

# GUIDE TO COMMUNITY ENGAGEMENT IN WASH

A practitioner's guide, based on lessons from Ebola



Community Health Volunteers receiving training in Clara Town, Monrovia, Liberia. Photo: Pablo Tosco/Oxfam

By Eva Niederberger, Suzanne Ferron and Marion O'Reilly

# ABOUT THIS GUIDE

**This guide is a compilation of best practices and key lessons learned through Oxfam's experience of community engagement during the 2014–15 Ebola response in Sierra Leone and Liberia. It aims to inform public health practitioners and programme teams about the design and implementation of community-centred approaches.**

# CONTENTS

<b>Acronyms</b> .....	<b>4</b>
<b>1. Introduction</b> .....	<b>5</b>
1.1 About this note.....	5
1.2 Ten key lessons.....	6
<b>2. Assessing contexts</b> .....	<b>7</b>
2.1 Pre-epidemic healthcare systems.....	8
2.2 Community history and leadership dynamics.....	8
2.3 Community capacity.....	9
2.4 Access to information.....	9
2.5 Diversity in affected communities.....	10
<b>3. Engaging with communities</b> .....	<b>11</b>
3.1 With whom should we work?.....	11
3.2 What approaches can we use?.....	14
3.3 Communicating with affected communities.....	17
<b>4. Scaling up engagement</b> .....	<b>21</b>
4.1 Context-specific approaches.....	21
4.2. Measuring and monitoring engagement.....	24
<b>5. Coordination</b> .....	<b>26</b>
<b>6. Advocacy and lobbying</b> .....	<b>27</b>
<b>Bibliography</b> .....	<b>29</b>

# ACRONYMS

<b>ACF</b>	<i>Action Contre La Faim</i>
<b>CCC</b>	Community care centre
<b>CHC</b>	Community health committees
<b>CLEME</b>	Community-led Ebola management and eradication
<b>MSF</b>	<i>Médecins sans Frontières</i>
<b>PHP</b>	Public health promotion
<b>SMAC</b>	Social Mobilisation Action Consortium
<b>WASH</b>	Water, sanitation and hygiene

# 1 INTRODUCTION

The Ebola response in Sierra Leone, Liberia and Guinea demonstrated that community engagement is critical in responding to epidemics. This was not always a guiding principle in the fight against Ebola, which initially prioritized biomedical and militarized responses. Working in partnership with communities – providing space to listen and acknowledge distinct needs – only came later in the response. Incorporating communities in different aspects of the response was partly hampered by the inflexibility of some agencies, which wanted to promote a perfect model for community engagement. Arguably, these tended to overlook the diversity within communities, and did not respond to the realities of Ebola's spread.

During an inter-agency social mobilization workshop organized by Oxfam in September 2015, a group of practitioners and technical experts agreed that it would be best to explore diverse models of community empowerment and action that adhered to specific key principles rather than promote a fixed 'one size fits all' model. The group acknowledged the need for phased and flexible approaches that support communities, and for further research into the most effective ways to respond to disease outbreaks.

## 1.1 ABOUT THIS GUIDE

This guide is a compilation of best practices and key lessons learned through Oxfam's experience of community engagement in the 2014–15 Ebola responses in Sierra Leone and Liberia.

It provides ideas for all stages of an intervention, including the importance of assessment; principles and methods for community engagement; the challenges of scaling-up responses and changing communities' behaviours; and reflections on how to better advocate for communities.

Drawing on semi-structured interviews and input from practitioners in various agencies, as well as a literature review, this guide aims to inform public health practitioners and programme teams about the design and implementation of community-centred approaches during a disease outbreak. The lessons learned can also be applied more generally to Oxfam's community-focused water, sanitation and health (WASH) programming.

## 1.2 TEN KEY LESSONS

1. Many of the lessons from the Ebola response can be applied to Oxfam's WASH programmes, especially cholera responses. Equally, Oxfam's experience with public health promotion (PHP) and WASH interventions means that it is well placed to support and develop capacity in community engagement and social mobilization.
2. A sound understanding of the diversity and varied vulnerabilities within affected communities is vital. Resources must be devoted to understanding community perspectives and advocating for community-focused interventions. Specialists, such as anthropologists and epidemiologists, may be required for information to be collected, documented and used effectively.
3. One-size-fits-all models of community engagement are not the best solution. It is better to recognize the potential capabilities of communities in each situation and provide context-specific support. This allows communities to take action to protect themselves using a 'menu' of different strategies, developed using a community-led approach. To do this effectively, key groups (e.g. male and female leaders, traditional healers, religious leaders, older people, youth and children) need to be identified.
4. Advocacy efforts should be directed at promoting inclusive and representative ideas, concerns, questions and solutions of communities, and ensuring that only useful and practical information is given to communities by humanitarian actors.
5. The information given to communities must be prioritized to ensure that the crisis affected population understands and uses the most effective protective actions (e.g., in the case of Ebola, early isolation and referral, and not touching the dead). The uptake and use of these specific actions must be monitored, and rumours about diseases and treatment processes should be documented in order to track progress.
6. It is important to work with others (from all sectors) to increase the transparency of medical and burial processes, especially where there is a lack of understanding and/or trust in the healthcare system. This can include step-by-step guides for referral or burial management, and showing videos to illustrate what to expect.
7. Support, training and supervision for newly recruited staff are vital to ensure responses are community-centred, effective and accountable.
8. Community engagement supports every other aspect of a response (e.g. testing and treatment, safe burials, etc). Therefore, active coordination and planning with other sectors is crucial at the local and district levels, as well as with national collaborators.

9. Programme managers should actively support and foster regular information exchanges between programme teams within and between organizations (e.g. daily debriefs).
10. Using fear to encourage changes in behaviour can be counterproductive. It is better to promote self-reliance and self-help among affected populations.

## 2 ASSESSING CONTEXTS

Community engagement requires a sound understanding of differences and vulnerabilities, and a genuine desire to understand community perspectives. Very little in-depth assessment information was documented at the beginning of the 2014–15 Ebola response. It was therefore vital to conduct structured assessments in order to work out priorities for responses, as well as to inform incoming programme staff.

### **Box 1: Space for community dialogue**

Some agencies had conducted knowledge, attitude and practice surveys. However, insufficient attention had been given to the collection of qualitative data, and the provision of space to listen to affected communities and hold dialogues. In the Ebola outbreak, this was partly due to fear, which initially overwhelmed aspects of Oxfam's response: for example, early standard operating procedures designed to protect staff health and safety restricted movement in affected communities. Confusion about Oxfam's role in the outbreak response – which in disease outbreaks usually focuses on working with communities to provide WASH services, not direct treatment of the disease – also made it difficult for technical teams to steer the organization towards community engagement in the first phase of the response.

Conducting structured assessments in an outbreak may require the early mobilization of anthropological and epidemiological experts:

1. Applied socio-anthropological analysis can help programme teams understand community perceptions of risk, norms and beliefs before and during the outbreak; community self-reliance and coping strategies; community (leadership) structures; and local concerns and priorities.
2. Epidemiological data analysis can help build an understanding of local transmission routes, and help set priorities for responses to rapidly evolving contexts.

Drawing on both areas of expertise can help the development of more effective control strategies by identifying how the disease is spreading, and which groups and locations are at greatest risk. Knowledge of community perceptions of, and beliefs about, the disease can help those



responding understand how these impact preventive and curative treatment-seeking behaviour.

## 2.1 PRE-EPIDEMIC HEALTHCARE SYSTEMS

It is important to understand how formal and informal healthcare systems are structured. Post-Ebola evaluations highlighted the significant role of private healthcare provision in Liberia, Guinea and Sierra Leone: active networks of health posts linked to faith-based institutions, traditional healers, drug peddlers and birth attendants are common across all three countries.<sup>1</sup>

Understanding how alternative providers – such as herbalists, traditional birth attendants and sorcerers – work with their patients can provide insights into risk factors, as well as highlight potentially important groups with whom to work.<sup>2</sup> Working with and through informal networks can potentially help to motivate communities seek early referral and build preparedness, depending on their degree of influence in the community.

