



Stopping Ebola in its Tracks: A Community-Led Response

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List of Abbreviations

ALERT	Assisting Liberians with Education to Reduce Transmission
CDC	U.S. Centers for Disease Control and Prevention
CLTS	Community-Led Total Sanitation
EHTs	Environmental Health Technicians
ETU	Ebola Treatment Unit
GOL	Government of Liberia
IMS	Incident Management System
IRC	International Rescue Committee
IWASH	Improved Water Sanitation and Hygiene
MOH	Ministry of Health
NGO	Non-Governmental Organization
ODF	Open Defecation-Free
OFDA	USAID Office of U.S. Foreign Disaster Assistance
PACS	Partnership for Advancing Community Based Service
PPE	Personal Protection Equipment
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Global Communities' response to the Ebola outbreak has been publicly highlighted by President Obama, Dr. Rajiv Shah, former USAID Administrator, Jeremy Konyndyk, Director, USAID Office of U.S. Foreign Disaster Assistance (OFDA), and many others as having been a key component in the successful fight against Ebola in Liberia in the 2014-15 outbreak (see pages 36-38). This publication therefore has two strands:

1. Describing Global Communities' response to the Ebola outbreak in Liberia
2. Deriving from this experience lessons learned and recommendations for preventing and dealing with future disasters

This publication describes the process of adaptation, collaboration and partnership which helped the response to be successful, detailing the challenges along the way that led to further adaptation.

Summary of Global Communities' Ebola Response

Global Communities, with support from USAID/OFDA undertook a multifaceted response to the Ebola crisis which continues at the time of publication. At the core of our response was, at all times, community engagement and a multi-stakeholder approach.

COMMUNITY ENGAGEMENT (PAGES 9-14)

Since 2010, Global Communities had been implementing a five-year, USAID-supported program in Water, Sanitation and Hygiene. Prior to the Ebola outbreak, this program had successfully turned 284 communities open defecation free (ODF) in Lofa, Nimba and Bong Counties of Liberia through a Community-Led Total Sanitation (CLTS) process.

The engagement strategy of this program formed the basis of how Global Communities scaled-up for the Ebola response. Building on our relationships with the Liberian Ministry of Health (MOH), county-level Environmental Health Technicians (EHTs) and "Natural Leaders" Global Communities grew our response to work with communities in all 15 counties of Liberia. In order to do this successfully, we engaged with traditional leaders. They enabled us to enter areas of the country where we had no prior footprint and to overcome resistance and hostility.

The CLTS approach also demonstrated its value by providing communities surrounded by Ebola hotspots with resistance to Ebola; no ODF community from our earlier work experienced Ebola, and communities which began the CLTS process were 17 times less likely to experience an Ebola infection (see pages 41-43).

SAFE BURIAL, SCREENING AND BODY MANAGEMENT (PAGES 17-24)

At the peak of activities in September/October 2014, Global Communities oversaw safe burials in all 15 counties of Liberia, with a team of more than 500 incentivized volunteers, working in partnership with the MOH and EHTs. In spite of being on the frontlines of the Ebola response, no team member was infected with Ebola. To counter resistance in Monrovia in response to the Government of Liberia's cremation policy, Global Communities developed a safe burial site at Disco Hill which obviated the need for cremations, opening on December 23, 2014. Alongside safe burials, Global Communities also ran ambulance services and undertook hotspot management to contain the spread of Ebola.

CONTACT TRACING AND BORDER SURVEILLANCE (PAGES 26-28)

Global Communities undertook additional activities to help contain and isolate the disease, and build the capacity of the MOH and community health workers. These included contact tracing and active case search, and border surveillance. Along the formal and informal border crossings with Sierra Leone and Guinea, Global Communities implemented a cross-border monitoring system and created a "hygiene barrier" by implementing CLTS in 175 border communities.

NEXT STEPS (PAGES 29-31)

Global Communities' continuing Ebola response and preparedness activities focus on transitioning out of emergency activities and expanding the community-level health system strengthening activities that we undertook prior to the outbreak, especially persevering in building the capacity of county EHTs to build long-term resilience.

Response in Numbers

Global Communities response:

- Supported more than 6,000 safe burials in all 15 counties of Liberia with up to 72 burial teams, 58 disinfection teams, 26 ambulances and more than 170 vehicles to transport burial teams and health workers at the peak of the epidemic, and burying up to 98% of dead bodies within a day of death.
- Engaged 15,000 community leaders between August and December 2014 to establish community-ownership of the Ebola response.
- Trained approximately 25,000 community health workers, the majority of whom are specifically engaged in public health surveillance, and helped improve health education and hygiene practices of more than 25,000 individuals.

Global Communities: Recommendations (pages 34-35)

From our experience in the Ebola response, Global Communities has developed specific recommendations:

STOPPING EPIDEMICS REQUIRES EFFECTIVE COMMUNITY ENGAGEMENT

Infectious diseases follow the patterns of daily social movements and interactions. Stopping the spread of disease, therefore, requires the development of strategies to engage communities in rapid behavior change. Attempts to force change can result in widespread resistance, prolonging the epidemic and failing to stop its spread. The results of the Ebola response demonstrate the effectiveness of social engagement strategies that enable community-led action for improved health behaviors, community resilience and protection.

PREVENTATIVE HEALTH THROUGH IMPROVED SANITATION

Disease spreads at the community level and must therefore be combated at the community level. Effective strengthening

of health systems must be complemented by preventative approaches, such as CLTS, which guard against not only Ebola but also cholera, dysentery, diarrheal diseases and many other illnesses that are endemic throughout much of the world.

ENHANCE LOCAL SYSTEMS

Responders should work through indigenous systems—community, traditional and religious, or through county and national government. By working through these structures responders gain local knowledge and build the capacity of the people who will face future crises. A localized response puts in place the knowledge, skills and structures to build resilience and make future disasters more manageable.

ENVIRONMENTAL HEALTH TECHNICIANS (EHTS)

Most countries in Africa and many in the world have a county-level EHT system in place to varying degrees. Liberian EHTs were able to undertake large-scale community education, and adapted to become burial team leaders, contact tracers and disease surveillance experts. These local experts should be recognized as a vital resource in fighting disease at the community level and their capacity built for future interventions. EHTs are also key implementers for sanitation, hygiene, general community health surveillance and supervision and connect communities to county health team leadership.

FLEXIBILITY

Responders must experiment and continually adapt according to developments on the ground and information from government, community and other sources. Many organizations have a specific area of expertise, but should adapt to fit the crisis, not bend the crisis to fit their expertise. Global Communities' most significant advances came from listening to the community, and local leaders within and outside of formal government.

BRUTE FORCE IMPLEMENTATION

Innovation is important; but sometimes it takes “brute-force” implementation to end a crisis. The Ebola response was successful because of communities engaging communities *en masse*; because of 500 people engaged in burial teams; 15,000 community leaders engaged in education/action planning in five months; hundreds of vehicles used in getting our responders to all ends of Liberia; and a donor willing to support this work to the scale it needed. This was a crisis solved by an enormous amount of human resources.



INTRODUCTION

Telling the Untold Story

The public view of the Ebola response was dominated by images and stories of medical workers and Ebola treatment units. But there is also the less-known story of the many thousands of Liberian health workers, government staff, traditional leaders, and volunteers who played the most significant role in building resilience to Ebola and reducing transmission and infection. It is these groups, working on the frontlines and at significant risk, which Global Communities partnered with throughout the Ebola response.

Global Communities wishes to reframe the existing narratives of the 2014-2015 Ebola epidemic and bring attention to the ongoing role of local leaders and Liberian citizens in resolving the epidemic. Community-led methods implemented by local actors, injected with strategic, flexible external support, allowed the community to take control of their own health, halting transmission chains, protecting the health of their communities and neighbors, and devising innovations for their own long-term resilience and capacity.

Global Communities has chosen to document this response in order to contribute to transparency, knowledge sharing and critical self-examination within the development sector. In particular, this document will:

- Outline the evolution of Global Communities and partners' activities before, during and following the 2014-2015 West Africa Ebola epidemic;
- Examine the dynamics that influenced these activities including successes, failures and pressures that led to adaptations; and
- Provide practical lessons learned to inform ongoing response efforts in West Africa and in future outbreaks or crises.

The aim is also to inspire broader discussion of the 2014-2015 West Africa Ebola epidemic, and to invite analysis of how these lessons may be applied to improve future intervention strategies in similar contexts.

**POPULATION**

4,195,666

AREA

111,369 sq km
(approx. same area
as US State of
Virginia); 15 counties

CAPITAL CITY

Monrovia; population
1.224 million

LANGUAGE

English is the official
language;
20 indigenous
languages are also
spoken.

GOVERNMENT

The oldest democratic
republic in Africa

History

The Republic of Liberia, formerly a colony of the American Colonization Society, declared its independence from the United States on July 26, 1847. Civil wars raged in the country from 1989-1996 and 1999-2003. President Ellen Johnson Sirleaf, the first female Liberian head of state, has been in office since January 16, 2006.

Historical Work in Liberia

Global Communities began working in Liberia in 2004, after the end of the civil war, partnering with communities in Lofa county on conflict resolution and peace promotion. Other notable programs included Goldman Sachs' 10,000 Women Certificate Training Program for Women Entrepreneurs; the Bill & Melinda Gates Foundation-funded Youth Engagement in Service Delivery program; and the Overseas Private Investment Corporation-supported Liberia Enterprise Development Finance Corporation. All three centered on training, supporting and building businesses to sustainably grow the Liberian economy.

Learn more at:

<http://www.globalcommunities.org/liberia>

Beginning Stages of Ebola in West Africa

Ebola first appeared in Gueckedou, Guinea, in December 2013. Liberia confirmed its first Ebola cases on March 30, 2014 in Lofa County. At that point, as part of the USAID-funded Improved Water, Sanitation and Hygiene (IWASH) program, Global Communities had already implemented a technique called Community-Led Total Sanitation (CLTS) in 350 communities in Bong, Lofa and Nimba counties, and had helped support 284 of these communities to become verified open-defecation free (ODF) by the Ministry of Health (MOH), one of the key goals of CLTS. Having started the program in 2010 and being well on track to achieve its targets, IWASH was designed to transition activities to full Liberian government oversight by the end of 2014.

