

Local Engagement in Ebola Outbreaks and Beyond in Sierra Leone

Containment strategies for Ebola rupture fundamental features of social, political and religious life. Control efforts that involve local people and appreciate their perspectives, social structures and institutions are therefore vital. Unfortunately such approaches have not been widespread in West Africa where response strategies have been predominantly top-down. Authoritarian tactics have had questionable effect, potentially worsening the epidemic and contributing to social and economic burdens. Failure to involve local people and their concerns is often justified by budgetary and practical restraints such as lack of time and resources. However, some of the current Ebola responses reflect problematic assumptions about local ignorance and capability. These sentiments are deeply rooted, having evolved with unequal power dynamics over long periods of time. The emerging evidence on successful local responses suggests that local populations can learn rapidly to adjust high-risk traditional practices and reduce transmission in conjunction with solid public health measures. Recognising and supporting local resilience will be essential in successfully and sustainably engaging populations in effective Ebola responses.

Authoritarian regimes

In December 2014, Sierra Leone's President Ernest Bai Koroma cancelled Christmas. Holiday travel and gatherings were banned in an effort to bring the country's worsening Ebola epidemic under control. Instead, the Freetown peninsula was to undergo the 'Western Area Surge' (WAS) devised by the National Ebola Response Committee (NERC). On the orders of the president, the WAS included house-to-house visits and the following 'fact-based messaging', designed to 'shock':

- 'How bad does it need to get before you take notice and start to fight this disease? You have wasted seven months, let's make the next one count.'
- 'Do you really want to die? Do you want to kill your family? Don't conduct secret burials.' For good measure, this was supplemented by a warning, 'Those that conduct secret burials are spreading this disease. It is their fault that your friends and relatives are dying. They are destroying our nation and I (the President) will see that they are punished for their illegal, selfish behaviour'.

It is hard to know if these messages actually reached people on the ground, but we do know that control efforts have been structured around curfews, mass cremations, lock-downs, quarantines – of houses, villages and entire regions – and the use of force to maintain these measures. These strategies have been justified as necessary in order to deal with unruly populations who have ignored advice and resisted medical teams due, it is said, to ignorance of biomedicine, irrational distrust and a refusal to abandon 'traditional culture'. Far less attention has been paid to the 'culture' of the response, specifically how dominant technical and biomedical norms and practices for outbreak control may have limited the scope of engagement with local actors. From a lacklustre start, national and international Ebola responses have mushroomed into vast and complex multi-actor operations. Coordination – both national and international – has been limited and differences in opinion, history, funding and style have led to a variety of approaches being implemented. This makes generalisation problematic. However, some 'cultural traits', as it were, are discernible.

Blame shifting

The WAS message that people had wasted seven months by ignoring instructions is especially hard to swallow when the national history of the response is considered. From the beginning of the outbreak, communication by the state has largely been one-way and inadequate. When people doubted the existence of Ebola they were repeatedly told through media, that 'Ebola is real'. Such messages did nothing to engage with people's suspicions that the outbreak was a political or financial ploy concocted by governments or foreigners with ulterior motives. Popular suspicion of the motives of foreign organisations and government is rooted in a long history of slavery, civil war, extraction and more recently, commercial and non-commercial foreign development efforts often diverted into the pockets of government and non-governmental organisation (NGO) officials. Similarly, berating people for avoiding Ebola treatment centres, overlooked fundamental concerns about lack of safe transport to the centres, inhumane treatment, unsafe triage, lack of food in the centres, the catastrophic familial costs of quarantine, and the fear of not being able to carry out dignified funerals. The persistence of an approach that individualises responsibility for stopping Ebola by scapegoating fictitious selfishness or supposedly traditional medical superstitions, while failing to deliver concrete support for people infected and affected, seriously limits the possibility of engaging with sceptical publics. Moreover, treating the sick – and sometimes their entire families – as criminal suspects has stigmatised those who are already vulnerable, and, in the case of quarantines, has made them more so by destroying their livelihoods as they lose jobs or cannot farm.

Models of 'communities' and 'community engagement'

The perception that people living in a similar geographical area make up a harmonious 'community' with a uniform culture has been thoroughly critiqued. As have 'community'-based consultations where plans that have already been made are presented to local residents for feedback. Uncritical approaches to 'communities' risk falling foul of important distinctions and power systems. These dynamics can help or hinder but they cannot be ignored. However, full consideration of such issues has so far been patchy.