## 2.2 COMMUNITY HISTORY AND LEADERSHIP DYNAMICS



Hon Paramount Chief Alie Balansama Marah III, Port Loko District, Sierra Leone, February 2015.  
Photo: Michelle Curran/Oxfam

Understanding networks of past and current relationships within communities is important. For example, during the civil war in Sierra Leone, the imposition of bylaws (e.g. preventing strangers staying in



villages) was seen as an important form of local governance. These were considered ‘particularly effective when adopted at community level and decided by the community natural leaders’.<sup>3</sup> Applied and rapid social research in the first phase of an outbreak can contribute to teams’ understanding of cultural beliefs, the role and acceptance of traditional communal leadership structures, and issues around power and culture.

### **Box 2: Exploring and challenging culture**

‘Culture is not a fixed entity’,<sup>4</sup> as demonstrated in the Ebola outbreaks in the Democratic Republic of the Congo, Uganda and Gabon. Recent research suggests that hygiene practices and death rituals might be less relevant compared to the culture of caregiving here. It further recommends assessing the ‘emotional ties that bind communities and families together’.<sup>5</sup> For example, older people in many West African societies traditionally play a crucial role in caregiving, which puts them at greater risk of contracting Ebola.<sup>6</sup> The extensively militarized quarantine process in Sierra Leone and the resulting fear for children’s lives if either they or their carers were taken out of their homes steered women away from treatment, and thereby had a negative impact on infection risks. Mapping out roles and responsibilities across diverse groups within communities helps to identify high-risk groups and those who can contribute as confidence builders to prevent and/or contain the spread of disease.

## **2.3 COMMUNITY CAPACITY**

In the early stages of the Ebola outbreak – when the focus of the response was on treatment and care – communities needed to generate their own solutions to managing the outbreak.<sup>7</sup> Detailing communities’ resources, capacity and coping mechanisms prior to and during the crisis could help to recognize their contribution and skills, and identify where they need support. Agencies can then build their work upon communities’ existing capabilities.

## **2.4 ACCESS TO INFORMATION**

In every emergency, ensuring communities’ access to accurate and culturally appropriate information is vital, as it helps people to make informed choices. This requires the use of appropriate communication channels, in order to reach people ‘where they are’. In the Ebola outbreak, the predominance of extensive top-down and negative communication – such as ‘Ebola kills’ and ‘there is no vaccine’ – resulted in increased fear and stigma, fed rumours and dissuaded people from seeking treatment in distant treatment centres.

### Box 3: Collecting information about rumours

At the height of the epidemic, when hundreds of people were dying each day, panic and rumours spread in chaotic communication environments. For instance, Internews found in November 2014 that there were more than '300 different types of social mobilisation or messaging systems in Guinea, Liberia and Sierra Leone'.<sup>8</sup> Understanding the level and type of rumours enables programme teams to develop culturally appropriate approaches to health communication. This includes showing who and how to engage to mitigate high-risk behaviour. Developing and sharing evidence-based and locally relevant information can also contribute to increasing communities' self-reliance and trust in the treatment process.

## 2.5 DIVERSITY IN AFFECTED COMMUNITIES

Communities are diverse – and so are their needs. The categorization of Ebola as a 'health' rather than a 'humanitarian' crisis led to a narrow focus on a top-down medical response instead of attempting to mitigate the wider impact of the epidemic on people's health and socioeconomic status.<sup>9</sup> While programme design needs to draw on sectoral focus and organizations' technical expertise, it is also important to encourage a broader dialogue with diverse communities. This involves listening unconditionally – without narratives and pre-identified solutions in mind – to the concerns and suggestions of crisis-affected groups and individuals. This could inform and shape advocacy, and thus be used to influence coordination mechanisms. For example, some people told us that ambulance sirens scared members of their communities so badly that they did not want to report suspected cases of Ebola. By taking this concern seriously, a simple change (switching off the siren in some areas) could result in an improvement in programme efficacy.

# 3 ENGAGING WITH COMMUNITIES

## 3.1 WITH WHOM SHOULD WE WORK?



Oxfam Community Health Workers in Freetown, Sierra Leone, November 2014. Photo: Pablo Tosco/Oxfam.

A number of evaluation studies have highlighted the importance of working with community members ('insiders') during an acute outbreak, instead of employing people from outside.<sup>10</sup> Although it may not always be possible or desirable to channel the entire response through community structures, pairing 'outsiders' with insiders might enhance the identification of mutually acceptable solutions. For example, using the skills of outsiders in translating general information for use in local contexts to dispel rumours might increase the confidence of trusted community representatives to provide effective support to their families and neighbours.

#### Box 4: Confidence builders

In Sierra Leone, Oxfam supported Community Health Committees (CHCs), whose members were seen as 'confidence builders'. They encouraged people to seek treatment and/or use ambulances, accompanied contact-tracing teams, and facilitated interactions between households and outbreak control teams.

The Active Case Finding Initiative team, launched by Oxfam in Liberia in December 2014, convinced people even in the urban townships of Monrovia – including gang members, drug users and sex workers – of the importance of revealing their contacts. General community health volunteers were known and trusted, and their regular presence helped to deepen communities' confidence in the services provided.

Sources: S. Ferron and J. Beesley. (2015a). *Community Care Centres for Ebola*; S. Ferron and J. Beesley. (2015b). *Active Case Finding in for Ebola*. Both Oxfam internal reports.

## Inclusion and representation

Engaging with communities to enhance their holistic understanding of the disease and identify key parameters to break local transmission chains requires interacting with a wide range of people. This in turn involves understanding past and present social hierarchies.

Oxfam's CHC model in Sierra Leone aimed to do this using a diverse community volunteer structure; however, the short timeframe and existing power dynamics made it challenging to identify active people that adequately represented their communities' diversity.

As a consequence, many of the volunteers mobilized by Oxfam in Liberia and Sierra Leone were young. This is a potential problem as the mobilization of exclusively young men can risk triggering 'surveillance like behaviours that can turn rather quickly into a remilitarization of social organization'.<sup>11</sup>

With hindsight, it might have been more useful to initially support individual focal points at community level and Ebola Task Forces, especially in areas without existing community outreach structures. In parallel, teams could have learned more about social structures and important stakeholders to get more systematically involved in health communication and action. For example, in Sierra Leone, traditional healers were recognized as critical enablers in promoting early referral, and research suggests that they could play a crucial role in strengthening community level preparedness capacity. The social mobilization review also highlighted the importance of involving women's groups and religious leaders more consistently in responses.<sup>12</sup>

Doing this well requires understanding barriers and enablers to community participation. For example, literacy was identified as a key barrier for female participation in programmes in Liberia.<sup>13</sup> Oxfam's *Gender Evaluation Study in Sierra Leone*<sup>14</sup> found that a better understanding of local conceptions of Ebola, and how these affect

gender dynamics and roles, was needed. While socio-cultural understandings of Ebola differ between contexts, affected individuals and groups are commonly stigmatized. In Sierra Leone, this has obvious implications for women, who, due to their traditional roles as caregivers, face a greater burden of blame and stigmatization if a family member falls sick or dies.

It also means recognizing the community's own initiatives and ability to organize themselves during a disease outbreak. For example, ethnographic research in urban Liberia provided an insight into how communities recognized the different roles of men and women, and were able to translate this into a gendered community-led surveillance model: it suggested that, while men should engage in the community task force, block watch and/or community action team, women should focus on their domestic roles, monitoring the health of family members.<sup>15</sup> This reflects women's reported preference for self-isolation, and recognizes the capacity of female community members to plan for dealing with sick family members. Inclusive community participation in urban contexts should seek to involve traditional female community leaders, such as 'Mammy Queens' in Sierra Leone, local women's associations and/or traditional birth attendants in community-level surveillance systems.

Research also suggests the need to examine the role of the elderly. For example, traditional burial management often involves older women. Therefore, the employment of young people in burial teams hampered community acceptance of interventions. Involving older people as 'burial advisers' could be one solution;<sup>16</sup> they could also play an important role as community liaisons between treatment structures and the community, due to their trusted status.

#### **Box 5: Faith-based leaders**

Faith-based leaders can help people to link religious and spiritual practices with preventative measures to protect themselves against Ebola. In Sierra Leone, CAFOD supported imams to positively influence cultural beliefs and practices around burials using the adoption of the 'Channels of Hope' methodology.<sup>17</sup> UNICEF worked in Liberia with faith leaders to adapt messages from the Koran and Bible to promote behaviour change at community level: Friday prayers and Sunday churches were used as important platforms to engage with different community groups.

