COMMENTARY

The Role of Faith-Based Organizations and Faith Leaders in the 2014–2016 Ebola Epidemic in Liberia

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Abstract

Since the time of Christ, caring for the sick and the poor has been a core distinctive of authentic Christianity. The response of Christians during many of the great plagues of antiquity played an important role in the spread of Christianity. In modern history, response to epidemics have been professionalized and, to a certain extent, secularized. The 2014–2016 Ebola outbreak in West Africa offers an important illustration of the role that faith leaders and faith-based organizations still play in providing a trusted link between communities and international relief workers. During the latter half of 2018, the world was faced with another outbreak of Ebola in the Democratic Republic of Congo. It is vital to build upon the lessons of prior epidemics as we support local efforts to prepare for, detect, and respond to inevitable future outbreaks.

Key words: Ebola, Liberia, epidemic, faith leaders, faith-based organizations, public health

Introduction

The Ebola and SARS outbreaks in the past decade have raised the specter of epidemics that could overtake the globe in coming years. In his book, *Factfulness*, Hans Rosling lists global pandemics as one of the 10 greatest risks for our future.[1] However, global epidemics (pandemics) are certainly not new to human history. Ancient plagues, including Yersinia pestis, influenza, smallpox, cholera, and typhus, claimed millions of lives and permanently altered civilizations. Throughout the centuries, many Christians and Christian leaders distinguished themselves by risking their own lives, caring for the sick, and dying while others fled.[2,3] Christians' sacrificial care during the time of the Roman Empire contrasted with prevailing culture, and their response may have been an important catalyst for the growth of early Christianity.[4] Most early hospitals and medical schools arose from Christian monasteries that played crucial roles in caring for the sick and the poor.[5] Christian missionaries and faith leaders played key roles in promoting the concepts of primary healthcare and health as a human right and a part of the Alma Ata Declaration of the World Health Association (WHO) in 1979.[6,7]

In more recent history, some may say that Christian leaders faltered in their initial response to the modern epidemics of HIV and Ebola but have

ended up playing vital roles in the global response. David Hughes, in his address to the 13th congress of the European Society for Evolutionary Biology, said of historic Christian responses to epidemics, "... the belief systems, for example, influenced whether people fled from the disease or tried to help those who were sick." He went on to outline the importance that Christian faith in Malawi played in people's likelihood to care for people with AIDS.[8] Reflections on the 2014–2016 Ebola outbreak in West Africa document the journey of faith leaders as they finally rose up to play an important role in implementing the social and behavioral changes necessary to decrease further transmission.[9]

Ebola comes to West Africa

The index case for the West African Ebola epidemic of 2014–2016 is believed to have been an 18-month old baby who died in December of 2013. In mid-March, Médecins Sans Frontières (MSF, also known as Doctors Without Borders) confirmed a case in Guinea and, subsequently, WHO declared an outbreak. Liberia's first confirmed case was only a week later, and by June, Ebola cases had been documented in the capital city of Monrovia. By July of 2014, cases had been reported in the capital cities of Guinea, Liberia, and Sierra Leone. It was not until August 8th that the World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC). This was the first time that this deadly virus had made its way from remote jungles to large urban centers, making containment a much more difficult task.[10]

The small West African country of Liberia had several decades of political unrest marked by violent coups, counter-coups, and civil war. Although there had been significant improvements in the healthcare system under the new leadership of Ellen Johnson Sirleaf in the years before the Ebola outbreak, there were still critical shortages of all cadres of health providers, and services were limited by poorly equipped facilities.[11]

By the time the region was declared Ebola-free in June of 2016, CDC reported over 28,600 Ebola cases and 11,325 deaths.[13] The human and economic costs of this horrendous season in West Africa's history will leave scars for generations to come. It is estimated that over 800 health workers were infected with Ebola during this period, and over 500 of them died. In Liberia, 8% of its already scant number of healthcare workers died from Ebola.[14] While we rightly honor the heroes who risked or gave their lives to help the sick and dying, it is also important to examine the national and international responses to the epidemic and how we can improve our readiness for future outbreaks of not only Ebola, but the many other emerging infectious diseases that could threaten populations in the future.

