COMMUNITY MOBILISATION: ESSENTIAL FOR STOPPING THE SPREAD OF EBOLA

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The Ebola crisis in eastern Democratic Republic of the Congo (DRC) is worsening, and it poses a serious threat to the ongoing humanitarian response on which nearly 13 million people depend for lifesaving aid. As of 27th May, 2019, over 1,832 confirmed cases of Ebola have been identified in eastern DRC, and there have been 1,193 confirmed deaths. Substantial community resistance to the response in many communities remains a serious obstacle, as indicated by persistent reports of individuals refusing the vaccine and avoiding treatment centres. In addition, since March there have been nearly 30 violent attacks on Ebola treatment centres and hand washing stations, including the murder of a WHO doctor during an attack on a hospital in Butembo on 19th May. As a result of these dynamics, efforts to slow the spread of new infections have been seriously hampered, and there is a severe risk that the disease will spread further south along the main road towards Goma.
The purpose of this brief is to provide donors, NGOs and technical agencies such as the WHO, UNICEF and OCHA with a snapshot of what the evidence says about why and how to deploy community mobilisation in public health emergencies, using a synthesis of the existing literature and a reflection on Mercy Corps’ evidence from a 2015 community mobilisation campaign in Liberia. Taking stock of the evidence about what works for community mobilisation in Ebola response is crucial at this point in the outbreak, as decisive investments in community mobilisation will be necessary to effectively reduce resistance and increase trust and community ownership of the response.

**Overview and Context**

While several previous Ebola outbreaks have taken place in fragile and post-conflict settings, this outbreak in North Kivu and Ituri is different in that it coincides with an active conflict zone with nearly 120 different armed groups that are fighting with each other and with the government. Battles between armed groups and acts of violence against civilians were common in the region before the start of the current Ebola outbreak. These types of violence have continued alongside the spread of the disease and the rise in attacks against the Ebola response. In the month of April 2019 alone, 9 battles between armed groups and 14 acts of violence against civilians were reported in or near the health zones where the outbreak is active.

The current outbreak is also different from other past outbreaks in that it has coincided with a highly disputed election campaign, which was marked by delays in voting, reports of electoral malfeasance that impacted the outcome, and a suspension of voting in areas affected by Ebola. The ongoing violence and contentious political environment have shaped community resistance by encouraging a lack of trust between communities, the government, and responders. Recently published research from the Harvard Humanitarian Initiative shows that in September 2018, 45.9% of surveyed individuals believed at least one incorrect rumor about Ebola, and 60% reported not trusting the government for Ebola response. The March 2019 Social Science in Humanitarian Response compilation of behavioural data confirms that many of the rumors that are based on political conspiracy theories, such as “The Ebola Virus disease was sent here by the Kabila government to take revenge on the people of the great North Kivu, because he understood that he is not welcome here.”
What is Community Mobilisation? Why Does it Matter for Ebola Response?

Community mobilisation in public health focuses on promoting the change and adoption of behaviours related to health through engagement with community leaders and organisations, training community volunteers and peer educators, and working with communities to implement community-designed projects. Sustained community mobilisation is especially important for changing behaviours that relate to deeply held beliefs or social norms, increasing levels of community trust towards medical service providers, and fostering community ownership of public health initiatives. Rigorous impact evaluations show that community mobilisation is effective at changing behaviour and health outcomes in a variety of areas, including perinatal care, HIV risk behaviours, and malaria prevention.

Mercy Corps and a number of other organisations operating in the DRC have made the case that addressing the roots of community resistance and mistrust will require focused attention to community mobilisation. Community mobilisation campaigns directly engage community members and trusted leaders in ongoing conversations about the risks posed by the Ebola outbreak and the behaviours that can help to prevent the spread of the disease.

Community mobilisation will be especially important in stopping the current outbreak in the Eastern DRC, due to the role of rumors and mistrust in driving community resistance to the response. However, implementers have limited shared knowledge about how to design and implement such community mobilisation programs so that they effectively address the drivers of mistrust and misinformation in the midst of an ongoing conflict and contentious political environment. Despite increasing emphasis on mobilisation and communications, most attention from donors and the government has focused on medical treatment and care, and not on designing and implementing grassroots-level mobilisation campaigns that are adapted to the unique aspects of the current outbreak.

