

**Ebola DRC, May 2018****Socio-cultural considerations for vaccine introduction and community engagement**

This brief summarises key socio-cultural issues related to the introduction of vaccine (rVSV-ZEBOV) to the DRC in relation to the Ebola outbreak, May 2018. A deeper dive should be undertaken, but given the imminent introduction of the vaccine, conveying key considerations and immediate recommendations, particularly for community engagement, has been prioritised. Informal discussions have been held with colleagues from WHO, UNICEF, University of Sussex, University of Edinburgh, Institut de Recherche pour le Développement, Réseau Anthropologie des Epidémies Emergentes, Social Science in Humanitarian Action Platform, London School of Hygiene and Tropical Medicine, Institut Pasteur and others, but responsibility for this brief lies with Anthrologica.

**Key considerations**

- Positioning the vaccine in the local context is critical to secure community acceptance and reduce the risk of negative ramifications that could impact the whole response.
- In the current protocols and guidelines, strategies for community engagement are limited and focus mainly on recruitment of participants into the trial and their consent.
- Ring vaccination will focus on contacts and contacts of contacts. There are significant (and potentially long term) implications related to some people in a community being vaccinated whilst others are not. Risks associated with distrust, suspicion and stigmatisation are high. To some degree, community engagement can minimise the risk of negative associations but to be effective, engagement must be implemented before, during and after the vaccine is introduced.
- The socio-political context in the affected areas (Bikoro, Iboko, Wangata and Mbandaka city) is likely to influence how the vaccine is perceived by communities. There is a strong historical precedent for strained relations due to issues of ethnicity, religion, marginalisation, contested land rights etc.<sup>1,2,3</sup>
- The lack of health infrastructure will also influence how the vaccine is received by communities:
  - Across the country, 40% of health zones have discontinued immunisation services due to logistical challenges and resource limitations.<sup>4</sup> In Equateur province, only 33% of children (12-23 months) are vaccinated. Low coverage rates of routine immunisation across the country means that 14% of children under 5 years old die from vaccine-preventable disease.<sup>5</sup>
  - There is a low level of knowledge about and familiarity with immunisation. Campaign-style routine immunisation usually occurs during World Immunisation Week (24-30 April) and focuses on children only (rather than the broader community).
  - Cost associated with seeking healthcare (including fees at the point of service delivery) prevents many from accessing services. When costs are assumed to exist, it has been shown that the strongest predictor of vaccine uptake is the education level of the recipient.<sup>6</sup>
- Local disease aetiologies influence how communities perceive Ebola and many explanatory models are rooted in local belief systems (e.g. witchcraft, causation linked to evil spirits, disruptive ancestors, punishment). This determines what is perceived to be 'appropriate' care, and can be expected to hinder the implementation of preventative measures including vaccination.<sup>7</sup>
- In previous outbreaks (e.g. Boende 2014) rumours circulated that response workers conducting surveillance and active case detection were injecting indigenous groups with Ebola, and that response workers were taking ('sucking') people's blood to sell it.<sup>8,9</sup> Other rumours (e.g. from Isoro 2012, Bas-Uele 2017) suggested that Ebola was imported by foreigners and there was a high level of distrust of western medicine, international 'white' response workers and non-local responders (e.g. from Kinshasa and other areas).<sup>9,10</sup> With the introduction of vaccination, these issues will likely be magnified.
- Outside the context of Ebola, it has been reported that some communities associate vaccination with infection and isolation (e.g. in Katanga).<sup>6</sup> This could heighten distrust of the ring vaccination particularly in an emergency context.
- Influential church groups have advised congregations against immunisation (e.g. for Polio), and in previous Ebola outbreaks (e.g. Boende 2014), some churches have counseled that 'only prayer' can stop the disease.<sup>11,12</sup>
- Ring vaccination is being introduced during Ramadan. There is little information about the acceptability of vaccination during the fasting month and the impact this may have locally.<sup>13</sup>

