LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

CATALYSING LOCAL LEADERSHIP TO SUSTAINABLY RESPOND TO SHOCKS

Policy actions from Ebola Gbalo research

Key Messages

Successfully tackling future humanitarian crises, and building future resilience, requires a transformation of international humanitarian and emergency response systems. Evidence suggests that these must be led, or shaped, through inclusive, equitable collaboration with local actors (both frontline responders and lay people; formal and informal leaders).

Background

Ebola was a newly detected disease for West Africa and exposed critical shortcomings in emergency responses across the region. Many lessons were learned during the world's largest outbreak as new response models emerged as the pandemic progressed.

The MRC-funded ***Ebola Gbalo*** research project (2016-18) on responses to the 2014-16 Ebola outbreak in Sierra Leone (MR/N015754/1), gathered new knowledge challenging global humanitarian response approaches and identified new opportunities to intervene. Our findings—published in leading peer-review journals—identify ways of effectively engaging with communities to improve outbreak response[1].

The Ebola Outbreak Response Plan for West Africa called for governments to: "*Work and share experiences with other countries that have previously managed Ebola outbreaks, in the spirit of South-South cooperation.*"[2] In this spirit, we share our key findings and highlight their implications for policy and practice actions.

Why effective engagement with frontline responders & affected communities is important

Poor community engagement undermines effective outbreak response, as we and others have documented in the 2014-16 Sierra Leone /West Africa[3] and 2018-20 DR Congo Ebola outbreaks[4] as well as across the world in Covid19 outbreaks[5]. Poor community engagement can lead to a lack of knowledge and ill-informed actions by responders resulting in local distrust in the medical and public health systems, failure to comply with contact tracing and quarantine rules, and the hiding of cases, all of which make transmission difficult to control and prolong outbreaks[6].

Our work shows strong evidence that building local trust and learning from frontline responders (both formal and informal) is key to establishing locally led decision making and effective actions during emergencies, in order to positively transform emergency responses in both the short- and long-term[7].

Building long-term resilience to shocks also requires establishing and sustaining trusted community engagement both for ongoing surveillance of risk and rapid response to crises. It also requires long term investment from national and international governments – in the long term it is cheaper to invest in adaptation, vulnerability/risk reduction and resilience measures than in disaster/emergency response[8].

Why is it so difficult to effectively engage responders and communities?

The political landscape of humanitarian aid and national security interests (which are increasingly closely linked) are dominated by

neo-colonial power structures in which governments, donors and international agencies are unwilling to concede decision-making power to people who are embedded in communities and have local knowledge[9]. This reluctance is often driven by distrust in relation to use of donated funds (related to financial accountability expectations) and fear of losing control of measures and narrative, and thus a clear linear claim to achievement (which may also be related to accountability expectations). As a result, emergency humanitarian response tends to be characterised by top-down command and control approaches which have little space for decentralizing decision-making to "non-experts" despite growing commitment to "engagement" in global response guidelines[10].

Establishing an approach that is more inclusive and acceptable to all key actors requires time, which at the moment of disaster is often scarce. Short cycles for funding and political elections and rigid accountability mechanisms often limit willingness to invest long-term in adaptation and resilience strengthening especially at subnational level[11].

There is also often a lack of local capacity to respond, unclear lines of local authority and crisis settings are often fast-moving and chaotic. Nevertheless, as was clear in the West Africa and DR Congo outbreaks, people will always fall back on the resources they have to save their own families and there are indications that significant local capacities and tacit knowledge can be built upon[12].

What works in an outbreak? Findings from Sierra Leone

ACTORS AND RELATIONSHIPS

Rapidly identify local leaders and trusted interlocuters with authority

Findings Local leaders (formal and informal) and individuals with authority are key to establishing trust and therefore compliance from community members which will curtail infection spread. Where trusted interlocuters were involved in developing and implementing mutually acceptable response actions, community members were more likely to comply with outbreak response actions and work with health systems officials.