Sources: ACAPS (Assessment Capacities Project). (2015a). *Ebola Outbreak, Sierra Leone: Communication: Challenges and good practices*. <http://reliefweb.int/report/sierra-leone/ebola-outbreak-sierra-leone-communication-challenges-and-good-practices>; ACAPS. (2015b). *Ebola Outbreak, Liberia: Communication: Challenges and good practices*. <http://reliefweb.int/report/liberia/ebola-outbreak-liberia-communication-challenges-and-good-practices>.



## 3.2 WHAT APPROACHES CAN WE USE?

### Supporting community ownership

In Sierra Leone, Oxfam helped medical agencies construct and manage community care centres (CCC). A comprehensive community consultation process was crucial to give people a sense of ownership and trust in these structures for tackling Ebola. Community-wide meetings were organized to explain the concept of safe isolation, address concerns and understand local priorities. In an environment ruled by fear and mistrust, transparency is of the utmost importance: in Port Loko district, CHC members and community stakeholders were invited to a demonstration before the CCC was opened, to show in detail what would happen inside an isolation unit. In Kumala, community leaders, teachers and parents were consulted before the decommissioning of one CCC, which had been located in a school, to discuss how to restore their confidence in the safety of the school. Oxfam also involved volunteers in the latter's decontamination process.<sup>18</sup>



The Kontoloh Community Care Centre, Freetown, Sierra Leone, January 2015. Photo: Abbie Trayler-Smith

### Supporting community initiatives

In the absence of adequate outbreak control services, communities often showed self-reliance and the capacity to respond and prepare themselves.<sup>19</sup> For example, in the early stages of the outbreak in Sierra Leone, stakeholder meetings with district (paramount) chiefs resulted in the creation of village-level task forces.<sup>20</sup> These groups implemented local bylaws to prevent the spread of disease, and there were clear reporting lines from the village to the district authorities when a person



showed symptoms.

#### **Box 6: Community response model**

In order to strengthen communities' capacity to respond to an epidemic, PHP teams should consider providing training on 'first aid', i.e. how to respond when specialist help is not immediately available. Advice could be given on protecting carers while providing locally available medication (e.g. analgesia, antipyretics and oral rehydration). This would be particularly useful in the first phase of a response, when outbreak control systems are not able to respond quickly enough, or in remote areas where services are distant. Training and technical support would not seek to substitute for referral to, and isolation in, medical treatment facilities, but would enable community and household carers to handle sick people more safely while waiting for the latter's transit to a referral centre.

The preventative focus should emphasize the proactive establishment of community-led surveillance systems. These should pay particular attention to reporting mechanisms through which community members 'have the ability to directly account for the health, illness, or death of each individual in the population'.<sup>21</sup>

## **Community-led approaches**

Inevitably, the early stages of an outbreak reveal people's ability to learn from and adapt to the experience of coping with people falling sick and dying from Ebola. Communities' capacities, motivations and coping mechanisms must be recognized while identifying locally acceptable outbreak control strategies. These should be augmented with tailored support in the form of information, training and resources, and assistance in monitoring the response.

One project that aimed to build on communities' existing coping mechanisms and capacities was the facilitation and support of CHCs in Sierra Leone (see **Box 4**). This involved community-wide meetings and training of CHC members to enable them to identify and address the obstacles to people taking action on Ebola. A learning review in March 2015 revealed, however, that these action plans were often lacking the strategic focus necessary to effectively break local transmission routes, and that the CHCs needed more support and supervision to both identify obstacles and drive change.<sup>22</sup> Rather than implementing widespread plans to address behaviours such as hand washing, it would be better to support CHC volunteers in tackling specific barriers and underlying negative behaviours.

A number of other community-led approaches (partly drawing on the community-led total sanitation project<sup>23</sup>) were employed during the response. For example, *Action Contre La Faim* (ACF) and the Social Mobilisation Action Consortium (SMAC) used a sequence of triggers<sup>24</sup> to help communities collectively realise the significance of Ebola, and decide on joint actions to reduce risks (e.g. by installing hand-washing stations and building isolation rooms).<sup>25</sup>

### **Box 7: Community-Led Ebola Management and Eradication**

The ACF project Community-Led Ebola Management and Eradication (CLEME) was particularly effective.<sup>26</sup> It involved working with small community groups who could support early referrals. It used interactive methods to stimulate discussions and ‘trigger’ action. It was implemented once the Ebola service system was established, and it helped to match community action with available services, such as ambulances.

As the CLEME model builds on collective identity as a strong driver for community-level behaviour change, it was found to be more appropriate for rural contexts, where social ties tend to be stronger. In response to the diversity of the populations of larger settlements, such communities divided themselves into sub-groups to ensure inclusive community participation.

However, CLEME’s use in urban settings should not be ruled out. The latter might require appointing individuals as ‘focal points’ to work as two-way conduits for communication in specific zones or neighbourhoods; mapping infrastructure, risks and vulnerabilities etc.; and mobilizing a variety of formal and informal stakeholders to reach the wider community.

Source: ACF (2015): *Sierra Leone Case Study Community Led Ebola Management And Eradication (CLEME) Trigger Behavioral Change To Strengthen Community’s Resilience To Ebola Outbreaks*. <http://www.alnap.org/resource/20509>.

### **Box 8: Community-led Ebola Action**

While CLEME was initially piloted in a few rural communities only, SMAC’s Community-led Ebola Action programme covered most of Sierra Leone’s districts, targeting both affected and unaffected communities. SMAC worked with ‘mobilizers’, who conducted a series of activities (such as body mapping, burial role play and/or the sharing of Ebola survivor stories) with communities. This approach actively involved local leadership, such as Ebola Task Forces, in developing and monitoring community-level action. Community-owned action plans, which the communities themselves would monitor, were created.

However, the vast geographical coverage and the dispersed network of community mobilizers made effective supervision, technical support and the establishment of trusting relationships between communities and external mobilizers more challenging.

Source: D. Pedi. (2014). *Community-Led Ebola Action (CLEA) Field Guide for Community Mobilisers: Social Mobilisation Action Consortium (SMAC) Field Guide*. Restless Development. <http://restlessdevelopment.org/file/smac-clea-field-manual-pdf>.

Oxfam’s social mobilization learning review found some issues with the concept of triggering and the focus on communities that are most motivated to act, therefore de-prioritizing those that are not as enthused. In an acute outbreak this might result in significant shortfalls in both preparedness and the effectiveness of the latter’s response.<sup>27</sup>

## Triggering behaviour change in an epidemic

Fear and trust, stigma and hope are strong drivers in an Ebola outbreak. Research conducted in Sierra Leone in March 2015 found that fear constituted a major barrier to seeking treatment – both at community and household levels.<sup>28</sup> However, fear is multifaceted and dynamic. In the Ebola outbreak, it was the result of a lack of familiarity: with the virus itself, the treatment process, the referral system (and burial management).

On the other hand, fear can also drive people to take action more rapidly. For example, during the 2000–2001 haemorrhagic fever outbreak in Uganda, highly affected communities showed greater motivation to adopt preventative behaviour, while populations in areas with few or no cases were less responsive. However, using fear as a trigger for behaviour change is controversial and should be balanced with positive drivers, such as self-efficacy. Those seeking to facilitate change should also work with local traditions and beliefs, putting greater emphasis on social learning. Local cultures can rapidly shift not only in response to disease outbreaks, but also to public health information and continuous community engagement.

## 3.3 COMMUNICATING WITH AFFECTED COMMUNITIES

Health communication is not just about encouraging people to wash their hands or warning them about the dangers of eating bush meat. The oversimplification of complex socio-cultural narratives and practices related to Ebola often undermined people's sense of agency during the outbreak, fuelling fear and mistrust. Hence, health communication must be based upon a thorough understanding of local cultures, beliefs and perceptions – and their impacts on key preventative behaviours.

### Box 9: Addressing information gaps

To equip people with the knowledge needed to prevent or reduce the spread of disease, it is vital to understand and respond to their information needs:

- Explore 'what if Ebola happens' at household and community levels.
- Identify rumours and misinterpretations and discuss these openly.
- Increase the transparency of treatment and management systems, for example by producing step-by-step guides to referral and burial management, and/or showing videos to illustrate what to expect.
- Clarify the rights and entitlements of crisis-affected populations (e.g. in relation to access to services).
- Ensure that communities have 'liaisons': trusted people who will, for example, support families in calling ambulances.