Ebola Virus Disease-Epidemiology

Ebola Virus Disease (EVD), formerly termed Ebola Hemorrhagic Fever, is a rare and deadly virus that causes disease in humans and other primates. There are a number of animal reservoirs for this virus, the most significant of which may be the fruit bat.[15] Human-to-human transmission is through contact with any bodily fluids from a person who is sick with, or has died from, EVD. Caring for the sick and burial of the deceased play enormous roles in the spread of the disease in a population. The modernization of transportation and porous borders also played roles in the rapid spread from Guinea to surrounding countries.[16,17,18]

The National and International Response

In addition to documenting the early cases in Guinea, MSF was the first organization to recognize the unprecedented danger of an outbreak in crowded, urban settings. They tried to raise the attention of international authorities, but with no timely substantial response. The book, *Politics of Fear*, recalls that during this time an unlikely partnership developed between the secular MSF and the overtly

Christian relief organization, Samaritan's Purse (SP).

> The people at Samaritan's Purse were the only ones to resolutely raise their hand and declare their willingness to help.... It was a courageous offer we could not refuse, and since then we have tried to work hand in hand, albeit with protective gloves, in the fight against Ebola.[19]

SP had a long-standing relationship with ELWA Hospital, a mission hospital founded by US-based mission SIM (a non-denominational Christian mission organization) in the 1950s.[12]

MSF is considered to be the world experts at managing Ebola outbreaks. They provided training and support for ELWA hospital as they established an Ebola treatment unit in what had previously been their hospital chapel. MSF worked with ELWA and SP to plan and construct a second, larger Ebola Treatment Unit (EBU) known as ELWA2. This unit was run by Dr. Kent Brantley, a physician working with SP at ELWA. SIM provided logistical support to get Ebola supplies (especially Personal Protective Equipment [PPE]) sent to the hospital.

As additional cases of Ebola were confirmed, the number of patients presenting to the hospital increased faster than their facility was able to manage. Even patients admitted for other conditions, such as diabetes or labor, succumbed to co-existing with Ebola and then infected a number of healthcare workers. It was clear to health personnel that this was an epidemic that was out of control, and early identification and isolation were critical to containment. The scale of death was also clear to the general public, especially around Monrovia, and fear and panic set in. The UN itself acknowledged that the level of trust that locals had in their state institutions was low, contributing to suspicion about the prevention messages that they were receiving, and that governmental and international agencies did not engage faith leaders early in the epidemic [9] A number of PPE-clad healthcare workers were attacked because the locals believed that MSF, SP, and other western influences had intentionally brought this disease to them and that their disinfecting sprayers were actually the source of the disease.[21]

This out-of-the-way hospital and its dedicated staff would soon explode out from anonymity as Dr. Brantley and a nurse, Nancy Writebol, were themselves diagnosed with Ebola. The world watched as news of their declining health started a frenzy of activity to save their lives. Close relationships with the U.S. State Department and other agencies allowed SIM and SP to facilitate the services of an evacuation airplane specially equipped with a biocontainment unit to fly into Liberia to evacuate Brantley and Writebol.[22] Both were showing a rapid decline in their conditions as they awaited evacuation, and the decision was made to use an untested, experimental Ebola drug called ZMapp first on Dr. Brantley and then Mrs. Writebol. Both were successfully evacuated to the U.S., and they eventually recovered.

Dr. Lance Plyler, the Medical Director of Samaritan's Purse's (SP) division responsible for disaster response (World Medical Mission), was head of the SP team working at ELWA during the epidemic and was one of two doctors caring for their team members who had become infected. Dr. Plyler reiterated the importance of the unlikely partnership between SP and MSF. They had both been active in health system development in Liberia for many years, but never worked collaboratively before the epidemic hit. The SP/ELWA team did not have the expertise of MSF in Ebola treatment, but they did have the courage to take on treating sick patients and a resource base to rapidly expand their capacity to respond to the need. MSF recognized that this team represented a valuable partner and willingly shared their experience, resources, and international spotlight to help ELWA become a major Ebola Treatment Center. Similar to fellow soldiers in a war, the relationship between these two organizations is now forever changed.