Trusted interlocuters varied from place to place and included: chiefs who developed and implemented local bylaws which were later implemented nationally; and community-embedded medical staff who encouraged and supported communities to test, trace and respect quarantine, but often lacked resources and support.

Future Action Rapidly engage District health managers, local council/local government leaders and other local leaders (chiefs, community-based organisation leaders (informal and formal), religious leaders, teachers) to add legitimacy to the response and identify the locally trusted interlocuters. The actors need to be involved in co-design and communication of the responses from the early stages.

Learn from frontline responders

Findings Frontline health workers who treated early cases recognised within the first few months that Ebola symptoms in Sierra Leone did not include the bleeding usually associated with the disease. Bo district, which was affected early on, changed its guidance to health workers to reflect this knowledge and we have documented how this saved lives as a result. However, it was not until nine months into the epidemic that official guidance was updated to reflect this, because frontline workers and district managers were not listened to early enough.

Similarly, early messages on eating of monkey meat as a key source of infection were considered irrelevant by community members because people in their affected districts did not eat monkey meat, so other messages originating from community actors were also disregarded.

Future Action District, national and international responders should involve and listen to frontline healthcare workers at the earliest stages when developing messages on symptoms, infection spread and control, development of standard operating procedures etc.

GOVERNANCE

Establish inclusive, flexible decision-making structures at sub-national (District) level

Findings Involvement of Paramount Chiefs and other trusted interlocuters in district and sub-district decision making over issues such as location of treatment facilities, messaging, quarantine rules and support, contact-tracing procedures, dignified handling and burial of the dead, homecare etc. proved critical in establishing and maintaining trust as the outbreak spread. Some areas where these actors were involved in the governance of the response fared better in containing the disease.

District Ebola Response Committees (DERCs) were established in Sierra Leone by the formal national/international response who appointed leaders centrally, without grassroots involvement. They were successful to a point in bringing together a wide range of stakeholders, but sometimes lacked trust and where locally established response structures had already been developed, these were ignored. Establishing these parallel structures created tensions and threatened to undermine what had already been achieved by local responders.

Future Action Establishment of response-decision making structures should not use one-size-fits-all templates but should build on existing structures to coordinate and support strong local initiatives rather than displace them. Local accountability (for decisions taken and for use of foreign aid received) should be strengthened and embedded in local structures.

Decision making structures and processes should be flexible enough to allow actors to negotiate, adapt and change the response actions

as necessary as new frontline evidence emerges from frontline responders and affected communities.

SOCIAL NORMS

Engage with social norms to enable mutual agreement of acceptable actions

Findings Understanding, respecting and acting on complex socio-cultural norms, such as burial procedures and secret societies in Sierra Leone, is necessary to avoid undermining effective outbreak response, especially where response requires curtailment of individual freedoms or cultural practices. In Sierra Leone the changing of burial procedures to reflect "safe and dignified burial" and acceptance of the establishment of locally staffed burial teams were key to promoting compliance for the safe handling of infected dead bodies. Local chiefdom taskforces also played a key role in enforcing lockdowns and restricting movement.

Future Action through trusted interlocuters and social science researchers (local, national and international) who should be integrated into the response, identify, monitor *then act on* social norms of relevance to outbreak response practices. Information should inform communications to address rumours and myths, mis-information spread through social networks including social media etc. and collaboration with key trusted interlocuters, including secret society members, to dispel such myths and mis-information. Enable flexible decision making in order to develop mutually acceptable response actions, which may involve negotiated compromises (e.g. on care protocols, burial procedures, siting and functioning of facilities).

RESOURCES

Rapidly decentralise disbursement & allocation of resources to frontline responders

Findings frontline health workers and community responders rapidly established effective operating procedures, but were hampered by lack of equipment and resources. In some places there were insufficient supplies (gloves, buckets, chlorine), poor testing and transport options for patients. In one tragic incident (in Kalia) very early in the epidemic 33 people died in appalling conditions because no treatment or care facilities were available. Bo district mobilised food packages for quarantined communities, but local resources were insufficient and people went hungry. Locally improvised PPE, transport of the sick by motorcycle or stretcher from remote areas were important and later the building of locally accessible care centres and provision of mobile laboratories for rapid testing/immediate results proved transformational.