Communication also requires understanding 'risk'. This includes risks related to the disease itself from a biomedical perspective; individuals' perceptions of risk to themselves and their families; and risks related to the use of services such as ambulances or care centres, or the consequences of seeking treatment, such as stigmatization. Communication can use this understanding to develop culturally appropriate information to address these risks, for example by illustrating what happens in a treatment centre.

The adoption of 'safe burial' practices that lower the risk of disease transmission often meant that family members would have to neglect socially meaningful funeral rites – within their belief systems, this would risk the deceased's passage into the next world. Health communication can seek to clearly explain why it is important to modify traditional burial practices that often involve the touching of dead bodies, and what happens to the deceased following their removal by a burial team. Different organizations developed short videos that clearly demonstrated the entire burial process and shared this among different communities.

Ongoing contextual and epidemiological analysis – alongside providing space for communities to continually ask questions – will help technical teams to understand who is particularly at risk and why. This can inform the design of specific behavioural objectives for defined sub-groups within diverse communities, which in turn leads to better communication to motivate people to adopt protective behaviours.

#### **Box 10: Get the content right**

Early, accurate and transparent information is critical in disease outbreaks to help people understand and manage risks, and inform them about available services. However, it is not just the provision of information; listening to communities is an essential aspect of communication.

Throughout the different stages of the Ebola response, the messages received by communities were often counterproductive. They focused on the dissemination of general information about Ebola, even though affected communities had specific and concrete informational needs (e.g. how to provide care for their loved ones, or what happens in a treatment centre).

In order to enable communities to protect themselves against the epidemic, communication should address information gaps and help to motivate the adoption of positive behaviours. This requires a sound understanding of the virus and transmission risks. For example, the extensive promotion of hand-washing may have led people to believe that they would be safe if they simply washed their hands.

As one member of staff from MSF said: 'The first messages spread to the communities in Gueckedou and Macenta were cholera messages. Chlorine and hygiene kits were distributed at the household level without sensitization about Ebola. In Freetown, the same posters used during the cholera outbreak in 2012 were used for Ebola, with the word "Ebola" simply replacing the word "cholera".'<sup>29</sup>

## Box 11: Effective health communication

Effective health communication:

- Promotes practical and feasible actions (e.g. how to transport a patient to a hospital without getting infected);
- Spreads evidence-based information (e.g. messages around the risk of sexual transmission of Ebola from survivors was not supported by scientific evidence and led to further stigmatization of survivors);<sup>30</sup>
- Is realistic and matched to available services (e.g. when messages began instructing people to call ambulances for sick people, actual ambulance capacity was only a fraction of what was required);
- Tailors information to communities' needs and priorities;
- Dispels rumours, addresses critical gaps in knowledge, and warns against risky behaviour and practices;
- Promotes locally appropriate technology (e.g. in Sierra Leone, hand-washing messages initially focused on chlorine, leading to rumours of chlorine being a cure for Ebola. To counter the subsequent overuse and occasional misuse, in April 2015, the use of soap and water was prioritized);
- Is positive, motivational, and instils hope (e.g. 'Ebola is real and you can survive it');
- Is consistent (e.g. early messages guided people with Ebola symptoms to seek care at a hospital or Treatment Centre. Later instructions said that any ill person should go to a Treatment Centre or Community Care Centre. In the latter stage, messages stated that patients with early signs of Ebola should go to a Treatment Centre).
- Is locally appropriate (e.g. in Liberia, most messages were in Liberian English, while people would have preferred to receive information in different local languages); and
- Listens to community perspectives and continuously tailors PHP activities to specific public health behavioural objectives.

Source: ACAPS. (2015a). *Ebola Outbreak, Sierra Leone: Communication: Challenges and good practices*. <http://reliefweb.int/report/sierra-leone/ebola-outbreak-sierra-leone-communication-challenges-and-good-practices>).

Several experiences from disease outbreaks demonstrated the importance of using a variety of communication tools and methods, ranging from face-to-face discussions to localized films and radio shows.

## Representation of local realities

During the 2000–2001 haemorrhagic fever outbreak in Uganda, the documentation of local environments helped to make the outbreak response system more transparent, which in turn encouraged referrals. This included the development of films involving local media and drama groups to address context-specific concerns, fears and information gaps (e.g. what is happening with the belongings of suspected and discharged cases).<sup>31</sup> In the recent Ebola outbreak, *Médecins sans Frontières* (MSF) developed an interactive guide that helped people to understand different steps in the treatment system.

## Radio programming

In Sierra Leone, radio was identified as a crucial medium to reach affected communities, as it is generally considered a trustworthy source of information. One popular media initiative launched during the recent Ebola outbreak was *Kick Ebola Nar Salone* ('Kick Ebola out of Sierra Leone')<sup>32</sup> by BBC Media Action, which aimed to provide information, tackle stigma and misinformation, and promote joint initiatives between technical pillars and sectors. Setting up 'listener groups'<sup>33</sup> alongside radio campaigns is an effective strategy to engage with communities.<sup>34</sup> Partnerships with local media groups should be fostered, not only for their value as communication platforms for information dissemination, but also to build their capacity to appropriately respond to disease outbreaks.

## Tell the Ebola story

In Liberia, storytelling and educational entertainment has been extensively used in past awareness campaigns to counter the stigma linked to HIV and AIDS. In the Ebola outbreak, the International Organization for Migration worked on a series of graphic stories called 'Spread the Message, Not the Virus'. These stimulated community dialogues, and the team were able to leverage this by listening attentively and answering questions related to both the story and Ebola in general.

## Acting upon rumours



One of many Ebola billboards in Freetown sharing prevention messages on how to stop the spread of Ebola, Sierra Leone, November 2014. Photo: Pablo Tosco/Oxfam

During the recent outbreak, various mechanisms were put in place to tackle rumours with instant information analysis and response. For example, in Liberia, Internews worked with a rumour-tracking system (Dey Say) using text messages to report rumours to hotlines.<sup>35</sup> Trends in rumours were analysed and responses disseminated through local radio



partners. Social media channels (Facebook and Twitter) were also used for this.

## Use of mobile phones

Mobile technology (including smartphone applications such as WhatsApp) can play an important role in providing information and updates. For example, in Sierra Leone, the Red Cross Society piloted an early warning system in 2013 that covered risks of natural hazards and disease. In addition, solar chargers were distributed to help people living in areas with poor infrastructure.<sup>36</sup>

# 4 SCALING UP ENGAGEMENT

Scaling up responses and reaching large numbers of people quickly is often challenging. Ensure that these responses are nuanced and context-specific requires an understanding of various disease transmission patterns in different areas. For instance, while some communities will be experiencing Ebola, others will not and may not feel at risk. Others may feel at risk but need support to prevent and prepare for cases. Responses will need to be tailored to their different needs; Oxfam's social mobilization model in Sierra Leone aimed to do this.

## 4.1 CONTEXT-SPECIFIC APPROACHES

Collecting, analysing and interpreting health data is necessary to define the geographical focus, scale and scope of a response. During the Ebola outbreak – in which cases spread rapidly and unpredictably across three countries – urban and cross-border areas were often identified as those with heightened risk and vulnerabilities.

### Box 12: Active case finding and contact tracing

'Contact tracing' involves following up all those who have been in contact with an individual who tests positive for an infectious disease. In an acute emergency, it may be necessary to also carry out home visits for an entire target population (rather than just an individual's contacts) in order to identify cases of a particular disease. This is usually known as 'active case finding'.

Source: Ferron, S., and Beesley, J. (2015b). *Active Case Finding for Ebola*. Oxfam internal document.

## Townships in Liberia

Based on daily analysis of epidemiological data, technical teams in Liberia quickly focused on actively finding cases in hotspot areas: densely populated townships with a high number of Ebola cases. This was particularly challenging due to the complexities of working in urban contexts, such as people entering and leaving the area; the diversity of the population, with its multiple layers of vulnerability; looser social ties; and low levels of trust in public services. The team therefore emphasized a solid volunteer supervision structure and mobile teams, which visited local communities daily to offer support with referral for people with Ebola symptoms. In one month, more than 350 volunteers were trained to use a simple flow chart explaining what to do when sick people were identified. Those General Community Health Workers were then divided into rapid response 'surge teams',<sup>37</sup> equipped with protective gear. The team held daily debriefings to inform the following day's work, and increased their budget for the teams' remuneration. In rural areas that did not experience any Ebola cases at the time of scale up, the team worked through existing formal and informal Ebola Task Forces in villages, mapping community stakeholders and supporting preparedness planning.