Because of this extensive experience implementing hygiene and sanitation initiatives in Liberia, well-developed relationships with local health authorities and communities, and a presence in Lofa County, Global Communities was well positioned to respond to Ebola. Global Communities' strategy was developed from the beginning in partnership with Liberian leadership, in this case the Liberian Ministry of Health's Director of Community Health Services, Dr. Tomba Boima. Already familiar with the effectiveness of the work of IWASH, and with the Ebola situation becoming more alarming by the day, Dr. Boima approached Global Communities to ask what could be done in response.



ALERT team members delivering safe burial supplies in Grand Bassa

Global Communities invited Dr. Boima to visit the Lofa County office. Over the next two days, he and the team sat together to co-design a plan. Dr. Boima approached his own network of colleagues—those most familiar with the situation and with Liberian customs and habits—and Global Communities approached USAID. These exceptional circumstances prompted USAID to provide Global Communities with considerable flexibility in the final months prior to the completion of a five-year award. Global Communities launched three initial responses:

- Provision of Infection Prevention and Control materials (including soap, chlorine, point-of-use water treatment products, latex gloves, jerry cans and nose masks) to three health centers on the border with Guinea;
- Rapid adaptation of existing health messaging, including radio spots, to provide Ebola-specific information such as safe burial practices, the avoidance of hand-shaking and bush meat consumption, and encouragement to contact local health workers in the event of any illness in the community; and

- Training and repurposing of Liberian general Community Health Volunteers and IWASH-associated Natural Leaders to provide Ebola education and sensitization to communities within their jurisdiction.

Cases declined and it seemed Liberia had escaped the brunt of the epidemic. However, in late July, transmission chains restarted and reached Monrovia. With that, the caseload abruptly exploded. With growing awareness of the seriousness of the situation, by August 21, 2014, USAID's Office of US Foreign Disaster Assistance (OFDA) released its first award for the response to Global Communities of \$700,000 to scale-up activities for four months. By September 2015 and on its fifth modification, this funding increased to \$32 million, as Global Communities took on a broader series of activities detailed throughout this publication. From that point on, this new program—Assisting Liberians with Education to Reduce Transmission (ALERT)—became the main vehicle for Global Communities' operations in Liberia.

COMMUNITY ENGAGEMENT

Rising Stakes: Community Engagement as a Matter of Life or Death

To tackle the 2014-2015 West Africa Ebola epidemic, new techniques were needed that instilled agency, capacity and hope in individuals and communities to encourage participation in behavior changes to stop disease transmission.

Drastic actions were being taken to halt the spread of the disease, including closures of schools, markets, churches and other public gathering spaces, along with the institution of behavior changes such as the “no-touch” policy put in place by the Government of Liberia (GOL). With the help of international organizations, the GOL instituted all of these policies and more, in desperate attempts to stem the tide of the epidemic and avoid the worst projections of the disease’s spread, with fears of up to 1.4 million deaths regionally.

These measures of epidemic control had significant effects on people’s movements, relationships and capacity to sustain livelihoods. They also took place in the context of widespread fear, mistrust and misinformation and high levels of mortality. As the need for centralized control of disease prevention increased, so too did the logistical complexity of enforcing the new regulations, as well as the pockets of resistance which arose that could undermine the effort.

As an example, in August 2014, the GOL used military and police to attempt to quarantine the entire population of West Point, one of the worst hit neighborhoods in Monrovia. The police were forced to abandon the effort in response to the resulting riots, quarantine escapes and widespread international concern.

Behavior change by force can inspire fear, anger and resistance. In Liberia, some people hid cases, conducted

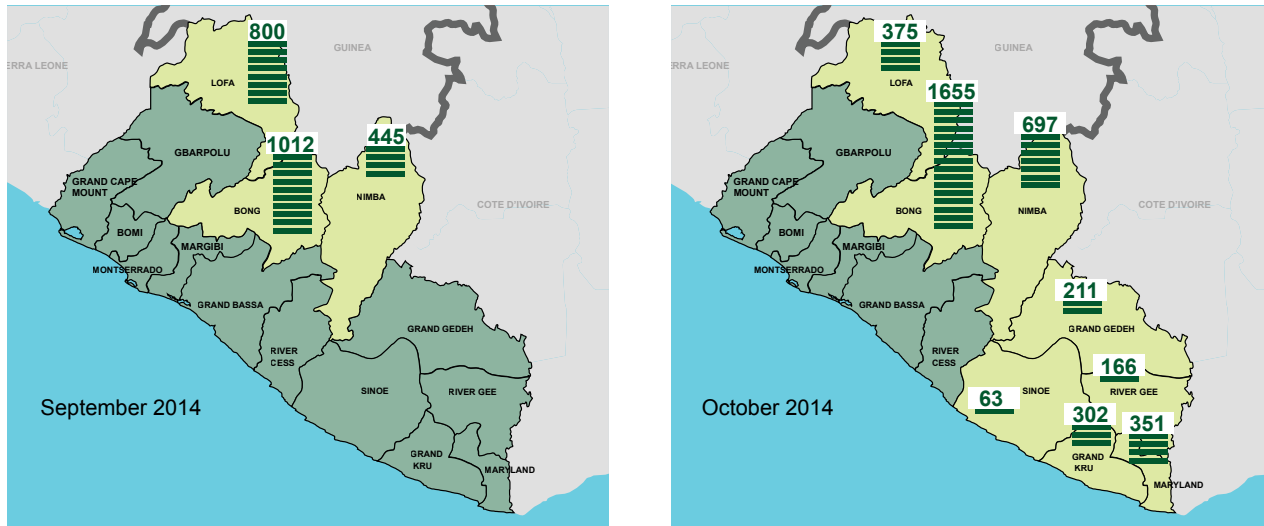
secret and unsafe burials, and traveled when ill to escape censure, thereby exposing many more potential victims to the virus.

As clinical staff worked furiously to open and operationalize sufficient numbers of Ebola Treatment Units (ETU), testing and transit centers, four other activities emerged as clear priorities required to stop the epidemic:

- A strategy of community engagement and education that would convince the public to undertake drastic behavior change, much of which ran contrary to cultural norms;
- Control and management of dead bodies to stop transmission to caretakers and handlers of bodies;
- Contact tracing for confirmed patients to isolate and monitor potential new cases; and
- Border surveillance and support to re-open cross-border trade.



Number of Engaged Leaders in Liberia Counties by Month



Social Engagement as a Tool for Rapid Community Led Behavior Change

Global Communities quickly recognized that in the context of Ebola community health campaigns fell far short of countering two rising tides—the growing numbers of Ebola infections, and the fear, misinformation, and distrust of external actors. What was needed was a mechanism to build trust and inspire individuals to rapidly change their behavior.

Global Communities, Dr. Boima and the county health teams partnered to develop an ambitious new plan that leveraged previous experiences with CLTS and other community development programs, as well as existing relationships fostered over the preceding four years with the Liberian Ministries of Health, Public Works, and with government entities in Bong, Lofa and Nimba counties.

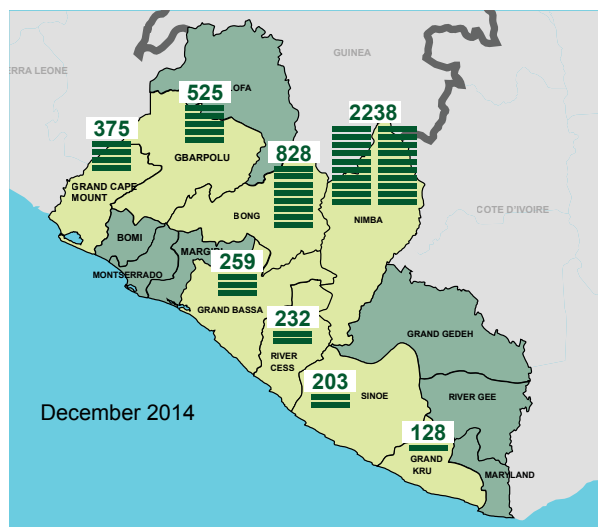
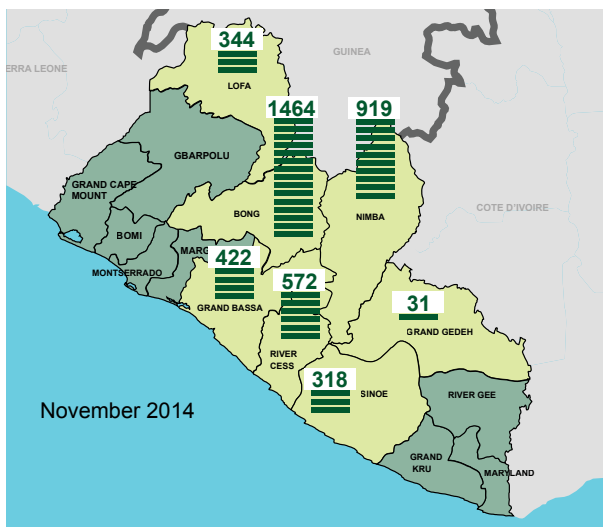
Over the ensuing months Global Communities implemented a social engagement strategy based on:

- Rapid scale-up of relationships with local and traditional leadership, engaging more than 15,000 community leaders for training and messaging support;
- Integrating social engagement into all burial team activities;

- Continuation of CLTS in Ebola hotspots to improve sanitation and hygiene and increase community resilience.

Community Meeting and Dialogue Sessions, our core method of community engagement, introduced awareness of the potential problem and then allowed the community to decide what response strategies work best for them. County health staff, supported by Global Communities, worked with local leadership to conduct these sessions, each of which took approximately half a day. After introducing the topic of Ebola, the Global Communities/MOH team would mediate the subsequent dialogue between community members as they responded to each other's concerns, and came up with strategies of how their own community could react. In the ideal case, each community developed a tailored action plan to ramp up safe hygiene and sanitation practices, monitor changes in the health of community members and institute other mechanisms to help prevent infection.

Responses to this approach varied. In Lofa, Bong and Nimba counties, where Global Communities had developed an extensive network of relationships and hundreds of communities had already undertaken significant community-led behavior change, the social



engagement approach proceeded smoothly. It became evident that sustained face-to-face dialogue efforts were far more effective than simply posting billboards and providing radio messaging about Ebola transmission.