Prior strategies for responding to outbreaks of Ebola often focused on preventing new infections rather than improving outcomes for those already infected.[23] Experienced relief organizations like MSF and Partners in Health (PIH, working in Sierra Leonne) also recognized that improving supportive care and reducing the delay in hospitalization could significantly reduce fatality rates.[24,25] The quality work that SP did in Liberia during the Ebola epidemic was later expanded as they once again put themselves in harm's way setting up a field hospital just outside of Mosul, Iraq. Often excluded from international planning processes, SP now has a seat at the table.[26] Since the end of the Ebola epidemic, ELWA has been recognized for its contributions and has further expanded its facilities and capacities, including running one of very few Ebola survivor clinics.[22]

Response of Liberian Faith Leaders

The Tear Fund report describes that the early response of faith leaders in Liberia did not help ease the fears of the population; rather, it created stigma that led many to refuse to let anyone know when a member of their household became ill. In July of 2014, the Liberian Counsel of Churches released a communication unanimously warning that, "God is angry with Liberia" and "Ebola is God's plague. Liberians have to pray and seek God's forgiveness over the corruption and immoral acts (such as homosexualism, etc.) that continue to penetrate our society."[9]

Governmental leaders and international organizations were late to recognize the important role that trusted faith leaders had in influencing community members to override stigmatization and engage in recommended Ebola prevention behaviors. The lack of trust in government and "western actors" needed to be supported by more trusted voices from within their own community.[27] In September, The World Council of Churches convened a meeting of Christian leaders, aid organizations, and UN agencies to highlight the importance of engaging faith leaders and faith-based organizations in this fight. This unified voice resulted in collective action from faith leaders around infection prevention activities and decreased the fear and stigma about Ebola. They were able to replace messages of fear with messages of hope.[9]

Both Christian and Muslim faith leaders drew lessons from their own religious texts (the Bible and the Quran) to support the recommended infection control and prevention measures for Ebola. These included seeking medical care when sick, avoiding contact with bodily fluid, and routine hand washing after contact with the sick or with dead bodies. They emphasized the need for safe and dignified burials, as well as acceptance and appreciation of Ebola workers. They validated the need for psychosocial support for those impacted by the disease, rather than stigmatizing them.[9]

Critique of the Public Health Response

The response to the first case of Ebola in Lagos, Nigeria, in July of 2014 can serve as an example of how rapid case detection and appropriate public health measures can limit the scale of an outbreak. A traveler had returned to Nigeria after caring for an EVD loved one in Liberia. He became sick during the flight and was admitted to the hospital upon arrival at Lagos. In total, 20 EVD cases were reported in Nigeria, with eight deaths. Eleven of these cases were healthcare workers; nine of these were infected from the initial case before his disease was identified. Within weeks, there were no new cases. Evaluation of the Nigerian response identified the key factors that limited further spread of the disease: 1) fast and thorough identifications of all contacts (894 individuals), 2) ongoing monitoring of all contacts, and 3) rapid isolation of all potentially infectious contacts.

The global response to the Ebola epidemic in Guinea, Liberia, and Sierra Leone has created another opportunity to evaluate preparedness for

epidemics. It is clear that these countries did not have systems for rapid identification of early cases and their contacts. Despite early dire warnings from MSF, the WHO and other international actors were slow in their response. On August 28th, 2014, the WHO finally declared the West Africa Ebola epidemic a Public Health Emergency of International Concern (PHEIC). An independent panel from Harvard University Global Health Institute and the London School of Hygiene and Tropical Medicine were tasked to review the Ebola response.[28]

The report states that "Ebola exposed WHO as unable to meet its responsibility for responding to such situations and alerting the global community." Early in the epidemic, it was clear that these countries did not have the capacity to detect early EVD cases, and none were properly trained or equipped with personal protective equipment to respond safely. This resulted in a large number of health workers becoming infected. As the disease took hold in these countries, there was a failure of political leadership to call for increased assistance. The in-country WHO teams were weak, and the WHO as a whole also failed to mobilize global assistance in a timely fashion. As funding and global attention increased, local media and police ignited fear and heightened distrust. As mentioned above, the faith community was not engaged early in the epidemic, and their initial response only increased fear and stigmatization.