## Strategies in Sierra Leone

In Sierra Leone, the Oxfam team initially covered a large geographical area using one-size-fits-all approaches. Its 'Getting to zero and staying at zero' public health strategy in March 2015 incorporated lessons learned over the preceding months: positive alerts (i.e. when someone showed symptoms) at district level would trigger active case-finding in both rural and urban 'hotspot areas'<sup>38</sup> affected by localized outbreaks. This triggering system was embedded in rapid community-level response planning, along with WASH provisions and unconditional cash support in quarantine areas. It also involved working with the local health system, culturally appropriate health communication and community interaction approaches, as well as an increase in the incentive rates for volunteers involved in daily activities, and close monitoring of epidemiological data.

In 'inactive' areas – those which had previously experienced geographically limited micro-outbreaks – the team invested in contingency planning at section (sub-district) level, involving staff from local health offices as well as other stakeholders (e.g. traditional healers, section chiefs, community members, Mammy Queens, youth leaders, etc). Compared to hotspot areas, this required fewer staff but an initial focus to build up a solid contextual understanding, relationships and trust.

In 'silent' areas – those without any Ebola cases during the outbreak – the team concentrated on preparedness planning at chiefdom-level with key community leaders and governmental district health management teams. In Koinadugu district, this entailed collaboration with other agencies to map the resources provided by each stakeholder and helped to establish clear communication pathways for example to clarify who would be responsible for calling ambulances, conducting active case

finding and/or, providing water to quarantined households and/or communities. The team did not incentivise volunteers in inactive and silent areas, but invested more in the recruitment and capacity building of the supervisors overseeing community health committee members.<sup>39</sup>



An Oxfam Community Health Volunteer talks to a community about Ebola prevention in Clara Town, a township north of Monrovia, Liberia, November 2014. Photo: Pablo Tosco/Oxfam

## How to plan initiatives

Decisions about the size and coverage of community-led initiatives will depend on internal and external capacity, but greater emphasis needs to be given to the ability of the team to support and supervise inexperienced staff.

In both countries, Oxfam found it difficult to quickly deploy internationally and nationally experienced staff. Fear was a major barrier to recruiting international technical experts, while contract lengths and pay were often not competitive when deploying national staff.

The Ebola response also revealed the need to rethink national and international/regional preparedness and response capacity. For example, in both Liberia and Sierra Leone, Oxfam effectively used mobile response teams – which included engineers, PHP and finance staff – to provide surge support in new hotspot areas, or additional help to existing teams when they scaled up. Developing surge capacity in the future would require proactively engaging with the government ministries responsible for health, social welfare, children and water to plan for secondments to Oxfam. It would also benefit from strengthened collaboration with anthropological and community development departments in universities, as well as access to the recruitment pools of other organizations to facilitate internships or short contracts for specific technical areas. When planning for preparedness the role of longer term programme staff is vital as it will contribute to developing a solid

understanding of how communities are organized. This will help newly recruited response teams to better engage with the affected population in times of a crisis.

Learning from the Ebola response, Oxfam deployed dedicated public health capacity builders and roving team leaders in its response to the 2015 Nepal earthquake. These provided practical support and on-the-job training for newly recruited national staff, as well as formal capacity building and supervision plans for teams and individuals. Internal talent spotting among national staff alongside clear mentoring frameworks can further strengthen capacity.

#### **Box 13: Volunteer incentives – beyond public health promotion**

In Sierra Leone, Oxfam worked with almost 4,000 community-based volunteers spread over a large geographical area. Incentive payments were intended to motivate staff and cover communication and transportation costs. Initially, the team planned to set up mobile finance teams to pay volunteers and, where possible, manage payments through mobile phones. Due to external challenges,<sup>40</sup> as well as limited financial staff capacity in the scale-up phase and confusion about the role of PHP staff in the payment process,<sup>41</sup> this plan failed. Instead, PHP staff had to personally manage these payments.

In future, greater emphasis should be placed on timely recruiting support staff such as finance teams to facilitate the payments directly to outreach staff. In addition, the distinctive roles and responsibilities of technical and support staff must be clarified: PHP staff must ensure timely requests to Finance teams with documentation to justify payments, but they should not need to be present when salaries or incentives are being distributed.

## 4.2. MEASURING AND MONITORING ENGAGEMENT

Meaningful community engagement requires the identification of specific and clear objectives for action, drawing on social science theory and evidence, as well as real-time data and analysis. Indicators relating to these objectives can then be developed.

In the 2014–2015 Ebola outbreak, the priority actions for stopping transmission were for people to get tested and minimize contact with others when they were sick, and to ensure that people who died (whether confirmed from Ebola or not) were buried safely – so that contact with a potentially highly contagious corpse did not put mourners at risk. The objectives needed to ensure a focus on these outcomes.

#### **Box 14: Impact level indicators**

'Impact level indicators' are a useful way of assessing the influence that programme teams have over local and national coordination mechanisms.<sup>42</sup> While the following impact level indicators are inevitably affected by external variables, they can still help with making judgements on whether community engagement activities are resulting in more effective and accountable health service delivery:

- Time between symptom onset and hospitalization;
- Reports/rumours of unsafe burials; and
- Reports of sick people being treated at home.

Extraneous variables will influence these indicators. For example, while the time between symptom onset and hospitalization will be influenced by the efficacy of information and communication, it is also affected by the availability of transport and access to health services and the degree of trust in the health service providers. Safe burials will similarly be partly dependent on the availability and attitudes of the burial teams in their approach to communities, as well as community acceptance of national guidance on safe burials.

Programme teams should set up mechanisms for real-time data collection and analysis, e.g. using smartphones to report the number of people with symptoms in a community. Such mechanisms will allow teams to assess whether affected communities and households are able to prevent and respond to an outbreak, and adjust their programmes to fit. Involving local representatives and outreach workers in monitoring and evaluation is therefore important. The following outcome indicators will be helpful to track:

- The time between the onset of symptoms and isolation within the household or community;
- The time between the onset of symptoms and a call to the Ebola response hotline; and
- The percentage of people who can describe the two priority actions (early testing/treatment and safe burial) which are necessary to prevent the spread of Ebola.

Source: S. Ferron. (2016). *Community ownership and social mobilisation indicators*. Oxfam internal document.

# 5 COORDINATION

In both Sierra Leone and Liberia, the coordination of social mobilization activities was very challenging – duplication was a particular problem. This was mainly due to the lack of effective leadership, and the considerable number and variety of social mobilization actors. The activation of the UN humanitarian cluster system might have been able to provide additional leadership, but did not happen because the outbreak was initially classified as a health rather than a humanitarian crisis. As a consequence, community engagement actors faced difficulties establishing and maintaining consistent feedback loops<sup>43</sup> between the various pillars and affected communities, which is essential in making services more effective and relevant to affected communities.<sup>44</sup> A number of reviews have since suggested that a decentralized approach supporting district- and local-level coordination for developing and implementing control strategies would have been more effective and ensured an ongoing dialogue between communities and the response system.<sup>45</sup>

In Sierra Leone, meetings with Paramount Chiefs (district leaders) were held at the beginning of the outbreak, and community preparedness measures such as bylaws were imposed. However, over the course of the response, such local leadership structures were not consistently consulted or considered as an integral part of decision-making structures. Meaningful engagement and coordination requires a solid understanding of power dynamics, including formal and informal leadership structures. Communities could also be encouraged to play an active role in coordination, keeping track of the agencies visiting them and monitoring their activities.

Evidence-based programming and active support by programme managers was shown to help technical teams gain greater leverage when coordinating community engagement activities. Programme managers could assist by, for example, insisting that technical teams shared information, and by taking specific issues forward with representatives of governments and NGOs. For example, in Port Loko, the results of qualitative research were shared by the Oxfam programme manager at general coordination meetings. This resulted in alliances with other stakeholders to address communities' fear and confusion about the referral and treatment systems. Oxfam can also play an instrumental role in ongoing WASH coordination platforms, for example in promoting safe and appropriate<sup>46</sup> sanitation options to contain the epidemic spread: this has been vital in the context of crowded and urban slum areas where, very often many people are sharing a single latrine.

The urban community engagement strategy developed by some of the social mobilization actors (ACF, MSF, Concern and Oxfam) at a meeting in Freetown in March 2015 proposed reducing the duplication of coverage in the city's wards, recruiting local supervisors and engaging with community leadership structures and other key influencers.