However, in new areas, and where the increase in fear inspired by Ebola also increased resistance to messaging, the basic approach did not suffice. In some cases, teams could not even safely access communities to speak with local leadership.² Although familiar with the communities within their jurisdictions, many county environmental health team members—the local actors with the mandate for sanitation-related community outreach—originated from other areas of the country, or other clans. Additionally, few had been sufficiently supported with resources for preventive health work prior to the outbreak of Ebola, limiting their influence in surrounding communities.

Moreover, where the presence of government officials might demand higher levels of respect among urban populations, those residing in rural environments tended to be farther removed from the influence of the official system. In spite of widespread success in certain communities and with the CLTS process, it became clear that even working closely with local actors like

the EHTs would not open all doors to community trust.

As pockets of resistance emerged in hotspots of Ebola transmission and the stakes for controlling the epidemic rose, it grew more and more imperative that those doors be opened.

² See page 32 for more on challenges faced in the response.





Country Director for Global Communities Liberia, Piet de Vries, receives the title of honorary chief from the National Council of Chiefs and Elders of Liberia for his leadership during the Ebola Outbreak.

Traditional Leaders: Reaching the Hardest-to-Reach

In late 2014, having heard of the work with community engagement and safe burials, members of the National Council of Chiefs and Elders of Liberia approached Global Communities to ask if they could be of help. Global Communities' Liberian staff recognized the Council as a potential missing link in the community engagement approach. They understood that in the more rural areas, where official government influence declined, trust in traditional leadership increased exponentially.

This was a second critical juncture in Global Communities' response efforts. The organization made immediate arrangements to send Paramount Chief Musa Kamara of Lofa County to Grand Cape Mount County where communities of his same clan had experienced multiple deaths from Ebola and were resisting outside intervention. Over several weeks, Chief Kamara visited the leadership and communities in the area, eventually convincing those communities to accept outside assistance and begin the process of behavior change to reduce transmission.

This was a significant moment in overcoming resistance. From that point on, the Council worked closely with Global Communities who, in turn, supported them with training and logistical resources to visit key areas to ensure the acceptance of the social engagement approach and, eventually, the security and effectiveness of safe burial operations.

The Council soon grew to be the source of many important ideas on how to tackle challenges to stopping transmission, many of which had not been considered by the international community, such as engaging “bush schools.” Each year, thousands of youth leave home to attend these camps to prepare for the role of traditional Liberian adulthood. The secretive nature of the rituals and oversight by only spiritual leaders had precluded integrating Ebola prevention into traditional teaching. Although practices in bush schools are not discussed with most outsiders, they are thought to include traditions like male and female circumcision and other practices with high potential to expose the community to Ebola and other infectious diseases.

In January 2015, Global Communities worked with traditional leaders to assist their travel to meet with bush school leaders and encourage them to halt risky practices and teach Ebola prevention until the disease was controlled. As outsiders were allowed no access, traditional leaders were the only individuals with the ability to monitor the bush schools.

Engagement with traditional leaders enabled Global Communities to “surge” trust in areas where previously no outsider could go, and would be vital in the successful operation of burial teams across the country.



Why It Worked: Community Engagement for Ebola Prevention

Trusted relationships with local implementers:

When Ebola began to spread in Liberia, the community connections established in the preceding years proved to be vital in the transition to the fight against the disease. The key to this response was strong and sustained community engagement, as we moved from areas with long-time relationships to new locations where the methods of the original approach proved adaptable.

Flexible strategy and listening to local needs: As the virus continued to spread, Global Communities continued this collaborative effort, remaining flexible and changing focus to meet needs as they emerged. By receiving feedback from national staff, county health teams, traditional and informal leaders and members of the community, messaging and practices could be tailored to meet the diverse needs of each community.

Modified CLTS for community-led Ebola-response:

Prior to Ebola, CLTS had never been identified as a potential means of helping to reduce the spread of an epidemic. Yet, in addition to bringing communities to ODF status, our experience implementing this technique at scale suggests that community engagement with a CLTS approach has several other expanding effects:

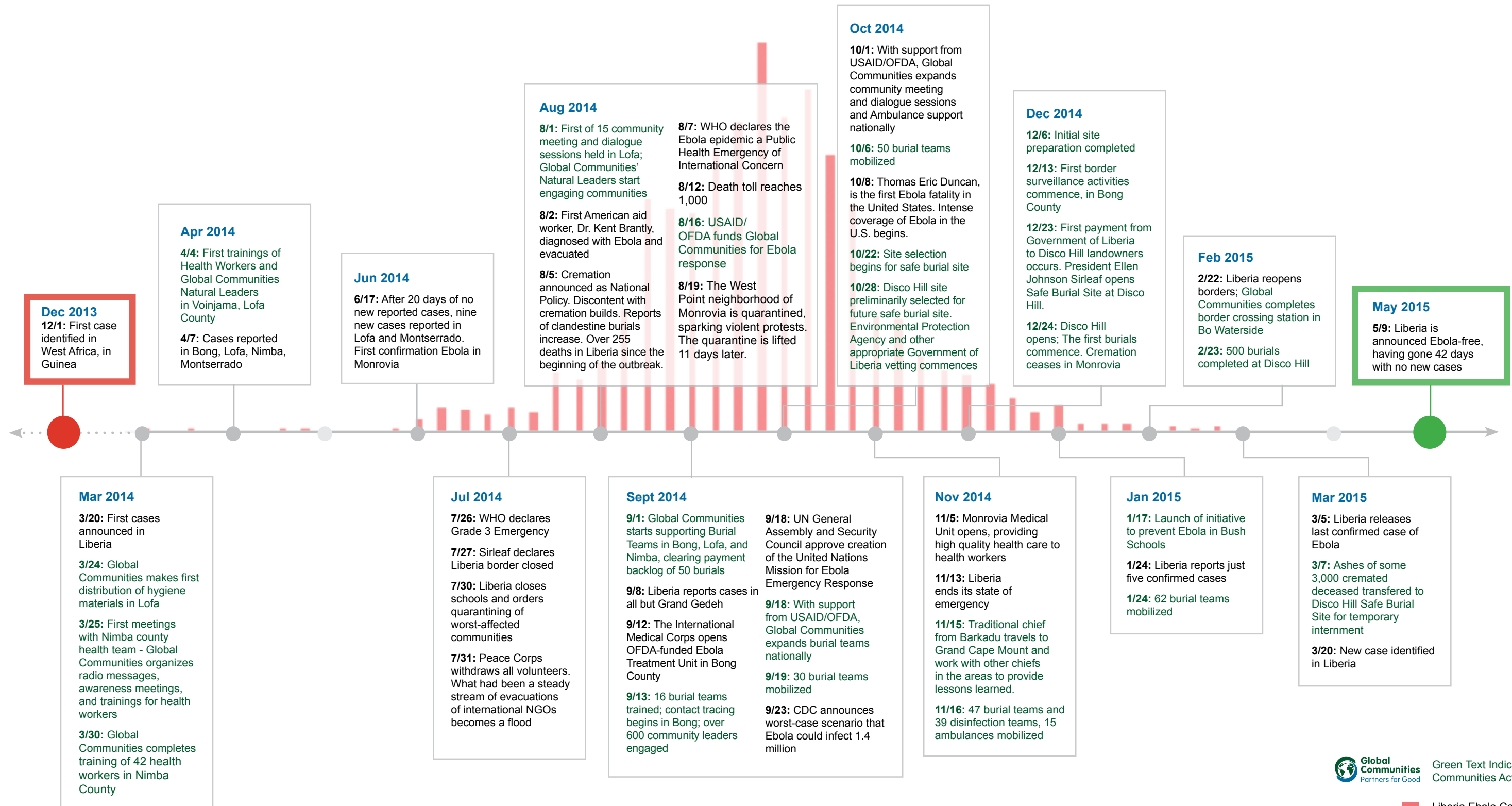
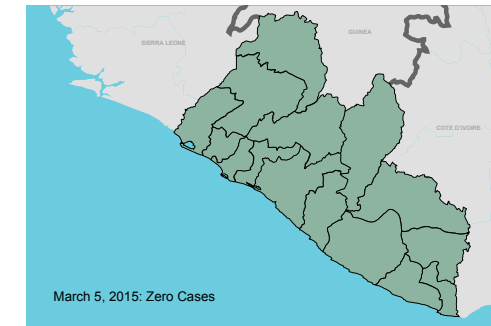
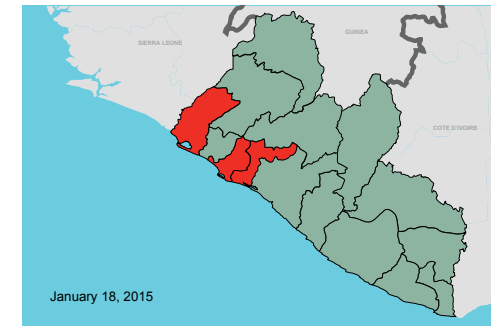
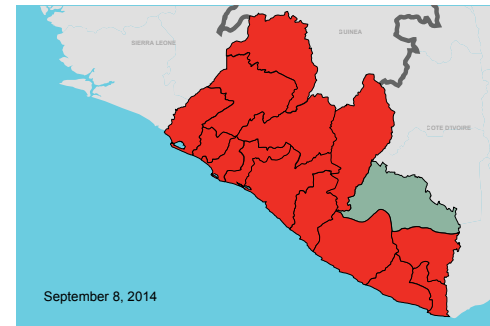
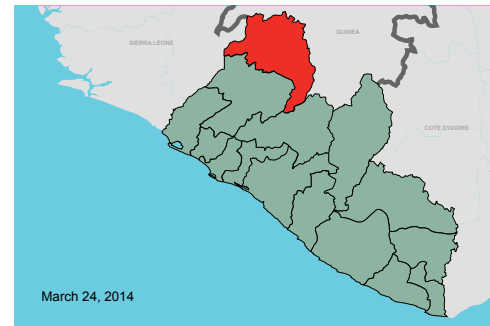
- Increased community trust in self-identified local leaders;

- The development of novel management strategies for community health;
- Increased sense of agency to effect change at the individual and community levels; and
- Increased individual and community ownership over addressing key behaviors and other sometimes intangible influencers of health outcomes.

