in the Ebola response.

Confidentiality

If you agree to take part in this study it would involve either a personal, one-on-one interview or being a part of a group interview. This interview will be recorded. While the opinions and observations that you share will be used in the study, your identity will only be known by the primary researcher and will be kept confidential in the final research publication. Once the research report has been written and accepted all interview recordings will be destroyed. In the meantime recordings will be kept in a locked cabinet and only the primary researcher will have access to them.

Benefits and Risks

A potential risk to study participation is that discussing events that happened during the Ebola outbreak could provoke traumatic or emotional memories. At any time during the interview, if you are uncomfortable or feel too emotional to continue you may stop the interview.

Study Results

Study results will be shared with any interested parties, including the Liberia Ministry of Health. It is anticipated that once the study is finished that the results will be published in some form. However confidentiality will be guarded even in published results.

Organizing and Funding of the Study

This study is funded by the European Union and organized by the London School of Hygiene & Tropical Medicine, located in London, England.

Appendix D: Semi-Structured Interview Guides

Questionnaire for NPC Leaders

- Initial Information
 - How long has the church been in the community?
 - How long has the head pastor been leading the church?
 - How many church members?
 - What type of education does the pastor have? Where did he/she receive this information?
- How would you describe the church's role in the community?
- In your opinion, how does the surrounding community view the church?
- When people in the community are sick, what are your observations? What do they usually do?
- Traditionally, when a church member is ill, what is their first response?
 - Is this response combined with or followed by any other actions or recommendations?
- When the Ebola outbreak first started, what were your initial thoughts or reactions?
- What was the reaction of church members?
- From where did you get information on Ebola?
- Did Ebola responders approach you? (i.e. international aid workers, MOH officials, etc.)
 - If so, how were you approached and when, in the timeline of the epidemic were you approached? (i.e. what month – Ebola started in Liberia in March)
 - How did you feel about their approach?
 - What aspects encouraged you to be involved in the epidemic?
 - Were there elements that discouraged you to be involved?
 - Were there certain groups, among the formal responders, that you trusted more than others or were more willing to work with than others? Explain.
 - What could responders do differently, in the future, to encourage your participation in a health action?
- What actions did the church initially do during the outbreak?
- As the outbreak progressed, did the church's actions change or evolve? If so why and how?
- Were there individuals in your church who were directly affected?
 - If yes, how has the church processed this?
- In retrospect is there anything that you would suggest doing differently, should there be another disease outbreak?
- Has your experience with Ebola changed anything in the way of how your church addresses illness in general or where you get health information?
- How would you describe your working relationship with other Ebola responders? Great – Good – Okay – Difficult – Bad



Questionnaire for NPC Members

- Are you a member of an independent Pentecostal/charismatic church?
- What do you appreciate about your church?
- When you or a family member is sick, what do you usually do?
- Who do you go to for help or advice when you are sick?
- What do you observe that community or church members do when they are sick?
- Does your church have a particular belief about how to respond to illness?
- What were your thoughts when you first heard of Ebola in Liberia?
- Who did you talk to for information on Ebola?
- Did formal Ebola responders come to your neighborhood? If so, how were they received?
- Who did you trust the most to give you accurate information about Ebola?
- What behavior changes did you make to protect yourself and your family from Ebola?
 - How did you learn about these behavior changes?
- How did your church respond to or talk about Ebola?
- At what point, in the epidemic, did your church begin publically addressing Ebola?
 - What exactly did your church do?
- Did you find your church's response helpful?
- If there were another disease outbreak, what would you like to see done differently?



Questionnaire for NPC community members

- Who would you identify as influential leaders in your community?
- Who do you trust and look to for information and guidance during a crisis?
- When you or someone in your family is sick, what do you usually do?
- Who do you go to for health advice?
- How many churches are in your community?
- Are any of these churches active in helping the community? If so please explain.
- According to your experiences or observations, how do the churches (or church members) in your community typically respond to physical illness?
- What was your initial response when you heard about Ebola in Liberia?
- Where or who did you go to for information on Ebola? Did you find that information accurate? Helpful?
- How did the churches in your community react to the Ebola outbreak?
- Why do you think that various churches responded as they did?
- Were the churches involved in the organized Ebola response that was coordinated by the Liberian government and various aid organizations?
- Were there churches that responded quicker or differently than others? Explain.
- When, in the timeline of the outbreak (i.e. how long after the initial Ebola announcement), did churches start adopting the Ebola containment recommendations? (i.e. did they adopt recommended responses immediately or was it several months before they did?)
- Did you find their responses helpful?
- What, in your opinion, encouraged or discouraged churches to respond?



Questionnaire for MOH, NGO's and Healthcare Professionals

- Start by asking the interviewee how long he/she has worked with the current NGO or health center. What is their title and what are their job responsibilities?
- In your observations, both professionally and personally, in your own community, how do people usually respond to illness?
- Who do people, in general, seem to go to for health information and advice?
- Does faith play a role in health decisions? If yes, describe.
- Do churches get involved in health issues (in general, not Ebola)? If yes, describe.
- When it was first announced that Ebola was in Liberia, what reactions did you notice?
- Who did people seem to trust for Ebola information? Or who did they turn to for Ebola information?
- How did your organization or health center initially respond?
- For an NGO:
 - How did you identify community stakeholders?
 - How did you contact these identified stakeholders?
 - Were the same methods of contact used for all identified stakeholders?
 - Do you feel that faith-based community groups were well represented among the stakeholders?
 - At what point, in the timeline of the outbreak, were the churches approached for participation?
 - Do you feel like the timing and methods used for engaging local churches were effective?
- Think about the initial Christian church (broadly speaking) reaction. How did the churches respond? Did certain church groups or denominations respond differently than others? If yes, describe. In your opinion, what accounted for the difference in response?
- In your opinion what factors seem to influence whether a church would respond or be resistant?
- What were the barriers in engaging local Christian churches?
- Did you see certain behaviors or advice being given, by local churches? Were these behaviors or advice helpful or inaccurate?
 - If so, were there specific churches (not church names, but genre of church) that were more prone to this than others?
- In retrospect, are there elements to faith-based community engagement that you would suggest being changed?