Learning from Experience Against Ebola in West Africa

The 2014 West Africa Ebola outbreak was the first mass deployment of community mobilisation approaches in a rapidly evolving public health emergency. There are no impact evaluations of effectiveness of community mobilisation in Ebola response, but some implementing agencies and researchers have shared qualitative reflections on lessons learned. Mobilisation activities started well after medical response activities and quarantines were underway, which fed into mistrust. Once communications and mobilisation activities became part of the response, they were carried out by a variety of organisations and actors, who each used a wide array of approaches across the three countries involved in the outbreak. Many of these early approaches to communication and mobilisation relied either on mass media or on top-down dissemination of information via social mobilisers as opposed to ongoing grassroots-level discussions that actively solicited community perspectives. Later in the response, there were many innovations in community mobilisation that used technology, anthropological insights, and community-based research. However, there was a lack of coordination in use of systems across responding agencies and a failure to pursue an integrated approach to mobilisation. As a result, there was a limited ability of data to keep pace with the evolution of the outbreak, and many implementers were unable to feed data and analyses back into programmatic adaptations.
Learning from the challenges of the early phases of the West Africa Ebola response, Mercy Corps implemented a community mobilisation programme called the Ebola Community Action Platform (ECAP) in Liberia from December 2014-June 2015. The program was funded by USAID’s Office of Foreign Disaster Assistance (OFDA). Population Services International provided technical expertise in the community mobilisation and communications methodologies and trainings. IREX worked with community radio stations to complement the face-to-face mobilisation with mass media messaging.

The programme focused on working with trusted community organisations and leaders to address information gaps and promote the adoption of behaviours and norms necessary to prevent the spread of Ebola, for example washing hands, not touching sick family members, and increasing community acceptance of Ebola Treatment Units (ETUs). Mercy Corps sub-granted community mobilisation activities to 77 partner organisations—73 of which were Liberian community-based organisations. Over 800 staff members from partner organisations were trained in a mobilisation methodology that emphasised listening to community concerns about Ebola, facilitated locally-driven learning about the diseases and practices, and supporting the development of plans for communities to act on what had been learned. Communities then worked with their local leaders to implement plans such as installing hand washing stations at homes or creating a local taskforce to support prevention activities.

Mercy Corps’s partners used this Listen, Learn, Act methodology to train over 15,000 community communicators—local residents who then mobilised the members of their own villages. Within this general approach, partner organisations were given flexibility to decide what specific kinds of mobilisation activities they would use and how they selected community educators. Working this way allowed Mercy Corps and our partners to reach 2.4 million people—approximately 56% of the total population of Liberia.

As part of the mobilisation campaign, Mercy Corps implemented a technology-based monitoring and learning platform and a rapid social science research team. Partners conducted monthly random-sample surveys on knowledge, attitudes, and practices in villages using smartphones donated by the Paul Allen Foundation. This allowed the programme team to track the evolving attitudes of a sample of over 7,500 people reached by the community mobilisation. Data and graphs from the monthly surveys were
shared with partner organisations using an online dashboard, which allowed them to adapt their mobilisation approaches and content in real time. The Mercy Corps rapid research team led a number of studies exploring issues emerging from the surveys. This team also led a qualitative socio-anthropological assessment of the intervention in April and May 2015 in 40 ECAP communities and a comparison group of 20 communities in which ECAP had not been implemented.

The monthly surveys indicate substantial and rapid changes in intended behaviours and stigmas over a five-month period from December 2014 to April 2015. The largest observed changes in attitudes over time were in acceptance of health workers who had been deployed in Ebola Treatment Units—from 15% to 68% and acceptance of Ebola survivors—from 19% to 75%. The survey data also indicate that by the end of the mobilisation program, acceptance of non-touching behaviours and burial teams was nearly universal.