## Recommendations

- Community engagement in the current guidelines must be adapted to go beyond issues recruitment to the potential of vaccination is introduced to the whole community using appropriate local language.
- In addition to conveying key information, the community strategy must aim to secure broad community buy-in and acceptance both within and outside the ring before vaccination starts. It must include strategies to reduce risks associated with distrust, suspicion and stigmatisation (associated with both being and not being vaccinated).
- Ring vaccination must be carefully explained to the whole community to ensure that both affected and non-affected communities broadly understood why some people are / are not vaccinated (including inclusion / exclusion criteria). It will also be necessary to explain why the vaccine is being introduced now as opposed to during previous outbreaks (particularly during Bas-Uele 2017).
- Different community entry points must be used. Whilst current guidance suggests engagement with 'local leaders', it must be sensitive to the often complex forms of leadership aligned to local social organisation. Local elites at all levels must be engaged: health system authorities (national, provincial, district and zonal); administrative authorities (national, provincial, *territoire, groupement*); and customary authorities who also have legal status (*chefferies*). Because of intra-group dynamics, it should not be assumed that local leadership is always trusted by everyone.<sup>2,3</sup>
- Who administers the vaccine and facilitates community consultation and engagement should be carefully considered given the socio-political context, particularly in relation to local power structures and distrust of international and non-local national responders. It is important to use trusted local mobilisers who can be trained specifically on engagement related to the ring vaccination in addition to the broader Ebola response. Who is best placed to act in this regard must be agreed locally.
- Working through and in alignment with existing trusted structures is imperative. The *relais communautaires* (RECO) and *Comités de Développement Sanitaire* (CODESA) are normally elected by their communities and are often less political than other community representatives. Similarly, the sleeping sickness mobile unit teams have a detailed knowledge of local health realities, particularly in remote areas, and should be engaged.
- Local healers are often serve as frontline care providers, particularly in contexts where access to formal health services is constrained. Again, they should be engaged as part of the broader community engagement strategy, but also provided with relevant and accurate information to support ring vaccination.<sup>14,15</sup>
- Local religious institutions have significant influence. They are a key channel for mobilising communities and to build trust and acceptance of the ring vaccination, must support the intervention. The introduction of the vaccine must be sensitive to Ramadan in Muslim communities.
- Community engagement should explain why adults are being targeted (as opposed to just children in routine immunisation) and should be tailored to address concerns of community members who may be more reluctant to accept vaccination (e.g. due to local beliefs, lower education levels, limited exposure to immunisation, membership of a marginalised group etc).
- The consent procedure is orientated towards enrollment in the trial. The process for securing informed consent should be considered more than 'just getting a form signed'. Whilst individual informed consent is necessary to assure an individual's voluntary participation, communal informed consent is necessary to secure the support of the wider community and explain risks to the participant in relation to their social networks. This is an important component of reducing distrust and potential stigma associated with / with not being vaccinated and should built into community consultation processes.
- Some messaging included in the existing guidelines is problematic and can be improved. Statements that could be seen as contradictory should be refined and should actively mitigate concerns that the vaccine will 'give' people Ebola. Messaging about the potential side effects should be consistent and directions about what to do if side effects occur and the care that will be given should be made clear to the broader community. A failure to assure cultural appropriateness and to make information accessible, relevant and understandable is tantamount to a failure to protect human subjects.
- Engagement strategies should emphasise that the vaccine is not a 'magic bullet' and should stress why protective behaviours (such as washing hands) and control mechanisms must be continued despite vaccination.
- Community engagement must be ongoing, so as questions and concerns are raised, community dialogue serves as a platform to a) provide further information so that a vacuum of the unknown is not allowed to develop; and b) enable the response to track emerging issues, rumours and popular interpretations (of the vaccine and other interventions) that can then be proactively and systematically addressed and resolved.
- A baseline KAP study (Base-Uele 2017 outbreak) indicated that whilst only 36% of all people surveyed knew about the vaccine, of those that did, 92% were willing to be vaccinated. This is positive and suggests that if vaccination had been appropriately introduced, it would likely have been well accepted. It is not known whether this reflects attitudes in the areas of the current outbreak. The KAP highlighted the community's questions (who would be targeted for vaccination and why; how effective was the vaccine; what were its side effects; when and where did the vaccine originate; was it manufactured specifically for the DRC). These questions should be directly addressed through community engagement strategies. Rapid KAP surveys should now be conducted in the affected areas to provide 'good enough data' to guide operations in these localities.