## 6 ADVOCACY AND LOBBYING

Throughout the Ebola response, Oxfam lobbied donors and others to recognize the need for community engagement. In Sierra Leone, PHP teams worked closely with advocacy colleagues to develop a joint position on the importance of social mobilization,<sup>47</sup> as well as the 'Community Voices' publication that reflected the views of communities on the Ebola response.<sup>48</sup>

Oxfam successfully used the data generated from a pilot of active case-finding in Freetown to lobby governments, donors and other NGOs for improvements in the telephone feedback hotline and response system.<sup>49</sup>

However, advocacy and lobbying for community engagement (and thereby a people-centred response) were not without challenges, partly due to a lack of research on how effectively Ebola referral and social mobilization management worked, and a lack of humanitarian leadership. Indeed, the Ebola response failed to achieve the humanitarian objective of a people-centred and rights-based approach. As one Overseas Development Institute report put it:

*'the securitisation of Ebola...pitted the human rights of individuals against the security of a public or nation and introduced a hierarchy whereby the security of some individuals would be protected at the expense of the rights and freedoms of others.'*<sup>50</sup>



Mohamed Kamara lost his wife and child to Ebola and, at the time this photo was taken, was in quarantine for the third time. A total of 14 members of his family have died. Kontoloh, Freetown, Sierra Leone, January 2015. Photo: Abbie Trayler-Smith/Oxfam.

With hindsight, more could have been done to proactively ensure the application of more accountable programme mechanisms adhering to core humanitarian standards, and thus consistent feedback loops between communities, Oxfam and wider Ebola response structures.

#### **Box 15: Quarantine in Sierra Leone – putting people first**

In Sierra Leone, the reduction of Ebola cases was partly attributed to the government's enforced quarantine strategies. In order to ensure that the needs of quarantined people were met, Oxfam provided WASH provisions as well as, in many cases, unconditional cash transfers to affected households. Drawing on their experience, technical and advocacy teams worked together on a position paper criticizing the quarantine system, emphasizing the violation of basic rights due to delayed or inadequate provision of water, food and other basic items.<sup>51</sup> However, internal sign-off processes made it challenging to lobby on this issue in a timely manner.

With hindsight, it might have been more useful to strengthen the feedback loop between quarantined communities and households, service providers and other actors, such as government authorities, NGOs, donors and the military. For example, MSF's social mobilization teams in Freetown conducted rapid household surveys and discussions in quarantined areas. They gathered systematic evidence about the quality of humanitarian assistance, which they regularly shared with the District Ebola Response Coordination committee and the Freetown District Ebola Response Coordination team's quarantine task force. The results showed that there was a need to strengthen coordination, as humanitarian assistance was often delayed and a number of actors were providing very similar services. It also put emphasis on improved contact tracing. Quarantine was considered controversial because of a lack of evidence of its effectiveness, which in turn undermined people's trust in the treatment system. It might have been better instead to actively engage with people, encourage timely household-level isolation and self-referral, and pairing any contact tracers brought into the community with insiders.

Source: Oxfam Rights in Crisis. (2015). *RIC Ebola – Talking points: Social Mobilisation*. Oxfam internal document.

Close collaboration between public health and advocacy teams can inform the priority areas of engagement, and allow better monitoring of the effectiveness of the response system as a whole. For Ebola, this could have included ensuring patient confidentiality, restoring communities' and households' trust in medical and response services, and reducing delays in the referral systems.

# BIBLIOGRAPHY

(All links last accessed July 2016, except where specified.)

Abramowitz, S.A., McLean, K., McKune, S.L., Bardosh, K.L., Fallah, M., Monger, J., Tehoungue, K., and Omidian, P.A. (2015). *Community-centred Responses to Ebola in Urban Liberia: The View from Below*. Ebola Response Anthropology Platform. <http://www.ebola-anthropology.net/?s=The+view+from+below>.

ACAPS (Assessment Capacities Project). (2015a). *Ebola Outbreak, Sierra Leone: Communication: Challenges and good practices*. <http://reliefweb.int/report/sierra-leone/ebola-outbreak-sierra-leone-communication-challenges-and-good-practices>.

ACAPS. (2015b). *Ebola Outbreak, Liberia: Communication: Challenges and good practices*. <http://reliefweb.int/report/liberia/ebola-outbreak-liberia-communication-challenges-and-good-practices>.

ACF (Action Contre La Faim). (2015). *Sierra Leone Case Study Community Led Ebola Management And Eradication (CLEME) Trigger Behavioral Change To Strengthen Community's Resilience To Ebola Outbreaks*. <http://www.alnap.org/resource/20509>.

Adams, J., A. Lloyd, and C. Miller. (2015). *The Oxfam Ebola Response in Liberia and Sierra Leone*. Oxfam. <http://policy-practice.oxfam.org.uk/publications/the-oxfam-ebola-response-in-liberia-and-sierra-leone-an-evaluation-report-for-t-560602>.

AI.COMM. (2010). *Bringing the Community Together to Plan for Disease Outbreaks and Other Emergencies: A Step-by-Step Guide for Community Leaders*. <https://www.medbox.org/preparedness-prevention/bringing-the-community-together-to-plan-for-disease-outbreaks-and-other-emergencies-a-step-by-step-guide-for-community-leaders/preview?q=>.

Cairns, E. (2015). *Ebola is Still Here: Voices from Liberia and Sierra Leone on response and recovery*. Oxfam. <http://policy-practice.oxfam.org.uk/publications/ebola-is-still-here-voices-from-liberia-and-sierra-leone-on-response-and-recove-345644>.

Campbell, A. (2015, April 23). *Empowering local media can make the difference: 5 lessons from the Ebola crisis*. Devex. <https://www.devex.com/news/empowering-local-media-can-make-the-difference-5-lessons-from-the-ebola-crisis-85948>.

Capps, J.M., and Njiru, H. (2015). *Open Defecation Status, Community-Led Total Sanitation and Ebola Virus Disease (EVD) in Voinjama and Kolahun Health Districts, Lofa County, Liberia (2014)*. Global Communities. [http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report\\_081015.pdf](http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report_081015.pdf).

Carter, S. (2015). *Ebola barriers and enablers to treatment seeking behaviour and causes of high risk practices; a qualitative case study from Sierra Leone*. Oxfam internal paper.

CORDS (Connecting Organizations for Regional Disease Surveillance). (2014). *Ebola outbreak in West Africa*.  
<http://www.cordsnetwork.org/2014/08/03/ebola-out-break-is-west-africa>.

DuBois, M. and Wake, C. (2015). *The Ebola response in West Africa: exposing the politics and culture of international aid*. HPG Working Paper. <https://www.odi.org/publications/9956-ebola-response-west-africa-exposing-politics-culture-international-aid>.

ERAP (Ebola Response Anthropology Platform). (2014). *Ebola and Older People in Sierra Leone, Liberia and Guinea*. <http://www.ebola-anthropology.net/wp-content/uploads/2014/12/Older-people-and-Ebola-Ebola-Response-Anthropology-Platform.pdf>.

ERAP. (2015). *Africa APPG inquiry: Ebola and community led health systems. Response to call for evidence by the Ebola Response Anthropology Platform*. <http://www.ebola-anthropology.net/wp-content/uploads/2015/07/Ebola-and-community-led-health-systems-ERAP-submission-to-Africa-APPG-inquiry.pdf>.

Farrington, M. and T'Kint, S. (2016). *Analysis of socio-cultural perspectives that have influenced Oxfam's responses to disease outbreaks from 2006 to 2015*. Oxfam. internal draft report.

Ferron, S. (2015). *Learning Review Report Sierra Leone and Liberia March 7<sup>th</sup> to March 29<sup>th</sup> 2015*. Oxfam internal report.

Ferron, S. (2016). *Community ownership and social mobilization indicators*. Oxfam internal document.

Ferron, S., and Beesley, J. (2015a). *Community Care Centres for Ebola*. Oxfam internal document.

Ferron, S., and Beesley, J. (2015b). *Active Case Finding for Ebola*. Oxfam internal document.

Johns Hopkins Center for Communication Programs. (2015). *Bridges of Hope Liberia Edition: Facilitator's Guide*.  
[http://www.thehealthcompass.org/sites/default/files/project\\_examples/Bridges%20of%20Hope%20Facilitator%20Guide\\_FINAL.pdf](http://www.thehealthcompass.org/sites/default/files/project_examples/Bridges%20of%20Hope%20Facilitator%20Guide_FINAL.pdf).