Contrast the murders in Womey, Guinea, of eight outreach workers (Ouendeno 2014), with the listening exercise carried out by anthropologists with 26 resistant villages in the same region as Womey (Anoko 2014). In the latter, historical tensions between ruling Muslim Fulani and Malinke elites with ethnic groups in the Forest region were taken into account, as were differences within those ethnic groups and villages. Efforts were made to identify people with various sources of knowledge and influence, not simply those in formal roles. This included healers, society officials,¹ hunters, elders, returned urban migrants and street vendors. Their opinions, fears and eventually help in reassuring others were successfully sought. In Womey, however, politicians joined a community sensitisation visit. A public meeting was called, ceremonial gifts given and then inhabitants were told not to be afraid and to cooperate – rather than being invited to share their experiences and concerns. At this point the assembled village population withdrew from sight. One hundred or so initiated women returned at first, followed later by armed youths who attacked the delegation. In process and outcome these efforts to 'engage communities' were dramatically, and tragically, different. These sensitivities have clear implications for the success of interventions. A rapid assessment of the Ebola Community Care Centre (CCC) model in Sierra Leone found that 'concerns and fears of communities about sites, were alleviated most rapidly in communities that had been actively and personally engaged in site design and construction... Community engagement and buy in were clear factors which were helping CCCs to succeed' (ICAP 2015).

Reliance on narrow forms of knowledge and expertise

The scant consideration of local perspectives is frustrating. Anthropologists involved in previous Ebola epidemics, and in Guinea and Sierra Leone during this outbreak, have documented how productive it is to take these into account. They have shown that traditions are rarely inflexible, and through collaboration between response teams and those with deep knowledge of the context, mutually acceptable solutions can be found. A study of 25 villages in three provinces of rural Sierra Leone, in which five experienced local Ebola outbreaks, explored how transmission was stopped in all five (Richards *et al.* 2015). The study found that this result was achieved by a combination of effective public health interventions and rapid local learning concerning the disease. Communities quickly adopted special measures and changed traditional procedures for preparing dead bodies and arranging burials. Community health workers with a good grasp of infection risks and local practices often facilitated this local learning, illustrating the importance of identifying and working with reliable local partners for an effective wider response. Similar flexibility of traditions was found in a Kissi village in Guinea, when a mother and her unborn baby died of Ebola. In that village it was forbidden to bury a woman with a foetus inside her as it represented a transgression of socioecological orders that could cause further harm. Yet for medical teams, removing the foetus was too risky. In discussions brokered by an anthropologist, a compromise was found: the transgression could be mitigated with a reparation ritual that allowed the woman and foetus to be safely buried (Faye 2014).

Achieving this on a wider scale requires institutions to be open to plural forms of knowledge and dialogue. In organisations like the World Health Organization or the Centers for Disease Control and Prevention in the United States, the number of social scientists employed is small and biomedical expertise dominates. In Sierra Leone, the Ebola strategy was heavily driven by the number of beds, an indicator that prioritised military logistics, engineers and medical solutions. However, treatment facilities were only part of what would stop Ebola. Collaboration with existing sources of authority and expertise – as in the 26 villages in Guinea – was not universally and systematically done. Implementing agencies were unwilling to accept that CCCs could be staffed solely with trained laypeople. Is a traditional birth attendant a layperson or a trained local expert, and how is this decided and by whom? On issues of health, funerals and hygiene the so-called ‘secret societies’ hold considerable sway and offer untapped potential. Given the evidence on the importance of involving local experts, responding agencies would do well to direct resources to the identification and integration of multidisciplinary and informal knowledge. In particular, and in light of empty beds in Sierra Leone and Liberia, including a nuanced understanding of local behavioural dynamics in predictive models would strengthen planning. Networks of national and international social scientists that have formed during this outbreak provide enhanced insight into social dimensions. If maintained, these networks offer potential for engaging with plural knowledge.

The foundations of a dysfunctional response

Effective engagement in West Africa suffered from a lack of dialogue and layers of mistrust between states, citizens and response partners. The tragedy demands a better understanding of the root causes of these problems. The long-term experience of structural violence has produced institutionalised forms of mistrust and exclusion that make collaboration and inclusion elusive. From slavery to post-colonial and post-war development, international extraction and local exploitation has set the tone in the Mano River region (Guinea, Liberia, Sierra Leone and Côte d’Ivoire), allowing a few to benefit at the expense of others. Deeply rooted ‘shadow state’ systems have emerged to connect local patronage systems with the spoils of new state architectures (Reno 1995). Ebola is not an exception. Indeed, money-making – by governments, ghost workers collecting hazard pay and NGOs – has been a central theme throughout the crisis. This world of ambiguous and unequal opportunities is rationalised through a ‘logic of suspicion’ where what is visible may well conceal powerful forces beneath (Ferme 2001). Accompanying this is a reification of secrecy, traceable to histories of violence and instability, which has been institutionalised in the ‘secret societies’ and their guarding of secret knowledge. At village level, the societies are sources of solidarity but they also maintain hierarchical orders. These, then, are unequal ‘communities’ and ‘states’ with divisions between citizens based on age, gender, ethnicity, wealth, connections, claims to land and possession of secret knowledge. Overall, therefore, there is very little generalised trust; in Sierra Leone, people trust those close to them but not ‘strangers’ or state institutions (Richards *et al.* 2015).

