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Key experiences of community engagement and social mobilization in the Ebola response

Glenn Laverack¹ and Erma Manoncourt²

Abstract: The ongoing outbreak of the Ebola virus in West Africa is the largest on record; it has undermined already fragile healthcare systems and presented new challenges to contain the spread of the disease. Based on our observations in the field and insights from referenced sources, we aimed to identify key experiences of community engagement and social mobilization efforts in the current Ebola response. We concluded that there is no excuse not to actively involve local people and that the United Nations (UN) agencies and other partners did learn from their earlier mistakes to make a genuine attempt to better engage with communities. However, bottom-up approaches have not been widely implemented during the response and the reasons for not doing so must be further assessed. Health promotion can make an important contribution, because it shows how to enable people to take more control over their lives and health. This commentary can provide a guide to agencies to understand an appropriate way forward when the next Ebola outbreak inevitably occurs. (*Global Health Promotion*, 2016; 23(1): 79–82)

Keywords: anthropologists, community action, community engagement, community resistance, disease management, Ebola, health promotion, outbreak response, public health, social mobilization

Based on our observations in the field and insights from referenced sources, we aimed to identify key experiences of community engagement and social mobilization efforts in the recent Ebola response in West Africa. These experiences were based on the approach of the Ebola response, the role played by anthropologists, the style of communication, community resistance, and cross-border and urban challenges. The community engagement and social mobilization activities were led by United Nations Children's Fund (UNICEF) and United Nations Mission for Ebola Emergency Response (UNMEER) and had an operational cadre of 'social mobilizers' that were employed by different agencies as field workers at the district and community levels. Their purpose was to assist with communication, training, stakeholder engagement, and the mobilization and coordination of targeted interventions such as 'lock-downs'. To bring the different partners together in a

common platform at the national level, a community engagement and social mobilization 'pillar' was established in Liberia, Sierra Leone and Guinea. The pillar met on a regular basis to better plan, to coordinate, to mediate between agencies, and to facilitate the delivery of activities and the policy response to a rapidly changing situation. We have interpreted that community engagement and social mobilization efforts are closely linked to a health promotion practice that recognizes the value of including local people in planning and implementation, and that seeks to listen to and respond to the expressed needs of communities. This is called a 'bottom-up approach'.

The Ebola response

The ongoing outbreak of Ebola virus disease in West Africa is the largest on record, with a mortality

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rate of approximately 70% and an unprecedented number of reported cases ($n = 27,479$ at 24 June 2015) and deaths ($n = 11,222$ at 24 June 2015) (1). The outbreak had had a rapid transmission of the disease within and across the countries of Guinea, Liberia and Sierra Leone. The epidemic undermined already fragile healthcare relationships and systems, and presented challenges to contain the spread of the disease and to develop new prevention and treatment options. The task of managing the outbreak was initially left to national governments and non-governmental organizations (NGOs), but as the epidemic continued to accelerate, it became apparent that the disease posed a bigger threat; and this triggered a global United Nations (UN)-led response. With many organizations being deployed on the ground, the first priority of sufficient beds for patients was soon met; and the focus shifted to surveillance, case management, safe burials, contact-tracing and to a lesser extent, community engagement and social mobilization.

The initial 'getting to zero' strategy was top-down and driven by epidemiological data and the perceived need to treat Ebola patients. The reported number of cases continued to increase and more severe measures began to follow; for example, in Sierra Leone on 19 September 2014 a three-day stay-at-home or lock-down period was enforced, with the threat of fines or jail if violated. During the stay-at-home period, social mobilizers went door to door in search of people showing symptoms of infection, providing information and giving out resources such as soap. In this manner, 263 cases of Ebola were identified and families and communities were quarantined, leading to food shortages and disrupted trade. Unsurprisingly, people continued to violate the quarantine requirements. The government decided to implement a modified three-day stay-at-home intervention in March 2015 which allowed people to attend prayers. This received more cooperation from the general population, as they sensed the end of the Ebola outbreak.

At an early stage in the epidemic, many community leaders recognized the value of prevention as the best strategy to curtail the disease, including improved hygiene, local surveillance, self-imposed quarantine and the community management of burials. Chiefdoms in Kono, Sierra Leone, for example, wanted their own burial teams to counter the culturally insensitive handling of their dead. Communities also wanted community Ebola cemeteries where they could bury

their dead, so future generations would have a referential ancestral burial site (2). Self-imposed quarantine proved to be an important factor in Ebola control, especially when it was led by local and religious leaders. It is crucial to minimize quarantine violations, as well as to trace contacts and new cases. The reliable delivery of resources was also an essential part of building community-led self-imposed quarantine, which included food, water, money and information (3). Coercion was found to be counterproductive after the negative repercussions of using large-scale forced quarantines controlled by the military, for example, in Liberia. The coercion was responsible for breaking down the trust that was required for successful community engagement (4).

The role of anthropology

Anthropological insights can significantly contribute to Ebola control, because they take into account local perspectives and help us to understand the complexity of the problem (for example, in regard to notions of purity, pollution and the exchange of bodily fluids); however, we observed that anthropological insights were not widely used in the ongoing Ebola response. Anthropological studies require in-depth and sometimes long-term input, whereas in a crisis response, new information is required quickly as the situation changes, often on a daily basis. We found that anthropological insight can provide useful information at the beginning of the outbreak; as the response progresses, however, it is the 'quick and dirty' studies, often produced by epidemiologists and social scientists, which can best meet the requirements of rapidly changing circumstances. For example, a rapid assessment of the siting and construction of Community Care Centers in Sierra Leone found that the fears of communities were quickly alleviated when they had been actively engaged in decisions (5).