Johnston, N. (2009). *Social mobilization: communicating with affected communities*. Presentation from short course on Infectious Diseases in Humanitarian Emergencies April 3, 2009.  
[http://www.who.int/diseasecontrol\\_emergencies/publications/idhe\\_2009\\_1\\_ondon\\_soc\\_mob.pdf](http://www.who.int/diseasecontrol_emergencies/publications/idhe_2009_1_ondon_soc_mob.pdf).

Kamal, K. and Chambers, R. (2008): *Handbook on Community-Led total sanitation. March 2008*. Institute of Development Studies with the support of Plan UK, ISBN 978-0-9550479-5-4.  
<http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation>

tion.org/files/cltshandbook.pdf

Lamunu, M., Lutwama, J.J., Kamugisha, J., Opio, A., Namboozee, J., Ndayimirije, N., and Okware, S. (2002). *Containing a haemorrhagic fever epidemic: the Ebola experience in Uganda (October 2000 – January 2001)*. Paper presented at the 10<sup>th</sup> International Congress on Infectious Disease, Singapore. <http://www.who.int/csr/disease/ebola/lamunu.pdf>.

Meredith, C. (2015). *A bottom-up approach in the Ebola response*. Humanitarian Practice Network. <http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response>.

Minor, M., and Kanneh, S. (2015). *Gender in the Ebola Response*. Oxfam. Internal draft report.

Munyinyi, W.W. (2014). *Quarantine in Sierra Leone: Putting people first in the Ebola crisis*. Oxfam. <http://policy-practice.oxfam.org.uk/publications/quarantines-in-sierra-leone-putting-people-first-in-the-ebola-crisis-336992>.

NERC (National Ebola Response Centre). (2015). *Lessons from the response to the Ebola Virus Disease in Sierra Leone May 2014–November 2015 Summary Report*. <http://nerc.sl/sites/default/files/docs/EVD%20Lessons%20Learned%20Summary%20A5%20FINAL.pdf>.

Omidian, P., Tehoungue, K., and Monger, J. (2014). *Rapid assessment for Montserrado County Study: Sept 2014*. <http://mhps.net/resource/rapid-assessment-for-montserrado-county-study-sept-2014>.

Oosterhoff, P. (2015). *Ebola Crisis Appeal – Response Review*. DEC. <http://www.ebola-anthropology.net/evidence/ebola-crisis-appeal-response-review>.

Oosterhoff, P., Mokuwa, E.Y., and Wilkinson, A. (2015). *Community-Based Ebola Care Centres: A formative evaluation*. ERAP. [http://www.ebola-anthropology.net/case\\_studies/community-based-ebola-care-centres-a-formative-evaluation/](http://www.ebola-anthropology.net/case_studies/community-based-ebola-care-centres-a-formative-evaluation/).

Oxfam Sierra Leone, Public Health Promotion Team. (2015a). *Active Case Finding Pilot, Ebola Response, Sierra Leone, January 2014*. Internal document.

Oxfam Sierra Leone, Public Health Promotion Team. (2015b). *Public Health Promotion Strategy, Ebola Response, Sierra Leone, April 2014*. Internal document.

Pedi, D. (2014). *Community-Led Ebola Action (CLEA) Field Guide for Community Mobilizers: Social Mobilization Action Consortium (SMAC) Field Guide*. Restless Development. <http://restlessdevelopment.org/file/smac-clea-field-manual-pdf>.

Thormar, S. (2013). *Evaluation of Ebola Response – Uganda*. Evaluation on behalf of Ugandan Red Cross. <https://www.medbox.org/assessment->

studies/evaluation-of-ebola-response-uganda/toolboxes/preview?q=.

WHO (World Health Organization). (2012). *Communication for Behavioural Impact (COMBI): A toolkit for behavioural and social communication in outbreak response*.

[http://www.who.int/ihr/publications/combi\\_toolkit\\_outbreaks/en](http://www.who.int/ihr/publications/combi_toolkit_outbreaks/en).

## NOTES

(All links last accessed in July 2016 except where specified)

1 M. DuBois and C. Wake. (2015). *The Ebola response in West Africa: exposing the politics and culture of international aid*. HPG Working Paper.

<https://www.odi.org/publications/9956-ebola-response-west-africa-exposing-politics-culture-international-aid>. p 10.

2 Ibid.

3 ACF. (2015). *Sierra Leone Case Study Community Led Ebola Management And Eradication (CLEME) Trigger Behavioral Change To Strengthen Community's Resilience To Ebola Outbreaks*. <http://www.alnap.org/resource/20509>. p 10.

4 S. Abramowitz et al. (2015). *Community-centred Responses to Ebola in Urban Liberia: The View from Below*. Ebola Response Anthropology Platform. <http://www.ebola-anthropology.net/?s=The+view+from+below>. p 4.

5 Ibid.

6 ERAP. (2014). *Ebola and Older People in Sierra Leone, Liberia and Guinea*. Institute of Development Studies. <http://www.ebola-anthropology.net/wp-content/uploads/2014/12/Older-people-and-Ebola-Ebola-Response-Anthropology-Platform.pdf>. p.1.

7 S. Abramowitz et al. (2015). p 3.

8 A.A. Iacucci. (2015). *Combating Rumors About Ebola: SMS Done Right*. Internews via Medium. <https://medium.com/local-voices-global-change/combating-rumors-about-ebola-sms-done-right-da1da1b222e8#uh1dz95qx>

9 M. Dubois and C. Wake (2015). pp 33–34. Also P. Oosterhoff. (2015). *Ebola Crisis Appeal – Response Review*. DEC. <http://www.ebola-anthropology.net/evidence/ebola-crisis-appeal-response-review>. p.18.

10 S. Carter. (2015a). *Ebola barriers and enablers to treatment seeking behaviour and causes of high risk practices; a qualitative case study from Sierra Leone*. Oxfam internal paper. p 9–10.

M. Minor, and S. Kanneh. (2015). *Gender in the Ebola Response*. Oxfam internal draft report. p 6.

A. K. Mbonye et al. (2014). Ebola Viral Hemorrhagic Disease Outbreak in West Africa- Lessons from Uganda. *African Health Sciences* 14(3):495–501. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4209631/pdf/AFHS1403-0495.pdf>. p 499.

11 S. Abramowitz. (2015). p 9.

12 S. Ferron. (2015). *Learning Review Report Sierra Leone and Liberia March 7th to March 29th 2015*. Oxfam internal report. p 15.

13 J.M. Capps, and H. Njiru. (2015). *Open Defecation Status, Community-Led Total Sanitation and Ebola Virus Disease (EVD) in Voinjama and Kolahun Health Districts, Lofa County, Liberia (2014)*. Global Communities. [http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report\\_081015.pdf](http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report_081015.pdf). p 31.