The 2018–2019 Outbreak in the Democratic Republic of Congo

On August 1, 2018, the Democratic Republic of Congo announced another outbreak in the mineral-rich and highly volatile province of North Kivu. This came only days after declaring victory over and outbreak in the Equateur province.[29] Responders had the advantages of lessons learned from the West African epidemic, as well as a number of experimental therapeutics and vaccines that were then available. However, responders faced additional challenges related to violence and political instability that made it complicated to deploy the workers and materials necessary to combat the epidemic. During his visit to DRC in January 2019, WHO Director-General Dr. Tedros Adhanom Ghebreyesus confirmed, "The main challenges are the security environment, pockets of mistrust among affected populations, and poor infection prevention and control in many public and private health facilities."[30]

Once again, MSF and Samaritan's Purse (SP) were on the front lines putting many of the lessons learned from West Africa into action. In January 2019, SP expanded their capacity with the addition of an 18-bed treatment unit that supplemented their existing field hospital. MSF had recently increased their bed capacity from 64 to 94 beds. In a recent report, MSF's Roberto Wright emphasized that "with Ebola, treatment centers alone are not enough. Connecting with the communities and building mutual trust is key to get the outbreak under control."[31]

Recommendations for Future Efforts

Wright's statement echoes Dr. Jonathan Quick's sage advice in his book, *The End of Epidemics*. "But counteracting panic and resistance can't just be a top-down, government-issued effort, because trust in government is eroding everywhere. Rather, trust evolves from community leaders and public-health officials working in concert."[32] Quick goes on to outline seven sets of actions needed to prevent future devastating epidemics: (1) ensuring bold leadership at all levels, (2) building resilient health systems, (3) fortifying three lines of defense against disease (prevention, detection, and response), (4) ensuring timely and accurate communication, (5) investing in smart, new innovation, (6) spending wisely to prevent disease before an epidemic strikes, and (7) mobilizing citizen activism.

The Harvard-London School of Hygiene and Tropical Medicine Independent Panel cited above listed 10 major recommendations for strengthening global systems to respond to epidemics.[28] However, a year before the epidemic in West Africa had started, Moon *et al* outlined a more concise list of recommendations for systematic investment to enable the global community to perform four key functions:

> 1) Strengthen core capacities within and between countries to prevent, detect, and respond to outbreaks when and where they occur;
>
> 2) Mobilize faster and more effective external assistance when countries are unable to prevent an outbreak from turning into a crisis;
>
> 3) Rapidly produce and widely share relevant knowledge from community mobilization strategies to protective measures for health workers and from epidemiological information to rapid diagnostic tests;
>
> 4) Provide stewardship over the whole system, entailing strong leadership, coordination, priority-setting, and robust accountability from all involved.[33]

Had these key functions been in place, the recent Ebola epidemic in West Africa would certainly not have exploded as it did. However, this list of functions only hints (leadership in function 4) at creating strong relationships with community and faith leaders in preparation for epidemics and early in outbreaks and the vital role of faith-based organizations. It would certainly be easy for international humanitarian actors to work to strengthen these functions and still miss the vital role that these leaders play in actual implementation of relief efforts. The Tear Fund document cited above also makes a number of recommendations for engaging faith leaders and FBOs in response and recovery efforts.[9]

Salient Points and Additional Recommendations

For donors, governmental leaders and international organizations

- **Authentic partnerships:** Include faith leaders and FBOs, in planning for preparedness and early response to epidemics, as genuine partners who hold expertise in knowing their communities and their culture. Create opportunities to engage faith leaders in doing their part to protect the health of their community and strengthen health services. Avoid focusing only on outputs, and be willing to make long-term investments in building quality institutions.
- **Faith literacy:** Strengthen understanding of the important role of faith and faith leaders in implementing health interventions, especially in settings where trust in government and "western influence" is low. Train humanitarian staff in the religious context of the communities in which they work, and encourage them to build relationships directly with leaders.
- **Highlight best-practices:** Assist FBOs and faith leaders in adopting program management skills and simple and contextualized monitoring and evaluation systems to evaluate their own impact and share best-practices. This allows for pride in their work and dissemination of lessons learned.