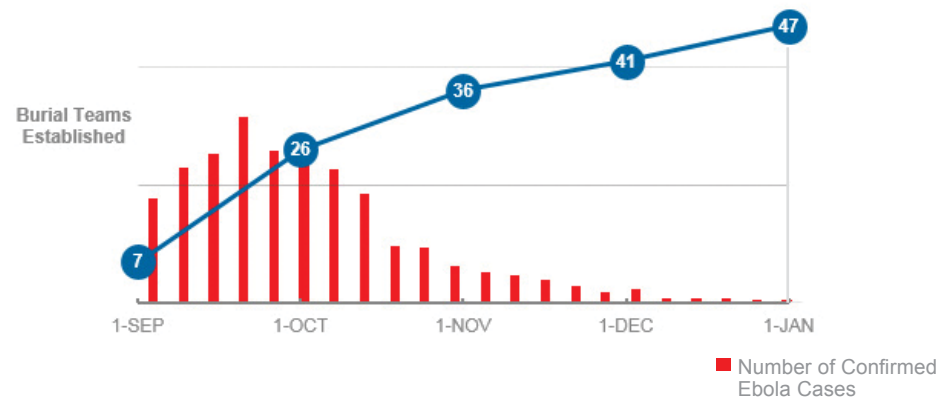
See “Appendix 2: Community-Led Total Sanitation in Liberia: a Protective Mechanism to Increase Community Resilience” on page 41 for more on the role of CLTS in preventing Ebola infection.

Empowerment of local actors for organic scale-up:

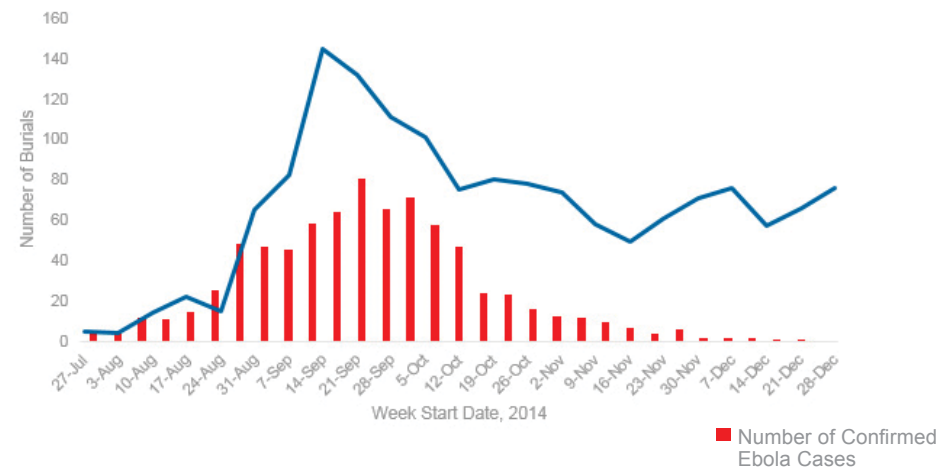
A core component of both the CLTS and social engagement for Ebola process includes capitalizing on existing community assets (such as Natural Leaders) and enabling communities to invest in the resources that they need (such as materials to build latrines, or fencing for the community to monitor all exiting and entering). This results in an empowerment effect that decreases dependency on outside entities. Establishing and supporting networks of community mobilizing agents, supported with appropriate monitoring and supervision, can support rapid mobilization for possible emergency activities while also facilitating future development activities.



Global Communities Established Burial Teams At Height of Ebola Crisis



Total Burials by Week for Counties (except Montserrado)



Percentage by Time Frame of Daily Body Collection by Ebola Response Burial Teams



Key

- # of Hygiene Kits Distributed
- # of Engaged Leaders
- # of Contact Tracers
- # of Ambulances (peak)
- # of Burial Teams (peak)

County	Hygiene Kits	Engaged Leaders	Contact Tracers	Ambulances (peak)	Burial Teams (peak)
Grand Cape Mount	375	267	5	5	
Gbarpolu	525	135	1	5	
Lofa	9,915	1,519	2	7	
Bong	4,097	4,959	51	2	3
Nimba	265	4,299	2	4	
Grand Gedeh	242	1			
River Gee	166	1			

as of September 2015

Key

- Monrovia, Capital
- Guéckédou, Guinea: First Ebola appearance in December 2013
- Foya, Liberia: First Ebola case confirmed on March 24, 2014
- Disco Hill Safe Burial Site
- Border Surveillance & Community-Led Total Sanitation
- Community-Led Total Sanitation
- Open Defecation Free Communities
- Active Community-Led Total Sanitation Communities

as of September 2015



County	Ambulances (peak)	Burial Teams (peak)	Engaged Leaders	Hygiene Kits
Bomi	2	3		
Montserrado	1	13		
Margibi	2	8	240	
Grand Bassa	2	8	681	
Rivercess	2	2	804	1,072
Sinoe	2	2	584	
Grand Kru	2	1	430	
Maryland	1	2	351	



SAFE BURIAL, SCREENING AND BODY MANAGEMENT

With Ebola infections in West Africa on the rise, it quickly became clear that dead body management was a serious problem. Although anyone infected may transmit the Ebola virus from the point of their initial symptoms, the bodies of those who have recently died from Ebola are thought to carry the highest viral load and to be most infectious, making handling of bodies extremely hazardous. U.S. government officials estimated that up to 70 percent of new infections could be attributed to unsafe practices in the management of infected dead bodies.³

Traditional Liberian burial customs exacerbated the threat, with caretakers and families often sleeping in the same room as the body overnight, washing the body and themselves with the same water, and practicing a range of other traditions that, in the context of Ebola, can be lethal. Without adequate information from trusted sources, many families continued these traditions. In West Africa, Ebola grew to be known as a killer of entire families, sometimes nearly emptying villages as it spread and, moreover, seeming to penalize families for the very care and compassion that kept them strong.

At the peak of activities in October 2014, Global Communities managed the process of safe burials in all 15 counties in Liberia through a team of more than 500 safe burial team members, working in partnership with and the MOH and county-level EHTs. In spite of high risk of the work, no burial team member was infected with Ebola.

Safe Burial Teams and Dead Body Management

Once burials were recognized as a major source of infection, county governments asked EHTs to assist with providing safe burials. Unfortunately, these staff had no training in conducting safe burials and no equipment to handle bodies representing biological hazards. Counties could also not afford to pay the EHTs more than a paltry sum, with no hazard pay or incentives. Having identified their most significant need but lacking training, equipment and logistical support, the county health teams approached Global Communities to help train and finance the EHT-led safe burial teams.

³ <http://www.bloomberg.com/news/articles/2014-11-02/ebola-infections-dropping-with-safer-burials-power-says>



Burial teams undertook incredibly difficult work. They entered communities stricken with grief and fear to carry out a task with great sensitivity, often hiking through thick jungle, taking boats or assembling make-shift bridges over bodies of water to reach the families. Both Muslim and Christian burial teams, each adhering to traditional customs as much as possible, were on-call to respond depending on the religion of the family of the deceased.

Each team included at least a team lead (usually a county-level EHT), two drivers, four carriers, and two chlorine sprayers. Burial team members such as carriers and sprayers were incentivized volunteers. Global Communities provided the training to educate staff, contributed a stipend for their work during the emergency, and undertook overall coordination.

By October 2014, Global Communities' safe burial teams covered the entire country, and were able to collect 93% of all identified bodies within one day of death, with collection rates often reaching as high as 98%, no matter the remoteness. All reported bodies were buried by burial teams, not just suspected Ebola cases.

Safe burial teams entered into all kinds of circumstances. In the earliest phases of the response, many collection attempts were met with terror from communities. In some cases, teams arrived to find bodies already washed and dressed—traditionally prepared for burial using the very practices the team and the social engagement strategies

were being employed to stop. Occasionally, teams found freshly dug graves where Ebola victims had already been buried next to empty villages—the victims' family, friends and neighbors—all potential contacts—having fled.

These experiences and other lessons learned during the broader social engagement strategy presented a steep learning curve. Each circumstance demanded incredible sensitivity and delicacy of management; as teams gained more experience trying different techniques to gain community trust, they reported back with suggestions of how to improve the overall strategy. Encouraging this process was fundamental to finding a flexible strategy that could match the many, nuanced needs of the diverse communities in Liberia.

Through this process several important lessons were learned relating to demystification and participatory community engagement. Teams sometimes experienced resistance if they arrived already in personal protective equipment (PPE), so they began instead to arrive dressed in normal clothing. Before attempting to retrieve the body, the team lead would request to speak with the local leaders and any community members who wanted to be part of the conversation. The teams would then enter into a community discussion, which often lasted for hours, about exactly what they are doing and why, welcoming input from community. This approach of community engagement, rather than forced compliance, proved extremely effective at gaining trust and facilitating safe removal of a body.

Once agreed, teams put on PPE in front of the community to ensure transparency and dispel rumors of clandestine actions. Community members who wished to would be invited to wear protective gear similar to the burial teams, and communities would be asked to bring water to mix with the disinfectant. Wearing items such as gloves and face masks, and participating in the process, albeit from a safe distance, helped to demystify the procedures and allowed communities to feel that they had taken the decision themselves to part with the deceased in this manner for the protection of other community members.

Importantly, safe burial teams took swabs from the dead bodies to test for the presence of Ebola. This strategy enabled identification of positive cases and swift follow-up for contact tracing, treatment and care for those subsequently falling ill. Swabbing played a vital role in the broader response, such as in July 2015, when the new cases were identified by a Global Communities burial team swab. However, since the possibility of false negatives exists the swab test alone is an insufficient means of dead body management.

At the time of writing, safe burial teams are now focused predominantly on swabbing and will transition to be directly managed by the MOH (see page 31 for more details).



County	# of Ambulance Services
Bomi	2
Bong	2
Gbarpolu	1
Grand Bassa	2
Grand Cape Mt.	5
Grand Kru	2
Lofa	2
Margibi	2
Maryland	1
Montserrado	1
Nimba	2
Rivercess	2
Sinoe	2
Total	26

Ambulance Services

Safe burial teams expanding to new areas of Liberia often arrived before any other Ebola services—including care and treatment for the ill. In one community in southeastern Liberia, frustrated residents accosted a burial team, asking why help only arrived when someone died. Why was there no help for those who were sick with the disease? At the time the Global Communities' burial teams were the only active Ebola responders operating in southeast Liberia.