We also found that anthropologists are trained to provide 'thick and dense' accounts, which are difficult to translate into practical recommendations, compounded by a poor understanding of how programs function. Anthropological recommendations, when they were provided, were sometimes disregarded for being too vague. The missing link has been a discussion between the program manager and the anthropologist, or an intermediary who could provide an interpretation of the practical relevance of the findings.

The communication approach

The findings from the Knowledge, Attitude and Practice surveys in Liberia and Sierra Leone suggested that knowledge levels about the transmission of the disease were consistently high, often above 90%. This is an endorsement of the communication approach used in the Ebola response: a combination of mass media, print materials and face-to-face communication. We observed that each country used a different variation on this approach. Liberia applied the principles of the Communication for Development (C4D) approach, social behavior change communication and information, education and communication techniques. Sierra Leone also used C4D, with a mixed-methods approach, strong on messaging and print materials. Guinea was the exception: it relied on the use of the radio and the Community Watch Committees or '*comité de veille*', a community-based approach that in practice did not seemingly deliver what was expected.

The rapid establishment and scale-up of more than 2000 Community Watch Committees throughout the country strained the monitoring and supervision by both the government and its implementing partners. Our estimation in the field suggested that only 25% of the Community Watch Committees were functional, and that guidance on community representation was not always respected by local leaders. There were exceptions, notably the Social Mobilization Action Consortium in Sierra Leone, which did develop a 'community-led Ebola approach' to trigger local action; however, the predominant communication approach relied on the mass media, refined messaging and interpersonal contact through thousands of social mobilizers. The quality and coverage of the interpersonal communication was variable, and was sometimes carried out without sufficient discussion of the key concerns.

The mass media approach was successful in Sierra Leone, Liberia and Guinea in reaching a large number of households to raise awareness; however, as the outbreak progressed, the response was too slow to adapt to a more targeted approach, to engage people in a dialogue to address deep-seated practices – in particular, those that continued to allow the transmission of the disease, including the hiding of sick people and dead bodies, and unsafe

burial practices. We observed that one reason why the outbreak has persisted may have been that overall, the response did not deliver bottom-up approaches that could build a dialogue and promote self-management, to convince those families and communities that were unwilling to change their traditional practices.

Community resistance and rumors

Non-compliant behavior was observed to be part of a cycle of unwillingness to change traditional practices that can be compounded by experiences of poor service delivery and weak information flow (for example, a lack of support for quarantined families and patients). This can then create an atmosphere of mistrust, fear, resistance and non-compliance. Building a narrative of trust through communication is difficult; ideally, community confidence should be maintained from the beginning through bottom-up approaches that include a respect for local perspectives. Community resistance was a key issue in Guinea, Liberia and Sierra Leone; as the outbreak continued, we observed that the nature of the resistance changed. For example, although the total number of incidents across Guinea decreased, the level of violence increased and continued to be confined to specific areas. The exact causes of resistance were unclear, but appeared to be a combination of rumor, misinformation and poor professional practice. Later in the response, efforts to collect and analyze rumors were initiated by *Internews* in Liberia, and this showed that people continued to be concerned about government interventions such as decommissioning, vaccinations, and back-to-school and other transition activities (6).

Urban and cross-border issues

Epidemiological data have correctly projected that the disease will recede into urban areas during the final phases of the outbreak; however, we observed that an alternative strategy to the ongoing rural-based communication approach was not developed in any of the three countries. The urban and rural contexts present unique challenges; and the response could learn valuable lessons from, for example, the UNMEER/UN-Habitat intervention in Montserrado, Monrovia, and approaches that engage local officials within administrative boundaries in urban areas.

In West Africa, international borders are porous and artificially separate closely interwoven communities linked by common languages, ethnicity, cultural traditions and access to markets. The cross-border movement of people is inevitable; whilst the closing of official border crossings had prevented motor vehicle traffic, foot and bicycle traffic has never stopped, and may even have increased in the remote areas, acting as a potential source of transmission. We observed that a systematic community management approach to record travel histories, contacts and symptoms of illness in the cross-border areas would improve the situation (for example, engaging with village chiefs in cross-border control is critical to organize patrols of the boundaries of their villages, to keep outsiders away and to record people's movements).

Conclusion

We conclude that Ebola control efforts must actively involve people and this is critical to success. The lead agencies did learn from their earlier mistakes in the present outbreak and have made a genuine attempt to better engage with communities; however, bottom-up approaches have not been widely implemented and this may lie in an agency preference to use pre-packaged and top-down approaches, which have an emphasis on behavior change communication. This raises concerns about whether or not the lessons on the success of community engagement have really been learned, or if top-down approaches will continue to dominate responses of the future. Commentators have suggested that top-down tactics have had a questionable effect, potentially worsening the epidemic, and contributing to a greater social and economic burden in West Africa (7).

The emerging evidence from the current Ebola response suggested that communities have understood what is required and can learn rapidly to change high-risk traditional practices to help to reduce transmission. In particular, community engagement can offer an added value through the self-management of quarantines, control of cross-border movement, safe and dignified burials, and the siting of Community Care Centers. Plainly put, there is no excuse not to actively involve local people

in an Ebola response and the reasons for not doing so must be assessed, including any assumptions about local ignorance, weak capacity, and the lack of trust between agencies and communities. Health promotion can make an important contribution, because it shows how to enable people to take more control over their lives and health. Community capacity building, participation and empowerment are already intrinsic to a health promotion practice that recognizes the value of a bottom-up approach. This can provide a guide to agencies to understand an appropriate way forward when the next Ebola outbreak inevitably occurs.

Conflict of interest

The authors declare that there is no conflict of interest.

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