For faith-based organizations

- **Promote excellence:** Help break down preconceptions and perceived barriers by producing excellent results from the work done. Know humanitarian and epidemic-specific guidelines as well as any secular organization does.
- **Promote partnership:** Be open to working with secular organizations, governments, and

other faith leaders in ways that build peace and strengthen collaboration.

- **Build people and not just programs:** The current requirements of many grants are so focused on short- and medium-term deliverables that there is not a priority (or money) for building the capacity of the people within the organization or community. Seeing people as cogs in a machine will never truly build healthy communities.

For faith leaders

- **Know your faith:** Many of the world's major religions and religious texts emphasize the importance of caring for the sick and building community. Educate yourself about how to live out your faith in community.
- **Know your community:** Look beyond the doors of your church, temple, or mosque, and know the needs of your community and how you are called to help meet those needs. Building resilient communities is the sign of healthy faith.
- **Stay connected:** Stay connected with what is happening in your community, district, and country, and explore how you can be leaders wherever you are.

References

1. Rosling H, Rosling O, Rosling A. Factfulness: ten reasons we're wrong about the world-and why things are better than you think. Flatiron Books. New York, NY; 2006.
2. Devaux C. Small oversights that led to the Great Plague of Marseille (1720–1723): lessons from the past. Infect Genet Evol. 2013;14:169–85. https://doi.org/10.1016/j.meegid.2012.11.016
3. Watson W. The Sisters of Charity, the 1832 cholera epidemic in Philadelphia and Duffy's Cut. U.S. Cathol Hist. 2009;27(4):1-16.
4. Wazer C. The plagues that might have brought down the Roman Empire. Atlantic. March 16, 2016. Available from: https://www.theatlantic.com/science/archive/2016/03/plagues-roman-empire/473862/.
5. Beal-Preston R. The Christian contribution to medicine. Triple Helix. Spring 2000:9-14. Available from: http://admin.cmf.org.uk/pdf/helix/spr00/11history.pdf
6. Litsios S. The Christian Medical Commission and the development of the World Health Organization's primary health care approach. Am J Public Health. 2004;94(11):1884-93. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448555/pdf/0941884.pdf
7. World Health Organization. Building from common foundations -The World Health Organization and Faith-Based Organizations in primary healthcare. WHO, Geneva, Switzerland; 2008. ISMB 978 92 4 159662 6.
8. Pennisi E. Does religion influence epidemics. Science. August 23, 2011. Available from: http://www.sciencemag.org/news/2011/08/does-religion-influence-epidemics
9. Featherstone A. Keeping the faith - the role of faith leaders in the Ebola response. TearFund; July 2015. Available from: http://www.tearfund.org/~/media/files/main_site/news/keepingthefaith.pdf
10. WHO Report: After Ebola in West Africa - unpredictable risks, preventable epidemics. New Engl J Med. 2016;375(6):587–96. https://doi.org/10.1056/NEJMsr1513109
11. Kentoffio K, Kraemer JD, Griffiths T, Kenny A. Panjabi R, Sechler GA, et al. Charting health system reconstruction in post-war Liberia: a comparison of rural vs. remote healthcare utilization. BMC Health Serv Res. 2016;16(1):478. http://doi.org/10.1186/s12913-016-1709-7
12. SIM.org. SIM's history in Liberia [Internet]. [cited 2018 August 30] Available from: http://www.sim.co.uk/sims-history-liberia
13. CDC.gov. 2014-2016 Ebola outbreak in West Africa [Internet]. 2017 Dec. 27. Available from: https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html
14. Evansa DK, Goldstein M, Popova A. Health-care worker mortality and the legacy of the Ebola epidemic. Lancet. 2015;3(8):e439–40. http://doi.org/10.1016/S2214-109X(15)00065-0