The concerns of the community inspired Global Communities to find solutions. Working with county health teams and OFDA, the program found ambulances for counties that needed them. With appropriate vehicles in high demand, the provision of an “ambulance” often took creativity. Teams retrofitted vehicles, installing protective measures such as plexiglass barriers to separate drivers and patients as during the outbreak many drivers of taxis, motorcycles and other transport had fallen sick after transporting passengers with Ebola symptoms.

By January 2015, the ambulance fleet contained 26 vehicles across 13 counties and, in the disarray of a health system crippled with closures, was one of only a handful of operating ambulance services equipped to handle Ebola-suspected patients nationwide.

Hotspot Management

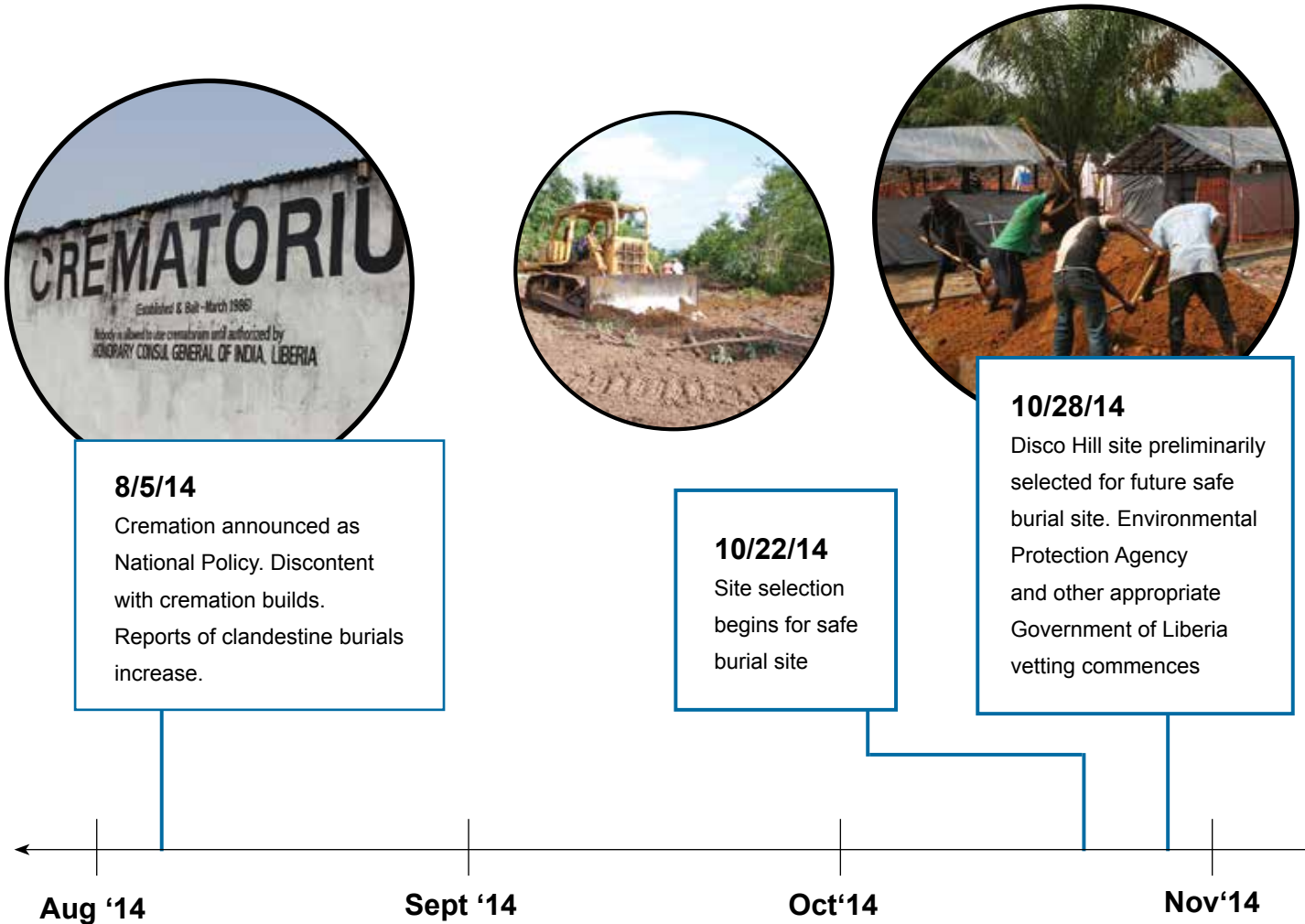
Most international organizations providing support during the epidemic focused on Montserrado County, one of the most accessible areas and also the location of the capital city, Monrovia, which experienced high Ebola caseloads from summer 2014 onwards. During the last months of 2014, cases in rural Liberia plunged to zero in most counties, while in Monrovia infection rates remained stubbornly high. With fear dominating the city many people fled, including contacts of Ebola victims and those already exhibiting symptoms. In the course of this movement, new hotspots appeared outside of Montserrado County, as the arrival of an Ebola case led to infections in that area.

Already operating in rural areas, and with strong relationships throughout, Global Communities set up a mobile system of rapid isolation and treatment for Ebola around these hotspots as they emerged. Global Communities prepositioned services around hotspots, specifically providing dead body management, as well

as, where not otherwise available, contact tracing, transport to Ebola treatment units and provision of water through hand-pump repair.

As Ebola cases declined towards the end of January 2014, Montserrado County remained a transmission hotspot. In response to the moving target of corralling the epidemic, the GOL and OFDA requested that Global Communities expand its focus to the capital city, taking over the Ebola case management for Sector 4, one of the geographic designations determined by the government. Working closely with the International Rescue Committee (IRC), which headed the Montserrado consortium, Global Communities began oversight of sector 4, which meant outfitting Ebola Operational Centers, directing activities and analyzing the response, and supporting GOL and other key actors for their work with contact tracing and active case finding.





Opening an Official Burial Site at Disco Hill

With a densely clustered population of more than 1.2 million, respectful, acceptable and practical means of disposing of dead bodies remained one of the most significant challenges to ending the transmission of Ebola in Monrovia. Whereas safe burials continued to be feasible in rural areas with low population densities, the high daily numbers of deaths and a lack of open land in Monrovia had pushed the GOL in August 2014 to requisition a crematorium to manage all dead bodies.

Alien to Liberian traditions, the threat posed by the idea of cremation only added to the fears associated with strangers in odd garb taking away loved ones who were often never seen again. Liberian tradition dictates that families make annual pilgrimages to visit the graves of their ancestors; with bodies incinerated and remains buried in large collective bins, no pilgrimage site remained which created a perception

of disrespect. Many Monrovia residents therefore resisted seeking care for sick family members or handing over the bodies of those who had died, significantly increasing the risk of ongoing transmission.

The push to create an official safe burial site for Montserrado County—though supported and recognized as a need by many—really came to fruition through Global Communities’ partnership with the traditional leadership. Greatly disturbed by the cremations, traditional leaders sent out urgent calls to their associated communities in Montserrado County to find suitable land. Multiple possibilities were identified, and the participation of traditional leadership framed the search in a way that ensured local support for the location of the burial site. Eventually, teams identified an appropriate site for purchase by the GOL.



12/6/14

Initial site preparation completed

12/23/14

First payment from Government of Liberia to Disco Hill landowners occurs. President Ellen Johnson Sirleaf opens Safe Burial Site at Disco Hill. The next day, the first burials commence, and cremation ceases

2/23/15

500 burials completed at Disco Hill

Dec '14

Jan '15

Feb '15

In November 2014, with more than 40 cremations taking place daily, Global Communities began construction on the 25 acre plot of land, an overgrown plantation known as Disco Hill. The site includes space for up to an estimated 5,000 burials, and by community requests has separate sections for both Christian and Muslim burials, with the Muslim section positioned to face Mecca. On December 23, 2014, President Ellen Johnson Sirleaf inaugurated the opening of the Disco Hill site.

The remains of those who were cremated between August and the opening of the site in late December are also interred in a separate building on the grounds. In March 2015 traditional leaders presided over a burial ceremony for the first group of transferred remains, performing the burial rites that had originally been denied those who lost their lives during this time, helping provide some closure

for families and offering the possibility of having a physical location for annual pilgrimage.

There are also plans to make the site a national cemetery and to establish a monument with the names of all those cremated before the site's opening.

The burial ground ended the requirement for cremation and helped reduce resistance of those families afraid to part with the bodies of their loved ones. The site at Disco Hill also represents the importance of working with communities and traditional leaders to understanding shifting needs, and to find solutions that are not only pragmatic or efficient in the context of a humanitarian response but also uphold human dignity and honor traditions for those who are still living.

Why It Worked: Safe Burials and Dead Body Management

Social engagement and trusted local leaders:

Traditional and local leaders and EHTs were central to Global Communities' approach, as they had been with our earlier CLTS work. These local actors took the lead in engaging with communities, using long-standing positions of trust and respect to persuade families to change behavior for health and disease prevention. In many cases, it was the blessing of these local leaders that allowed the burial teams to safely remove victims.

Rapid response to community-identified needs:

The management of dead bodies began with a single objective—safely collect the bodies of those who have died from Ebola, and contribute to improving safe burial practices. But through implementation of a community-engagement strategy, Global Communities was able to identify other needs equally important to safe body management as our approach led to community trust and increased the likelihood of community participation in prevention measures. As a result of community dialogue, Global Communities responded

with further social engagement, ambulance services, hotspot management and creation of a safe burial site in Montserrado. All of these interventions arose from discussion with the communities themselves, and helped to smooth the success of an integrated Ebola response.

Creating the space for ownership and pride:

Participatory methods and responding rapidly to community requests demonstrate respect and trust in the knowledge and capacity of communities. Those that were instrumental in this process—particularly the traditional leadership—gained a vital sense of ownership and pride in the outcomes. In providing logistical support, technical assistance and high-level negotiations, Global Communities facilitated the deployment of strong, but under-resourced, community capacity. In sharing the process of identifying problems, Global Communities also shared the outcomes of celebrating solutions, building a legacy of trust in these areas.



