

Building a Community Health Worker Programme During the Ebola Outbreak in Sierra Leone



Three Ebola survivors trained as facility-based ERVs – known as ‘caregivers’ – being briefed on infection and prevention (IPC) practices by doctors at the Maforki ETU in Port Loko city.

PHOTO: CORA NALLY

This SSHAP Case Study explores the effective implementation of a community health worker (CHW) programme during the Ebola Virus Disease (EVD) epidemic within a collapsed health system in Port Loko district, Sierra Leone. Fear, misinformation, and distrust meant that a comprehensive community-based response was needed to support effective disease screening and referral to Ebola treatment facilities. Partners in Health (PIH), a health-care non-governmental organisation (NGO) founded in the USA, delivered a CHW programme that provided 250,000 people affected by Ebola in Port Loko district with health system services and linkages required to combat Ebola.

The challenge: lack of trust in and referrals to biomedical health care

In January 2015, the Ebola epidemic was at a peak in the Port Loko district of Sierra Leone. Fear, panic, and distrust in response partners had led to a complete collapse of the health system. In a desperate bid to curb the spread of the disease, the British military had established a District Command Centre (DCC) in the compound of local Ministry of Health offices in Port Loko city and was leading the coordination of all NGOs and the three Ebola Treatment Units (ETUs). A community-based needs assessment amongst Ebola-affected communities conducted by PIH showed that setting up ETUs alone was not enough. Additional support was needed to ensure that referrals were made, and that people had enough trust to turn up for appointments once referred.

Key findings of an initial assessment of community needs

PIH staff undertook an initial assessment of the Ebola response within affected communities using qualitative research methods, including interviews with stakeholders and assessment of

existing response mechanisms and partners. This initial assessment was necessary in order to understand the operational context, and it helped to identify the following gaps in response mechanisms.

Challenges with active case

finding: The assessment showed that aid workers entered communities using a surge pattern,

where 20-30 workers boarded a bus into the centre of a community, and once off the bus, they 'surged' through the community, providing education about the signs and symptoms of Ebola,

and explaining how to call an ambulance. At the same time, NGO and government partners reported that no one was specifically looking for sick people or systematically surveying and checking communities and families for symptoms of Ebola.

Reported fear of treatment: Fear of the Ebola response – due to a combination of historical grievances, lack of information, and misinformation – caused affected people to flee instead of seeking treatment, thereby spreading the disease. The following reasons were presented by communities during the assessment: fear of what may happen at the ETUs; limited information on treatment pathways; and fear of army-enforced quarantines in which there was limited availability of food, water, and power. These all contributed to unnecessary suffering and anger over response measures, which were often not completely understood.

Mistrust of information about Ebola and its

prevention: Misinformation was omnipresent and caused many to fear, and lose trust in, Ebola response mechanisms. A particularly prevalent belief was that Ebola was 'invented by foreigners' and that 'you would catch it if you went to a hospital'. Another was that the NGOs who were fighting the disease were 'actually spreading it'. Such misinformation caused people to fear health-care workers, and delayed notification of cases and access to essential care.

Stigma and lack of reintegration plan: When survivors or people who were tested for Ebola (regardless of whether the test was positive or negative) arrived back in their communities, they were often ostracised and faced discrimination. For example, those who survived the virus were blamed for those who had died, and they were often avoided out of fear of contamination.

“**The CHWs were selected and monitored by their communities, and had to be literate and be regarded as 'community leaders'.**”

Programme design: cadres of CHWs to improve surveillance, care, and Psycho-Social Support

To fill the identified gaps, a programme in Port Loko district was created with a total of 656 newly recruited CHWs and it ran between January and July 2015. It was rolled out in three of the chiefdoms (third-level units of administration in Sierra Leone) with the highest disease incidence: Port Loko, Kafu Bullum, and Maforki. The CHWs were selected and monitored by their communities, and had to be literate and be regarded as 'community leaders'. PIH paid the CHWs a monthly stipend and all volunteers received a three-day training and additional specialised training depending on their roles, as detailed below.

Emergency Response Volunteers (ERVs):

519 ERVs were hired as 'active case finders'

“Continuous communication, with integrated feedback loops monitoring performance and improvement, created a flexible and dynamic programme that had the capacity to adapt quickly as the epidemic evolved.”

and delivered evidence-based health messages in their own communities. On a day-to-day basis, they went from door to door to find sick people in the community and provided supporting health messages to families. The ERVs spoke with approximately 17,000 people every week during the normal course of their work.