15. CDC.gov. What is Ebola Virus Disease [Internet]? 2018 March 14. [cited 2018 Aug 31] Available from: https://www.cdc.gov/vhf/ebola/about.html
16. Kramer AM, Pulliam JT, Alexander LW, Park AW, Rohani P, Drake JM. Spatial spread of the West Africa Ebola epidemic. Roy Soc Open Sci. 2016;3(8):160294. http://doi.org/10.1098/rsos.160294
17. Park DJ, Dudas G, Wohl S., Goba A, Whitmer SL, Andersen KG, et al. Ebola Virus epidemiology, transmission, and evolution during seven months in Sierra Leone. Cell. 2015;161(7):1516 –26. http://doi.org/10.1016/j.cell.2015.06.007
18. IFRC.org. Preventing disease from crossing borders in West-Africa post-Ebola [Internet]. International Federation of Red Cross and Red Crescent Societies. 2016 March 21. Available from: http://www.ifrc.org/en/news-and-media/news-stories/africa/guinea/preventing-diseases-from-crossing-borders-in-west-africa-post-ebola--72032/
19. Hofman M, Au S. The politics of fear: Médecins Sans Frontières and the West African Ebola epidemic. New York, NY: Oxford University Press. 2017.
20. CBS News.com. Liberia clinic attack overwhelms overworked Ebola aid workers [Internet]. 2014 August 17. Available from: https://www.cbsnews.com/news/liberia-clinic-attack-overwhelms-overworked-ebola-aid-workers/
21. Sacra D. Trauma health after Ebola in Liberia: sociocognitive analysis of a Bible-based psycho-educational approach. [Forthcoming 2019]
22. Personal interview with Bob Blees, Director of Global Services, SIM
23. Cancedda C, Davis S, Dierberg K, Lascher J, Kelly J, Barrie M, et al. Strengthening health systems while responding to a health crisis: lessons learned by a nongovernmental organization during the Ebola Virus Disease epidemic in Sierra Leone. J Infect Dis. 2016;214 (suppl. 3):S153–63. https://doi.org/10.1093/infdis/jiw345
24. Lamontagne F, Clément C, Fletcher T, Jacob S, Fischer W, Fowler R. Doing today's work superbly well — treating Ebola with current tools. New Engl J Med. 2014;371(17):1565-6. https://doi.org/10.1056/NEJMp1411310
25. Fowler R, Fletcher T, Fischer W, Lamontagne F, Jacob S, Brett-Major D, et al. , D. Caring for critically ill patients with Ebola Virus Disease. Perspectives from West Africa. Am J Resp Crit Care. 2014;190(7):733-7. https://doi.org/10.1164/rccm.201408-1514CP
26. Personal interview with Dr. Plyler, August 30, 2018.
27. Marshall K, Smith N. Religion and Ebola: learning from experience. Lancet. 2015;386(10005):e24-5. https://doi.org/10.1016/S0140-6736(15)61082-0
28. Moon S, Sridhar D, Pate MA, Jha AK, Clinton C, Delaunay S, et al. Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the global response to Ebola. Lancet. 2015;386(10009):2204-21. http://doi.org/10.1016/S0140-6736(15)00946-0
29. Damon I, Rollin P, Choi M, Arthur R, Redfield R. New tools in the Ebola arsenal. New Engl J Med. 2018;379(21):1981-3. https://doi.org/10.1056/NEJMp1811751
30. *WHO* News Release. WHO Director-General concludes New Year visit to Ebola-affected areas in the Democratic Republic of the Congo [Internet]. World Health Organization, Geneva. 2019 January 3. Available from: https://www.who.int/news-room/detail/03-01-2019-who-director-general-concludes-new-year-visit-to-ebola-affected-areas-in-the-democratic-republic-of-the-congo
31. MSF.org. Ebola patient care increases amid growing tensions in North Kivu-project update [Internet]. Médecins Sans Frontières.2019 January 18. Available from: https://www.msf.org/ebola-patient-care-increases-amid-growing-tensions-north-kivu-drc
32. Quick J, Fryer B. The end of epidemics: the looming threat to humanity and how to stop it. New York, NY: St. Martin's Press. 2018.
33. Frenck J., Moon S. Governance challenges in global health. New Engl J Med. 2013;368:936-42. https://doi.org/10.1056/NEJMra1109339

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