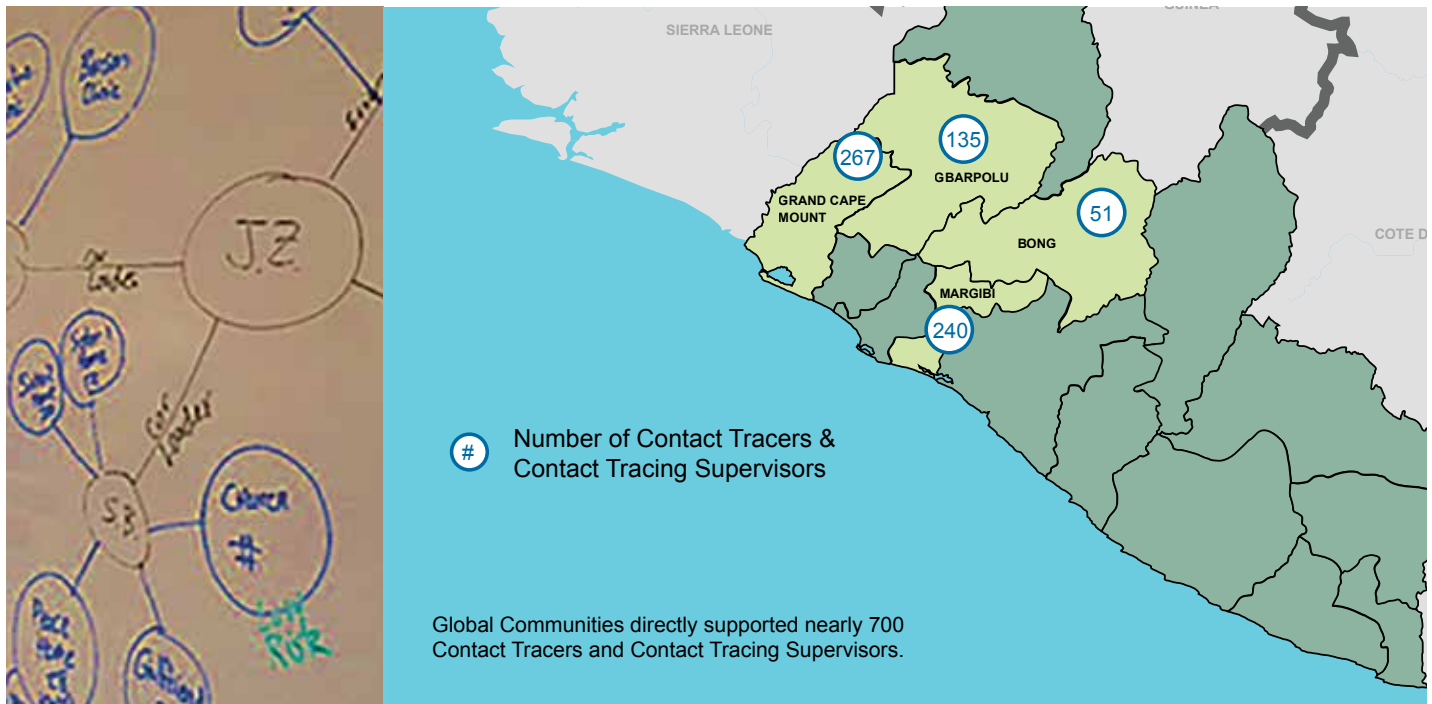
Urban Ebola

While Ebola spread rapidly in both rural and urban settings, urban environments cause particular challenges as newly urbanized populations often bring with them practices at odds with conditions of high population density such as open defecation and poor hygiene practices, the impacts of which are magnified in a densely populated environment.

The capital city of Monrovia proved to be a particularly challenging environment for the Ebola response. Many of the responses of the GOL, such as the cremation policy and quarantining entire areas of the city, were considered counter-productive and significant efforts were later required to overcome the negative reactions of the populace. Coordination of the various actors, national and international, was also extremely difficult. And while safe burials were possible in sparsely populated rural environments, they were not initially possible in Monrovia, which has one-quarter of the total population of Liberia. All of this led to a serious spike in infections which proved difficult to counter.

A different approach was required in Monrovia. The GOL, through the coordination of the Incident Management System (IMS), organized Monrovia into several geographic sectors and designated different NGOs to manage each sector. Each organization was responsible for receiving information about any deaths or potential Ebola cases in their areas, coordinating the active tracing of potential and confirmed contacts for 21 days, ensuring that the deceased were swabbed and samples sent to the labs for testing, and that the bodies were buried safely. Each partner was also responsible for reporting all case figures into the national system in a timely manner, so that sector, city, county and country wide data could be collated by GOL, WHO, and CDC working within the IMS. Global Communities worked in partnership with the IRC in a consortium, coordinating with the IRC and other partners to ensure an integrated approach to meeting the full health needs of communities throughout the city. This consortium mode of operations is now being continued in the new USAID Partnership for Advancing Community-based Service (PACS) program (see page 31).

CONTACT TRACING AND BORDER SURVEILLANCE



Contact Tracing and Active Case Search

While working in Bong County on safe body management and social engagement, the county health team approached Global Communities to ask for support with contact tracing. Global Communities began contact tracing in the county, but when infections from Bong spilled over to Gbarpolu, so did Global Communities' contact tracing efforts as Gbarpolu also lacked a partner for this activity. The project continued to support contact tracing where requested, eventually working also in Grand Cape Mount, Margibi and Rivercess. In partnership with IRC, Global Communities also worked in Sector 4 Hub, a division of Montserrado County's Ebola response system, to coordinate contact tracing and active case search.

Effective case investigation and contact tracing was crucial to stem the tide of Ebola. For those infected with Ebola, receiving early care and treatment improves the likelihood of survival, and limiting the movements of those who may be infected and monitoring them for symptoms during the 21-day incubation period reduces the likelihood of transmission to more potential victims.

Contact tracing requires teams to work like detectives, retracing each step of a known Ebola patient from the point of their exhibition of symptoms to identify individuals who might have been exposed. This work is particularly challenging in a complex environment, often including finding taxi drivers, medical workers, and even strangers who, acting as good Samaritans, might have assisted a sick individual.

Border Surveillance

By February 2015, Ebola was rapidly declining in Liberia. But with the virus still raging in neighboring countries, the need to prevent cross-border transmission became critical. For many communities, the re-opening of the borders and re-emergence of cross-border trade would play a vital role in restoring lost livelihoods.

With approximately 40 official border crossings, countless unofficial entry points, several hundred villages on or near Liberia's borders with Sierra Leone and Guinea, and fluidity of travel between the three countries, border surveillance posed an immense challenge. Many communities, families and ethnic groups also span borders, which made collaboration between the Liberian government, community leaders and traditional leaders along the entire border essential to keeping the country safe.

In this context, Global Communities developed a coordinated strategy to implement a cross-border monitoring system. This involved engaging and supporting community health workers and leaders in 350 communities, including implementing CLTS in 175, across five border counties by the end of October 2015. Health workers attend regular, weekly meetings to discuss border health surveillance and record cross-border traveler movement

in ledgers, while establishing more than 25 triage/isolation checkpoints at formal border crossings.

The idea behind this strategy was based in part on what seemed to be a protective effect demonstrated by CLTS-triggered and ODF communities against Ebola infection (see page 41). Implementing the method in border communities could create a "hygiene barrier," a buffer zone to protect both sides of the border. With many of these communities sharing social, economic and cultural ties to Sierra Leone and Guinea, the CLTS modifications of deploying trusted, local Natural Leaders for continued messaging and triggering became even more critical.

Global Communities also worked with communities to mobilize volunteers for county health teams who were charged with staffing screening posts at border crossings. Screening posts consist of booths for temperature checking, hand-washing stations, disinfection teams, and quarantine rooms for suspected cases.

Implementing these hygiene and screening activities along the border enabled the re-establishment of cross-border trade and routine movements to assist Liberia in its return to the "new normal," where the risk of Ebola remains.





Why it Worked: Contact Tracing and Border Surveillance

After the peak of infections had passed it became essential to reduce transmission from community to community. And as Liberia drew closer to zero infections, it also became essential to ensure that infections did not cross the porous borders with Guinea and Sierra Leone.

Investing in community networks to reduce infection:

Effective contact tracing depends upon careful community engagement and trust. Through the relationships Global Communities had developed, we were first invited to undertake contact tracing and then able to effectively track down and isolate contacts, even in cases of, for example, gang violence. Without investing in community engagement, contacts were less likely to come forward and receive early isolation and treatment.

Creating a hygiene barrier:

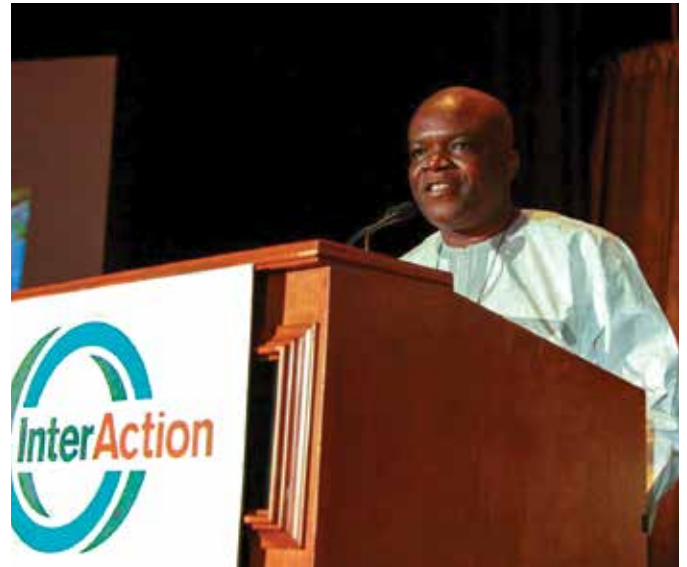
With porous borders and unofficial crossings, it is essential that the communities living along the border are empowered to protect themselves and able to identify potential Ebola cases. As well as formal measures, Global Communities was able to use our experience with CLTS (see page 41) as a community preventative health measure to empower communities to create a hygiene barrier through behavior change. This barrier is not only an effective response short-term, but builds resilience against future cross-border outbreaks that may come.

CONCLUSION: NEXT STEPS and LESSONS LEARNED

Next Steps: October 2015 - Onwards

At the time of writing (October 2015) Liberia is currently Ebola-free and Sierra Leone has been declared free of active Ebola infections. Global Communities and our partners nevertheless remains active and vigilant. Ebola is likely present in natural reservoirs among wildlife in Liberia and there is still the possibility of re-emergence from transmission, unknown cases, or cross-border movement from Guinea.