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- <sup>1</sup> Gorleau, G. (2017). *A Silent Crisis in Congo: The Bantu and The Twa in Tanganyika*. International Rescue Committee Report, Governance Technical Unit.
- <sup>2</sup> Lewis, J. (2000) *The Batwa Pygmies of the Great Lakes Region*. Vol. 209. London: Minority Rights Group International.  
<http://archive.niza.nl/docs/200301301200533545.pdf>
- <sup>3</sup> Samndong, R. A. (2016). *Institutional Choice and Fragmented Citizenship in Forestry and Development Interventions in Bikoro Territory of the Democratic Republic of Congo*. *Forum for Development Studies*, 43:2, 251-279.
- <sup>4</sup> Gavi Tailored Approach for the DRC, 2013-2017; quoted in Path (2016) *Immunization in the Democratic Republic of the Congo. Landscape Analysis and Policy Recommendations*. <https://www.path.org/publications/detail.php?i=2664>
- <sup>5</sup> DRC Comprehensive Multi-Year Plan, 2015-2019; quoted in Path (2016) *Immunization in the Democratic Republic of the Congo. Landscape Analysis and Policy Recommendations*. <https://www.path.org/publications/detail.php?i=2664>
- <sup>6</sup> Merten, S., Schaetti, C., Manianga, C., et. al., (2013). *Sociocultural Determinants of Anticipated Vaccine Acceptance for Acute Watery Diarrhea in Early Childhood in Katanga Province, Democratic Republic of Congo*. [www.ncbi.nlm.nih.gov/pmc/articles/PMC3771276](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3771276).
- <sup>7</sup> UNICEF (2017). *Plan de Communication*, UNICEF, Bas-Uele outbreak 2017.
- <sup>8</sup> Ministère de La Santé Publique (2014). *Module de formation sur l'apport de l'anthropologie à la riposte aux flambées de l'épidémie de la MVE*.
- <sup>9</sup> Ministère de La Santé Publique (2014). *Module de formation en communication sociale, comportementale et de risque et / ou crises en cas d'une flambée de l'épidémie de la maladie à virus Ebola*.
- <sup>10</sup> Musene Santini, B. (2017). *Aspects socio-anthropologiques de la riposte post-Ebola dans la ZDR de Likati*. OMS.
- <sup>11</sup> UNICEF (2016). *Maternal and Newborn Health Disparities: Democratic Republic of the Congo (DRC)*.  
[https://reliefweb.int/sites/reliefweb.int/files/resources/COD\\_country%20profile.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/COD_country%20profile.pdf)
- <sup>12</sup> UNICEF (2012). *In DR Congo, communications efforts are turning back religious resistance to the polio vaccine*.  
[https://www.unicef.org/health/drcongo\\_65183.html](https://www.unicef.org/health/drcongo_65183.html)
- <sup>13</sup> Peiffer-Smadja, N. et al. (2017). *Vaccination and blood sampling acceptability during Ramadan fasting month: a cross-sectional study in Conakry, Guinea*. *Vaccine* 35(19): 2569-2574.
- <sup>14</sup> Maganga, G. D. et al. (2014). *Ebola virus disease in the Democratic Republic of Congo*. *New England Journal of Medicine* 371.22: 2083-2091.
- <sup>15</sup> Falisse, J, et al. (2018). *Indigenous medicine and biomedical health care in fragile settings: insights from Burundi*. *Health policy and planning* 33.4: 483-493.