Future Action Rapidly deploy (through district health systems and/or district councils/local government structures) resources to frontline affected districts, facilities and communities to support locally appropriate and acceptable solutions including: local transport options (including hand carried stretchers, motorbike taxis etc.); provision of PPE, gloves, buckets and chlorine (with proper instructions for use); equipping of locally accessible isolation wards/local treatment centres and food; provision of mobile laboratories; food and other support for quarantined households and communities.

LEGACY

Contributions to building resilience into the future

Findings Much of the resources and equipment that had made it to local level during the outbreak were requisitioned to Freetown (e.g. ambulances), or was removed by international responders (e.g. field hospitals and equipment) once the outbreak was over. In some places, though, the local treatment centres have been repurposed as regular health facilities and local task force members and surveillance teams with access to computers and disease surveillance software, were reinstated for work during Covid-19 and other outbreaks.

Respondents contrasted the years of training and investment given by donors to strengthening the military in Sierra Leone, with the failure to invest even a fraction of these resources into strengthening the health system. This meant it was the military, not the health sector, that had capacity to coordinate the Ebola response, but this choice was controversial and certainly in some areas significantly undermined trust in the response. Military deployment to tackle health-related crises is not a sustainable solution.

Future Action To build resilient capacities to respond to future outbreaks, or other health-related crises, structures and equipment (including ambulances and mobile labs) should be used after an outbreak to increase the capacity of the local health systems as far as possible, and donors should significantly increase their long-term commitments to strengthening these local systems, including retaining trained staff.

How can responses be made more effective in future?

Placing inclusive, equitable governance at the centre of responses would enable trusted interlocuters and frontline responders to connect social institutions with health systems institutions and shape mutually designed and acceptable local responses. External agencies should connect with (or establish) and support these rather than create new structures.

These findings informed the development of a guidance document for people and organisations involved in crisis response: **Rethinking Humanitarian Approaches: Practical Guidance on Strengthening Community Engagement in Crisis Response**. Electronic copies of the Guidance document, this Policy Brief and published articles from the research are available from: https://www.lshtm.ac.uk/rethinkinghumanitarianresponses

Ebola Gbalo lessons for actions

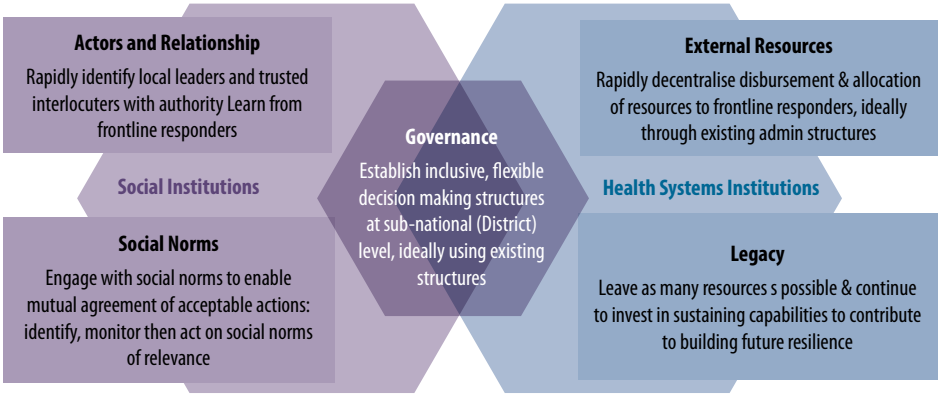

Figure 1: Key Actions to Promote Successful Humanitarian Response.

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For further information please see: www.lshtm.ac.uk/RethinkingHumanitarianApproaches
Or contact: Susannah Mayhew: Susannah.Mayhew@lshtm.ac.uk

Endnotes

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