Facility-based ERVs (referred

to as 'caregivers' inside the ETUs): 19 facility-based ERVs provided psychosocial support to patients inside the ETUs and acted as communication links to the village and families. Their role included fulfilling practical care, such as supplying patients with water when requested, and also offering mental support, like comforting chats or prayers.

Psychosocial support ERVs: 118 Psycho-Social Support ERVs provided emotional and social support in their communities; specifically, organising the community to support quarantined families, helping Ebola survivors reintegrate, and keeping families updated on the health status of any member who was Ebola positive and in an ETU.

Programme coordinators: Programme coordinators made weekly visits to the programme chiefdoms to meet with their CHWs in order to collect data, provide ongoing training, and solve programme- and epidemic-related issues as they arose in the communities.

Data collectors: Four data collectors manually inputted data collected by the volunteers using a randomised controlled method. As data was collected from over 17,000 people each day, it was not possible to enter all of the data collected. To address this, a randomised program identified which pages would be entered into the database.

Lessons learned

The CHW programme provided the following lessons learned:

- Community support, including that of local leaders, is essential to ensure trust in the CHWs. This can be done by gaining approval from community and government leaders early in the process and allowing communities to select the CHWs.
- Continuous communication, with integrated feedback loops monitoring performance and improvement, created a flexible and dynamic programme that had the capacity to adapt quickly as the epidemic evolved. This was done by utilising a management structure that promoted the flow of information both up and down. There were weekly meetings with the CHW managers in the field, where issues with implementation

were discussed and resolved, data were collected, and health messages for the following week were shared. Managers were then charged with delivering this information to their CHWs and the coordinators returned to headquarters with information that was used to inform programme decisions for the following week.

- Paying CHWs a fair stipend meant that they took their responsibilities very seriously and, at times, even filled other health system gaps caused by the epidemic. For example, a midwife who was part of the programme began visiting all the pregnant women in her catchment area in her own time, as there were no clinics providing prenatal care.

Further reading

Cancedda, C. *et al.* (2016) '[Strengthening Health Systems While Responding to a Health Crisis: Lessons Learned by a Nongovernmental Organization During the Ebola Virus Disease Epidemic in Sierra Leone](#)', *Journal of Infectious Diseases* 214.suppl.3: S153–63

Commission on a Global Health Risk Framework for the Future and National Academy of Medicine (2016) *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*, Washington DC: National Academies Press

Dynes, M.M. *et al.* (2015) '[Perceptions of the Risk for Ebola and Health Facility Use Among Health Workers and Pregnant and Lactating Women – Kenema District, Sierra Leone, September 2014](#)', *Morbidity and Mortality Weekly Report (MMWR)* 63.51: 1226–27

Credits

This SSHAP Case Study produced by **Cora Nally**, Epione Consulting, with support from **Mary B. Adam**, Kijabe Maternal Newborn Community Health, and **Patrick Van de Voorde**, University Hospital Ghent, Belgium.

Citation: Nally, C.; Adam, M.B. and Van de Voorde, P. (2020) *Building a Community Health Worker Programme During the Ebola Outbreak in Sierra Leone*, SSHAP Case Study 6, UNICEF, IDS and Anthrologica.

This document has been funded by UNICEF and the U.S. Agency for International Development (USAID) Office of U.S. Foreign Disaster Assistance (OFDA). However, the views expressed herein are those of the author(s) and do not necessarily reflect those of USAID or OFDA, or the partners in the Social Science for Humanitarian Action Platform (SSHAP).



This is an Open Access paper distributed under the terms of the Creative Commons Attribution 4.0 International licence (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original authors and source are credited and any modifications or adaptations are indicated. <http://creativecommons.org/licenses/by/4.0/legalcode>.

© SSHAP 2020

About

The Social Science in Humanitarian Action Platform (SSHAP) aims to establish networks of social scientists with regional and subject expertise to rapidly provide insight, analysis and advice, tailored to demand and in accessible forms, to better design and implement emergency responses. SSHAP is a partnership between the Institute of Development Studies (IDS), the London School of Hygiene and Tropical Medicine (LSHTM), Anthrologica and UNICEF Communication for Development (C4D).



Institute of
Development Studies



Social Science in Humanitarian Action

E info@socialscienceinaction.org **W** www.socialscienceinaction.org



USAID
FROM THE AMERICAN PEOPLE

This Case Study is part of a portfolio on Social Science Lessons Learned in Epidemics and was supported by the Office of U.S. Foreign Disaster Assistance (OFDA) and UNICEF.