Questions must be asked about whether development efforts can reduce the socioeconomic and political inequalities that hinder effective collaboration in outbreak responses. Overseas development efforts – commercial or not-for-profit – have not had a substantial impact on improving the quality of social and political relationships. Indeed, dominant modes of development – such as ‘land grabs’ and mining deals driven by local elites, international partners such as the World Bank, the International Monetary Fund and the private sector – have contributed to inequality, and played into logics of ill-gotten gain, by producing dramatic economic growth for some at the expense of others, and to the detriment of rural livelihoods and institutions.

Implications

- The current Ebola outbreak in Sierra Leone highlights how cultures of mistrust and exclusion can drive epidemics. Long-term efforts are needed to address the sources of systemic violence that have bred mistrust and corrode social and political relations. However, in the short term, evidence emerging from the epidemic and from other outbreaks shows that these can be better addressed through decentralised but coordinated collaborations between biomedical experts and those with a range of other forms of expertise.
- Local knowledge and perspectives on containing Ebola – and other disease outbreaks – must be at the heart of the public health and biomedical responses. Radically greater investment is needed in learning from and supporting the successful local responses that have taken place and that show how collaborations can be realised at scale.
- Coalitions of people from broad sections and levels of society should be involved in national policy processes to integrate and institutionalise multiple forms of expertise into planning.
- Networks of local and international social scientists, already emerging from this crisis, should be maintained. These can deepen evidence on the social dimensions of health and emergencies so such understanding can provide a knowledge base in the event of future epidemic outbreaks.

¹ Society refers to the gendered initiation societies found in all villages and in many urban areas.

Local Engagement in Ebola Outbreaks and Beyond in Sierra Leone

Further reading

Anoko (2014); Ferme (2001); Hewlett and Hewlett (2008); Richards *et al.* (2015); Rothstein and Uslaner (2005).

References

- Anoko, J.N. (2014) *Communication with Rebellious Communities During an Outbreak of Ebola Virus Disease in Guinea: an Anthropological Approach*, www.ebola-anthropology.net/case_studies/communication-with-rebellious-communities-during-an-outbreak-of-ebola-virus-disease-in-guinea-an-anthropological-approach/ (accessed 29 January 2015)
- Faye, S. (2014) 'How Anthropologists Help Medics Fight Ebola in Guinea', *SciDevNet*, www.scidev.net/global/cooperation/feature/anthropologists-medics-ebola-guinea.html (accessed 14 October 2014)
- Ferme, M.C. (2001) *The Underneath of Things: Violence, History, and the Everyday in Sierra Leone*, London: University of California Press
- Hewlett, B.S. and Hewlett, B.L. (2008) *Ebola, Culture and Politics: the Anthropology of an Emerging Disease*, Belmont, US: Thomson Wadsworth
- International Centre for Aids Care and Treatment Programs (ICAP) (2015) *Rapid Mixed Methods Assessment of the Ebola Community Care Center Model in Sierra Leone*, New York: Columbia University
- Ouendeno, M. (2014) 'Report of the Mission in the Sub-prefecture of Womey, Prefecture N'zérékoré of September 16, 2014', unpublished field report
- Richards, P.; Amara, J.; Ferme, M.C.; Kamara, P.; Mokuwa, E.; Sheriff, A.I.; Suluku, R. and Voors, M. (forthcoming) 'Social Pathways for Ebola Virus Disease in Rural Sierra Leone, and Some Implications for Containment', *PLOS Neglected Tropical Diseases*, <http://blogs.plos.org/speakingofmedicine/files/2014/10/Richards-et-al.1.pdf> (accessed 30 January 2015)
- Richards, P.; Amara, J.; Mokuwa, E.; Mokuwa, A. and Suluku, R. (2015) *Village Responses to Ebola Virus Disease in Rural Central Sierra Leone: An Interim Report to the SMAC Program*, DFID Freetown, Freetown: Njala University
- Rothstein, B. and Uslaner, E.M. (2005) 'All for All: Equality, Corruption and Social Trust', *World Politics* 58: 41–72

Credits

This Practice Paper In Brief was written by Pauline Oosterhoff and Annie Wilkinson. It was produced as part of the IDS Strengthening Evidence-based Policy programme, funded by UK Aid from the UK Department for International Development. The opinions expressed are those of the authors and do not necessarily reflect the views of IDS or the UK government's official policies.

Readers are encouraged to quote and reproduce material from issues of Practice Papers in Briefs in their own publications. In return, IDS requests due acknowledgement and quotes to be referenced as above.

© Institute of Development Studies, 2015

AG Level 2 Output ID: 565



Institute of Development Studies Brighton BN1 9RE UK
T +44 (0) 1273 606261 F + 44 (0) 1273 621202 E ids@ids.ac.uk W www.ids.ac.uk