Prior to the Ebola crisis, Global Communities was undertaking programs considered developmental—focused on economic growth, long-term resilience building and health-improvement. During the crisis, our work shifted to emergency response—an immediate, rapid and flexibly changing response to a crisis. A year after the peak of the crisis, Global Communities and Liberia more broadly are moving back into a development approach, focusing again on resilience and community-based preventative health. This development-relief-development continuum is one Global Communities has effectively managed previously in Colombia and Haiti, and now in Liberia.



In June 2015, Global Communities' George Woryonwon received the InterAction 2015 Humanitarian Award for his work assisting communities in Liberia to contain and prevent Ebola.

A community celebrates the elimination of all Ebola cases in Liberia in May 2015







CLTS, EHTs and Community-Based Preventative Health

Since June 2015, Global Communities has been implementing the five-year PACS project in Lofa, Bong and Nimba Counties with funding from USAID. The project builds on Global Communities' experience in Liberia implementing the USAID-funded IWASH program. The PACS project aims to support sustainable country ownership of community-based health, social welfare, and WASH services. Working with partners, IRC and Population Services International, the project is helping to broaden the capacity of the MOH by working with its community health teams and community organizations to implement and manage community services, increase availability of community-based health and social welfare services, and improve health-seeking behaviors and practices among communities.

Through PACS, Global Communities is expanding its CLTS work and continuing to put the EHTs and community health teams at the center of our health system strengthening strategy.

Dead Body Management, Swabbing and Border Surveillance

As Ebola wanes in West Africa, the emergency border surveillance activities are gradually winding down. However, Global Communities still plays an important role in dead body management throughout the country, with the teams gradually transitioning to swabbing teams. This continued monitoring proved vital in identifying the brief resurgence of clusters in July 2015, when Global Communities-supported swabbing activities identified the new clusters. Safe burials and dead body swabbing will continue, and Global Communities will support the transition of the direct management of these activities to the MOH. Global Communities continues and will continue for the foreseeable future to be a partner for good for the GOL, staying the course in assisting Liberian communities to direct their own development.

For more information on Global Communities work in Liberia, visit www.globalcommunities.org/liberia

CHALLENGES AND ADAPTATIONS

Global Communities experienced a number of challenges during the Ebola response that informed adaptations and fed into the overall response strategy.

Resistance in Rivercess

With trust established through previous programming, Global Communities experienced minimal community resistance in Bong, Lofa and Nimba counties. In southeastern counties where we did not have an existing network of relationships, however, teams experienced sometimes violent resistance. Still fearful and having had little prior interaction with Ebola responders, community members in Rivercess damaged vehicles and attacked Global Communities staff with stones. Likewise, in Margibi, teams were attacked.

Global Communities' burial teams quickly realized that this was because they were collecting dead bodies with no prior engagement with communities. No significant government or NGO outreach had occurred in the region, and the southeast's first Ebola cases had recently occurred. This inspired the establishment of ambulance teams in those counties, so that help came when infected people were still alive, not just when they died. And the whole experience led to a new community engagement strategy that involved all sectors of society in an effort to "surge" trust. The relationship with the traditional leaders was essential here; chiefs would enter a community with the county health teams, creating a trusted link where there was little trust in government or in outside intervention of any sort (see page 13 for more on engaging traditional leaders).

Muslim Burial Teams

Liberia's population contains a significant Muslim minority at around 12% of the population, dispersed throughout the country with some concentration in the west. All burial teams were composed similarly until Global Communities experienced resistance from Muslim communities in Gbarpolu. With advisement from religious leaders, Global Communities developed and deployed special Muslim burial teams that were staffed by Muslim Liberians and trained to be compliant with Muslim burial traditions. This sensitized our teams to the diversity of religious, cultural and other traditional norms within close geographic proximity, and ensured that a Muslim-specific burial area at Disco Hill was planned from the beginning.

Delays at Disco Hill

The Disco Hill safe burial site reduced resistance linked to cremation. But there were significant delays in its opening while the land-owners awaited payment for the site. The land was quickly identified and prepared, but U.S. government regulations dictated that the GOL needed to purchase the land, not USAID/OFDA or Global Communities. Eventually, with the advocacy of U.S. Senator Chris Coons, the GOL was able to organize the purchase of the land so that safe burials could proceed, but the challenge with finding a funding mechanism for land payment further slowed down the process by several weeks.

Coordination – Government Versus International Aid Structures

Global Communities' response was closely integrated with the GOL, especially the MOH and county health teams. The GOL was Global Communities' primary partner in implementation and strategy, with USAID as the primary donor. This did, however, present some coordination challenges, as the majority of UN and NGOs coordinated independently from the GOL, and centered their operations in Monrovia. The latter is a standard approach in emergency response.

Nevertheless, Global Communities did coordinate with other organizations, especially in swabbing and testing of dead bodies, for example, and played a role in helping those organizations to coordinate with the GOL. Global Communities recommends that country governments, where functioning, play a central role in all coordination in emergencies, to reduce overlap of activities, to counter preconceived notions, and to inform strategies with local knowledge.

Lessons Learned

Global Communities' strategy in fighting Ebola was not to drop in from the outside and fix the situation. Working through local actors and constantly revising our strategy meant that the response was locally driven and locally implemented in partnership with Liberian stakeholders and health teams.

The central tenets of our response were:

- scaling up from existing relationships and networks to develop a country-wide response;
- adapting strategies to meet the changing trajectory of the disease;
- building on existing local capacity where possible—and simultaneously further building capacity;
- listening to needs expressed by those closest to the disease and adapting appropriately.

From this experience, Global Communities has drawn a number of lessons learned, as follows:

Stopping Epidemics Requires Effective Community Engagement

Responding to an epidemic requires a different set of approaches than for other kinds of humanitarian emergencies. Infectious diseases follow the patterns of daily social movements and interactions; stopping the spread of disease requires the development of strategies to engage communities in rapid behavior change. Attempts to force behavior change resulted in widespread resistance with the opposite outcome from what was intended. Global Communities believes the results of our Ebola response demonstrate the possibility of deploying scalable and highly effective social engagement strategies to enable community-led action for improved health behaviors and community resilience.

Preventative Health through Improved Sanitation

Safe burials and dead body management were extremely effective in reducing the rate of infection in Liberia. But the most effective method of overall prevention, in Global Communities' experience, was our prior work in CLTS in

Bong, Nimba and Lofa counties. The 284 communities that were certified ODF by Global Communities prior to the crisis were also Ebola free, despite being surrounded by Ebola hotspots. Additionally, communities that began the CLTS process but never finished it were 17 times less likely to experience Ebola infection. This research is detailed in a separate report by Global Communities.⁴

Disease spreads at the community level and must therefore be combated at the community level. Clinical infrastructure is extremely expensive. Community-led sanitation initiatives are not. Any curative health system strengthening work must be complemented by preventative approaches, such as CLTS, which guard against not only Ebola but also cholera, dysentery, diarrheal diseases and many other illnesses that are endemic throughout much of the world.

Read more about CLTS in Appendix 2, page 41.

⁴ See "Open Defecation Status, Community-Led Total Sanitation and Ebola Virus Disease (EVD) in Voinjama and Kolahun Health Districts, Lofa County, Liberia (2014)," June 2015, Jean Meyer Capps and Haron Njiru http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report_081015.pdf

Enhance Local Systems

Emergency responders should work through indigenous systems—whether community, traditional and religious or through county and national government. By working through these structures responders can gain local knowledge and simultaneously build the capacity of the people who will be in place to deal with future crises.

Even at the earliest stage of an emergency, a localized response can begin putting in place the future knowledge, skills and structures that will build resilience and make future disasters—Ebola or others—manageable. There need not be a division between "humanitarian assistance" and "development assistance" if the response is driven through local structures. And by working through people already known to the communities, trust can be quickly established and barriers to trust are overcome with cultural sensitivity.



Children in the town of Rick's Farm in Liberia use a hand washing station during a CLTS meeting

Environmental Health Technicians

Most countries in Africa and many in the world have a county-level EHT system in place to a greater or lesser degree. These EHTs were at the center of our approach. The EHTs were able to undertake large-scale community education, they were able to adapt to become burial teams, and they were able to become border surveillance and contact tracing experts. These local experts should be understood in the future as a vital resource in fighting disease at the community level and putting prevention into practice. At the same time, EHT capacity varied widely. Building their capacity should be a priority for health interventions.

Flexibility

Responders must experiment and continually assess what more can be done. They must be open to suggestions from all quarters, especially from the community and other sources of local knowledge. Many organizations have a specific area of expertise, but they should not seek to bend the crisis to fit their expertise; they should bend their expertise to fit the crisis.

Brute Force Implementation

In an age when every latest technological innovation is heralded as a silver bullet to one problem or another, it is worth noting that the Ebola response was an example where the most effective strategies could be considered “brute-force” strategies: it took 500 people engaged in burial and disinfection teams, 15,000 community leaders engaged in education/action planning in five months; hundreds of vehicles used in getting our responders to all ends of Liberia; and a donor willing to support this work to the scale it needed. No form of engagement was more effective than face-to-face discussion, and there are no technological short-cuts for safe burial and body management. This was not a crisis solved by new technologies and innovations, but by an enormous amount of human and other resources.

GLOBAL COMMUNITIES EBOLA RESPONSE— IN THE WORDS OF OTHERS



In October, when I got back from West Africa, folks were panicked across the board and I couldn't even go to my kids' soccer game that weekend because, you know, people were just anxious and nervous.

There were 120 or about 120 new cases of Ebola a day in Liberia when I was in West Africa a few months ago. Today, there's less than one. That didn't just happen.



Dr. Rajiv Shah at the Brookings Institute. Photo Credit: Brookings.edu

I know the *Washington Post* and the *New York Times* will make it seem like it's just a random occurrence.

It's not.

It happened because America invested a billion dollars. It happened because American service personnel created the mindset of safety and purpose. It happened because our health professionals just rushed in. **It happened because an NGO we had supported not just for the Ebola fight, but for five years prior, called Global Communities was already working in Ebola-affected communities and they came up with the concept of trusted burial teams that could remove dead bodies from the setting very quickly and efficiently and respectfully. And you saw the main vector of transmission just caused the disease to go straight down. No one expected that.**

People who do this work have an expertise and a commitment to it and they absolutely make our country safer and more secure. ”

—Dr. Rajiv Shah, USAID Administrator, February 3, 2015, at the Brookings Institution



“ What is clear in retrospect is that we did not isolate our way out of this crisis; we behavior changed our way out of this crisis. And it was through behavior change at scale, which was really community driven, that the epi-curve started bending downwards.