14 M. Minor, and S. Kanneh. (2015). p 6.



- 15 S. Abramowitz et al. (2015). p 9.
- 16 P. Oosterhoff et al. (2015). *Community-Based Ebola Care Centres: A formative evaluation*. ERAP. [http://www.ebola-anthropology.net/case\\_studies/community-based-ebola-care-centres-a-formative-evaluation/](http://www.ebola-anthropology.net/case_studies/community-based-ebola-care-centres-a-formative-evaluation/). pp 5, 8.
- 17 ACAPS (2015a). *Ebola Outbreak, Sierra Leone: Communication: Challenges and good practices*. <http://reliefweb.int/report/sierra-leone/ebola-outbreak-sierra-leone-communication-challenges-and-good-practices>. p 9.
- 18 S. Ferron, and J. Beesley. (2015a). *Community Care Centres for Ebola*. Oxfam internal document. p 4.
- 19 S. Abramowitz et al. (2015). pp 2–3.
- 20 Sierra Leone is subdivided into three provinces, 14 districts and 149 chiefdoms/wards.
- 21 S. Abramowitz et al. (2015). pp 2–3.
- 22 S. Ferron. (2015). p 5–6.
- 23 K. Kamal, and R. Chambers. (2008). *Handbook on Community-Led total sanitation. March 2008*. Institute of Development Studies with the support of Plan UK. <http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/cltshandbook.pdf>.
- 24 The triggering is based on developing a joint understanding of the health problem and situation in the specific context resulting ideally in an ignition moment which motivates people for action. Ibid, p 11.
- 25 D. Pedi. (2014). *Community-Led Ebola Action (CLEA) Field Guide for Community Mobilisers: Social Mobilisation Action Consortium (SMAC) Field Guide*. Restless Development. <http://restlessdevelopment.org/file/smac-clea-field-manual-pdf>.
- 26 Later integrated with the Community Event-based Surveillance System. IRC (International Rescue Committee). (2015). *Evaluation of the functionality and effectiveness of community event based surveillance (CEBS) in Sierra Leone, February to June 2015*. <http://reliefweb.int/sites/reliefweb.int/files/resources/ERC%20CEBS%20Evaluation%20Report.pdf>
- 27 S. Ferron. (2015). p 13–14.
- 28 S. Carter. (2015). pp 4–9.
- 29 Interview with member of MSF staff, October 2015.
- 30 ACAPS (2015a). p 13
- 31 M. Lamunu et al. (2003). *Containing a haemorrhagic fever epidemic: the Ebola experience in Uganda (October 2000—January 2001)*. Paper presented at the 10th International Congress on Infectious Disease, Singapore. <http://www.who.int/csr/disease/ebola/lamunu.pdf>. p 35.
- 32 ACAPS (2015a). p 8.
- 33 In Liberia, listening to the radio is often a group activity. Setting up listener groups encourages the discussion of the content as well as a feedback loop in terms of the community dialling to ask questions. See: ACAPS. (2015b). *Ebola Outbreak, Liberia: Communication: Challenges and good practices*. <http://reliefweb.int/report/liberia/ebola-outbreak-liberia-communication-challenges-and-good-practices>. p 6.
- 34 Ibid, p 6.
- 35 DeySay uses an SMS short code provided by UNICEF free of charge to hundreds of health workers, NGOs and volunteers throughout Liberia. When anyone connected to the system becomes aware of a rumour, they text it via the short code to a central coordination hub in Monrovia. The information is then collected, analysed for trends, and disseminated to local media partners in the field with details about the rumour so they can stop its spread. For more information, see A.A. Iacucci. (2015).
- 36 ACAPS. (2015a). p 8.
- 37 Surge teams are groups sent into a crisis situation when a quick response is needed at

scale. In the Ebola response, the effective supervision and monitoring of community health volunteers and activities required a trebling of technical staff.

- 38 In Sierra Leone, hotspot areas were internally defined as those with a larger concentration of (suspected and confirmed) cases, which narrowed over the course of the epidemic from entire districts (e.g. Port Loko) and cities (e.g. Freetown) to specific neighbourhoods and/or villages.
- 39 This was only possible and acceptable to communities because, at this stage of the epidemic, there had been a shift in governmental hazard payment policy (decreasing financial volunteer incentives) and Ebola treatment services were closer and of better quality.
- 40 For example, mobile phone companies' capacity to deal with volunteer payments from various organizations, and mobile phone signal coverage.
- 41 PHP staff were requested to be present when incentive payments were made, which meant that one or two PHP staff were often dedicating entire working weeks to processing payments.
- 42 In Sierra Leone during the Ebola Response these included: district- and/or national-level Ebola Response Centre meetings with local authorities; local and international NGOs; pillar meetings to coordinate social mobilisation, case and/or burial management activities; technical meetings, such as WASH sector meetings; community meetings with key stakeholders; and coordination with local Ebola Task Force members.
- 43 Such feedback loops involve communities sharing their perceptions, fears and recommendations in view of services provided as part of the Ebola response with those delivering these services, and generate solutions to address these issues in a timely manner.
- 44 Unlike in Liberia, the national coordination for the Ebola outbreak response in Sierra Leone was entirely managed through a system of pillars covering surveillance, case management, safe burials, social mobilisation, child protection and psychosocial, food security, logistics, communication and coordination. For more information, see NERC (National Ebola Response Centre). (n.d.). *Pillar/Clusters*. <http://nerc.sl/?q=pillarclusters>.
- 45 M. DuBois and C. Wake. (2015). pp 31–32.
- Also: NERC. (2015): *Lessons from the response to the Ebola Virus Disease in Sierra Leone, May 2014–November 2015*. Summary Report. <http://nerc.sl/sites/default/files/docs/EVD%20Lessons%20Learned%20Summary%20A5%20FINAL.pdf>. pp 15-17.
- 46 In terms of the infection risk
- 47 Oxfam Rights in Crisis. (2015). *RIC Ebola – Talking points: Social Mobilisation*. Oxfam internal document.
- 48 E. Cairns. (2015). *Ebola is Still Here: Voices from Liberia and Sierra Leone on response and recovery*. Oxfam. <http://policy-practice.oxfam.org.uk/publications/ebola-is-still-here-voices-from-liberia-and-sierra-leone-on-response-and-recove-345644>.
- 49 Oxfam Sierra Leone Public Health Promotion Team. (2015a). *Active Case Finding Pilot, Ebola Response, Sierra Leone, January 2014*. Internal document.
- 50 M. DuBois and C. Wake. (2015). p VI.
- 51 Oxfam Rights in Crisis. (2015).

© Oxfam International November 2016

This paper was written by Eva Niederberger, Suzanne Ferron and Marion O'Reilly. Oxfam acknowledges the assistance of the programme staff who reviewed this guide. It is part of a series of papers written to inform public debate on development and humanitarian policy issues.

For further information on the issues raised in this paper please e-mail [advocacy@oxfaminternational.org](mailto:advocacy@oxfaminternational.org)

This publication is copyright but the text may be used free of charge for the purposes of advocacy, campaigning, education, and research, provided that the source is acknowledged in full. The copyright holder requests that all such use be registered with them for impact assessment purposes. For copying in any other circumstances, or for re-use in other publications, or for translation or adaptation, permission must be secured and a fee may be charged. E-mail [policyandpractice@oxfam.org.uk](mailto:policyandpractice@oxfam.org.uk).

The information in this publication is correct at the time of going to press.

Published by Oxfam GB for Oxfam International under ISBN 978-0-85598-824-1 in November 2016.

Oxfam GB, Oxfam House, John Smith Drive, Cowley, Oxford, OX4 2JY, UK.

## Oxfam

Oxfam is an international confederation of 20 organizations networked together in more than 90 countries, as part of a global movement for change, to build a future free from the injustice of poverty. Please write to any of the agencies for further information, or visit [www.oxfam.org](http://www.oxfam.org).

Oxfam America  
([www.oxfamamerica.org](http://www.oxfamamerica.org))

Oxfam Australia ([www.oxfam.org.au](http://www.oxfam.org.au))

Oxfam-in-Belgium ([www.oxfamsol.be](http://www.oxfamsol.be))

Oxfam Canada ([www.oxfam.ca](http://www.oxfam.ca))

Oxfam France ([www.oxfamfrance.org](http://www.oxfamfrance.org))

Oxfam Germany ([www.oxfam.de](http://www.oxfam.de))

Oxfam GB ([www.oxfam.org.uk](http://www.oxfam.org.uk))

Oxfam Hong Kong  
([www.oxfam.org.hk](http://www.oxfam.org.hk))

Oxfam IBIS (Denmark)  
(<http://oxfamibis.dk/>)

Oxfam India ([www.oxfamindia.org](http://www.oxfamindia.org))

Oxfam Intermón (Spain)  
([www.intermonoxfam.org](http://www.intermonoxfam.org))

Oxfam Ireland ([www.oxfamireland.org](http://www.oxfamireland.org))

Oxfam Italy ([www.oxfamitalia.org](http://www.oxfamitalia.org))

Oxfam Japan ([www.oxfam.jp](http://www.oxfam.jp))

Oxfam Mexico  
([www.oxfammexico.org](http://www.oxfammexico.org))

Oxfam New Zealand  
([www.oxfam.org.nz](http://www.oxfam.org.nz))

Oxfam Novib (Netherlands)  
([www.oxfamnovib.nl](http://www.oxfamnovib.nl))

Oxfam Québec ([www.oxfam.qc.ca](http://www.oxfam.qc.ca))

Oxfam South Africa  
(<http://www.oxfam.org.za/>)

Observer:

Oxfam Brasil ([www.oxfam.org.br](http://www.oxfam.org.br))

Please write to any of the agencies for further information, or visit [www.oxfam.org](http://www.oxfam.org).