<table>
<thead>
<tr>
<th>Change in Behaviour</th>
<th>December 2014</th>
<th>April 2015</th>
</tr>
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<tbody>
<tr>
<td>Increase in adoption of non-touching of sick family members</td>
<td>75%</td>
<td>97%</td>
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<tr>
<td>Increase in intent to call a burial team after a family member died of Ebola symptoms</td>
<td>87%</td>
<td>97%</td>
</tr>
<tr>
<td>Increase in acceptance of Ebola Survivors</td>
<td>19%</td>
<td>75%</td>
</tr>
<tr>
<td>Acceptance of health workers exposed to Ebola</td>
<td>15%</td>
<td>68%</td>
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<tr>
<td>Correctly reporting that Ebola cannot be spread through the air</td>
<td>68%</td>
<td>93%</td>
</tr>
<tr>
<td>Correctly reporting that Ebola can be spread through sexual intercourse.</td>
<td>78%</td>
<td>90%</td>
</tr>
</tbody>
</table>

“*It helps us to understand the messaging because they sit with us to discuss and make us understand that Ebola is real.*”
—ECAP Focus Group Participant

The qualitative case studies support these findings by comparing patterns of discourse and behaviour in ECAP communities and non-ECAP communities. The qualitative analysis reveals several key insights. First, ECAP’s use of repeated, ongoing mobilisation by community-based communicators set it apart from other behaviour change communications that communities experienced. A focus group participant from an ECAP community described their experience of the programme by saying that “It helps us to understand the messaging because they sit with us to discuss and make us understand that Ebola is real.” In contrast, participants described that they learned less well from other mobilisation approaches that relied primarily on broadcasting messages through loudspeakers or mobilisers who were moving from village-to-village. A participant in a non-ECAP community described mobilisation by a different organisation by saying that “We
did not get the message well because the people used to be in rush to go to another community, we were not able to ask questions to get clarity.”

Second, the ECAP program was associated with a deeper level of understanding about how to prevent the spread of Ebola. Focus group participants in both ECAP and non-ECAP communities were able to correctly recount key messages about Ebola behaviour change. However, in ECAP communities, participants were able to articulate the public health rationale behind the messages that had been delivered by Mercy Corps’s partners, while focus group participants in non-ECAP communities were generally not able to provide similar explanations of the reasoning behind the communications they had received.

Finally, ECAP communicators helped community members to understand the linkage between knowledge, behaviours, and health outcomes, which supported the durability of behaviour change. In ECAP communities, participants were able to connect the new practices that they learned from communicators to changes in the health of their communities. As one focus group participant put it, “Reporting early sick cases has saved our families from other diseases and we must continue to do that, because the health centre is the right place for diagnosis.” In contrast, in non-ECAP communities, there were fewer directly acknowledged links between knowledge and behaviour, especially regarding hand washing and behaviour towards Ebola survivors.

Implications for Ebola Response and Preparedness
For Donors: Committing urgent flexible funds for community mobilisation
One of the key lessons from the available evidence on 2014 West Africa Ebola outbreak is that community mobilisation is critical to curbing the spread of Ebola and controlling this epidemic. While mass media communications should remain a central part of the community engagement strategy, the evidence from Liberia indicates that media messages should be supplemented with direct mobilisation. Mobilisation activities that are geared towards building community ownership are crucial to preventing further cases as well as preventing the recent uptick in violence against medical responders and treatment facilities, which threatens the medical response and puts more people in danger.

Organisations implementing community mobilisation activities urgently need more direct, flexible and long-term support from global donors to fight this epidemic. With 24-month funding cycles, Mercy Corps and our peer organisations can design more innovative community mobilisation initiatives and invest more time in building long-term trust and ownership in communities. Direct funding should be increased for agile partners who are already on the ground in conflict-hit areas and are now on the frontlines of the epidemic too – especially those who already have long-term and trusted relationships with local communities. The U.S. Government recently increased its investment in community engagement, including by funding NGOs directly. Other donors should follow this lead. Donor governments should also fund community mobilisation as part of their Ebola prevention and preparedness programs in neighboring countries that are at risk, particularly South Sudan, Uganda, and Rwanda.
For Technical Agencies: Integrating medical, communication, and mobilisation efforts

The response has primarily relied on a medical strategy that assumed that the outbreak would be contained quickly. The rapid spread of the disease and the related violence against the response indicates that a different approach is needed. Although the WHO, UNICEF, OCHA and the other technical assistance organisations have recently started to emphasise community engagement and ownership, initiatives along these lines have not been well-integrated with the medical response. The lessons learned from the West Africa outbreak indicate that the current response needs to be proactive and coordinated – bringing both medical and community-focused prevention efforts together. At present, community engagement sits within the Communications Commission, even though the challenges posed by distrust and rumor cut across all aspects of the response. Decision makers in each commission should be accountable for addressing community feedback to ensure that each commission and each sub-coordination hub integrates community engagement across all pillars of the response. Additionally, there should be a senior community engagement lead appointed at the highest strategic level of the response to ensure effective community ownership is achieved in practice and is being supported across the response as a cross-cutting issue.

“I'm scared because I have to supervise 432 schoolchildren who have to respect hygiene conditions. Thanks to the accompaniment of Mercy Corps in hygiene promotion sessions with the teachers, we will be able to prevent the Ebola disease.”

—Boniface Kambale, Director of Kesheni Primary School, North Kivu

For NGOs: Adapting mobilisation approaches to address conflict dynamics

We must bring the communities on board as partners to help us stop the spread of Ebola, and quickly. Mercy Corps’s ECAP program in Liberia reached 2.4 million people and contributed to substantial behaviour changes by working through partnerships with local organisations and trusted actors at the community level. This coordinated and localised mobilisation campaign allowed for two-way flows of information between responders and communities, which was essential for preventing the transmission of the virus, building trust, and creating local ownership. Locally-embedded, coordinated, and adaptive approaches to mobilisation are especially crucial in the current outbreak, given the complex relationships between violence, distrust of the response, and the spread of Ebola in the eastern DRC.

However, the same conflict and political dynamics that necessitate community mobilisation in the current Ebola outbreak in Eastern DRC also pose severe operational challenges to designing and implementing effective grassroots campaigns. Given the sheer number of armed groups operating within the area where the outbreak is most intense, the deep roots of distrust, and the wide array of local variation
in the nature of the outbreak, simply replicating mobilisation models that worked in the West African Ebola response will not work. Instead, successful community mobilisation in a conflict setting will require the commitment of substantial people and resources that allow for flexible, context-specific adaptation and learning. NGOs need to be aware of how local perceptions shape community acceptance of response activities and should ensure that community mobilisation initiatives model good governance principles such as transparency, fairness, inclusion, and accountability. For Mercy Corps’s own activities in the current outbreak, this has meant recruiting and making purchases locally and paying careful attention to tailoring framing and communications to local dynamics. Organisations implementing community mobilisation in the current outbreak should continue to assess and adapt their mobilisation approaches using a variety of data sources and methods, including surveys, data visualisation, socio-anthropological participant observation, political economy analysis, and local case studies.

Conclusion
The evidence presented in this brief indicates that community mobilisation should be a central element of Ebola response in eastern DRC and neighboring countries. Given the unique political and conflict dynamics in the current outbreak, we cannot simply repeat mobilisation activities that have worked elsewhere. Mercy Corps’s experience in Liberia highlights several key mobilisation practices that can be adapted to the DRC context, including partnering with trusted local communicators, engaging in ongoing direct conversations with individuals, and using community feedback to meaningfully shape the response. All actors involved in the DRC Ebola response need to take coordinated action to design, test, and learn from locally-tailored mobilisation approaches that adapt these mobilisation practices to the particular challenges of preventing the spread of a disease during an active conflict.
References and Further Reading


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About Mercy Corps
Mercy Corps is a leading global organisation powered by the belief that a better world is possible. In disaster, in hardship, in more than 40 countries around the world, we partner to put bold solutions into action — helping people triumph over adversity and build stronger communities from within. Now, and for the future.

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