And the burials, I agree, are a great example of that dynamic and why the cultural aspects are so important. There were some burial teams that were highly successful right from the beginning and in Liberia our main partner working on the burial teams was Global Communities. And the reason their teams were very successful was because they built that program on the framework of an existing community based water and sanitation program. And so they were building those teams on community networks that already existed, using those community contacts and ensuring that the communities themselves were the owners of that team, rather than some NGO vehicle coming in from outside that no one knew.

And so that meant that the teams were being staffed by people who actually were from the communities, knew how the communities would react, and could design the intervention with that in mind. And they were much more successful right from the get-go than some of the others where it was more like aliens showing up from another planet.

So it is a really important point, not just for this response, but more generally for what we do in the humanitarian response field, which is: the intervention, if it doesn't take account of the cultural context, will not succeed. So you can't take an intervention based just on the science or the tech or whatever, and then fail to consider how it will interact with the local context or it will not succeed.”

—Jeremy Konyndyk, Director, USAID Office of U.S. Foreign Disaster Assistance
“What Ebola tells us about aid,” October 16, 2015, ICRC Humanitarian, Geneva, Switzerland

“ Brett [Sedgewick] went to Liberia with Global Communities, which is an NGO that partnered with us to respond to Ebola. Brett supported safe burial teams that traveled to far-flung corners of Liberia to ensure that those who lost their lives to Ebola were carefully, safely and respectfully buried so that they could not transmit the disease to anyone else. And Brett reflects the spirit of many volunteers when he said, ‘If you need me, just say the word’. That’s a simple but profound statement. That’s who we are. Big-hearted and optimistic. Reflecting the can-do spirit of American people. That’s our willingness to help those in need. ”

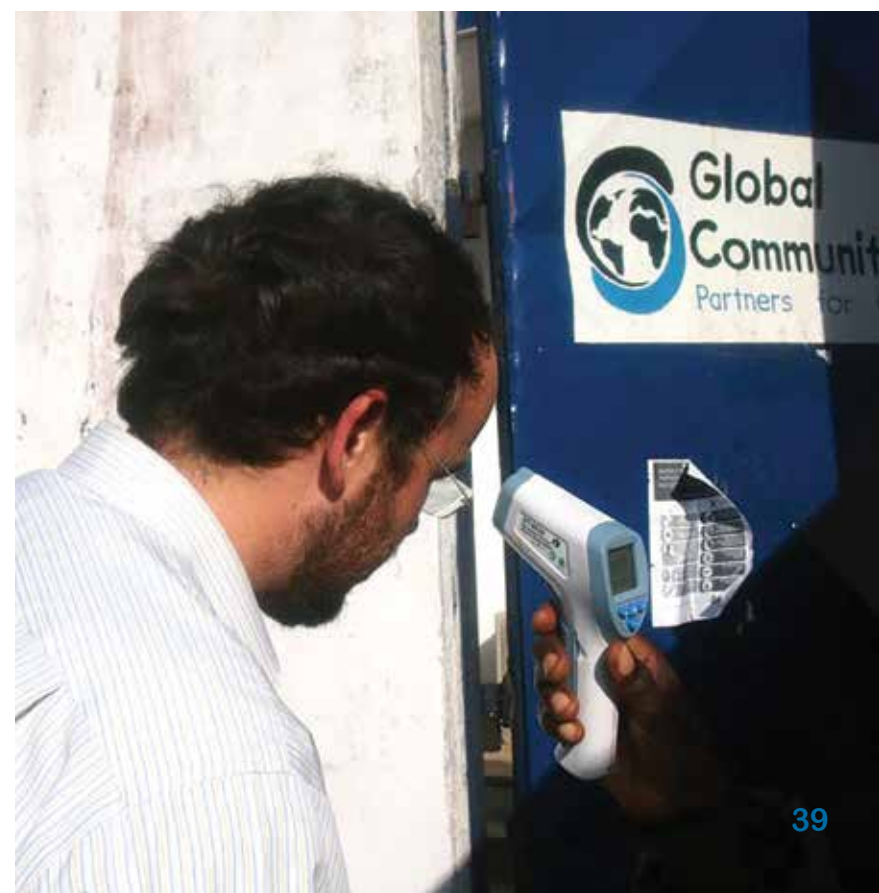
—President Barack Obama, February 11, 2015,
White House press briefing on “Getting to Zero”

Brett Sedgewick (top right) represents Global Communities at President Obama’s Ebola Response Briefing. Photo Credit: White House





PHOTO: Peter Biro/ICRC



Appendix 1: Why community development?

Most operating theories of international aid assume that community-based development methods are too cumbersome and their strengths too dependent on long-term engagement to be effective strategies for use in emergency response. Instead, top-down strategies that deploy international experts and leverage significant external resources are put in place, even if so doing comes at the expense of all but the most necessary community buy-in.

This approach unfortunately does not address the underlying contributors to and causes of a given disaster. These challenges are generally left to the “post- emergency phase” when diplomacy, trade and investment, bilateral aid and international NGOs are meant to engage in long-term development of a country or a region.

The distinction of pre-, during- and post-disaster phases presumes a linearity that rarely exists. Although rapid scale-up of international attention and resources is absolutely integral to an effective emergency response, neither the continuum of a country’s health and vulnerability nor the effective deployment of international aid is well-served by this reductionist understanding of disaster.

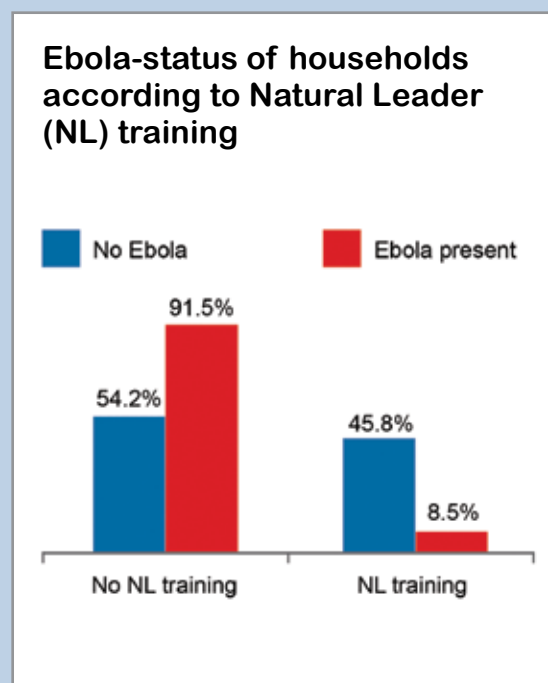
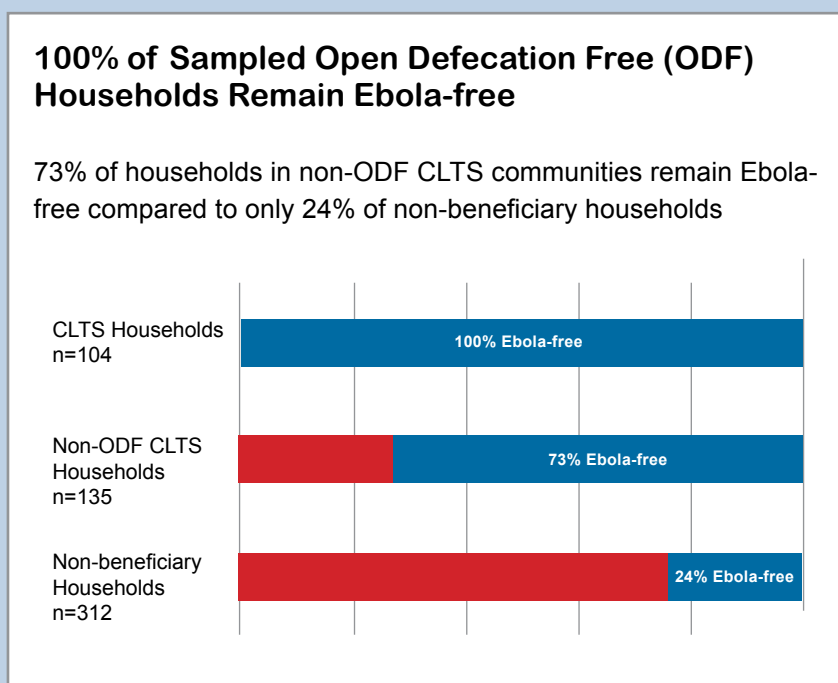
This is especially acute in the context of an infectious disease epidemic. Diseases diffuse across social networks and spread by intimate connections between groups of people. Diseases thrive in the context of instability and high individual and collective vulnerability; halting infection requires not only targeted interventions at strategic junctures (e.g. closing schools, hand-washing campaigns) but also widespread behavior change on the part of individuals, something which cannot be imposed by external actors, whether government or aid organizations.

Inspiring durable behavior change is notoriously complicated but previous lessons learned have demonstrated that forced behavior change more often than not results in covert actions that strengthen mechanisms of disease propagation rather than reduce them. Methods of community development and participation which are predicated upon community buy-in to behavior change have much to contribute in addressing the underlying vulnerabilities that make crises and poverty so conducive to disease propagation.

Global Communities’ experience in Liberia provides one example of how global health and development organizations can leverage existing networks of trust and social capital for at-scale response during an active humanitarian crisis to both protect populations at a critical juncture, and also develop long-term community resilience through remediation of underlying vulnerabilities.

Appendix 2: Community-Led Total Sanitation in Liberia: a Protective Mechanism to Increase Community Resilience

Despite being surrounded by Ebola hotspots, all 284 ODF-verified communities that went through CLTS prior to the outbreak—and many more villages that became ODF during the outbreak—reported remaining Ebola-free throughout the crisis. Villages that had even begun the CLTS process as part of our programs but did not reach ODF status were still 17 times less likely to experience an Ebola infection than those with no CLTS training at all. Global Communities is continuing CLTS work in Liberia due, in part, to this compelling evidence that suggests a relationship between community-led sanitation and hygiene activities and increased community resilience.



Source: "Open Defecation Status, Community-Led Total Sanitation and Ebola Virus Disease (EVD) in Voinjama and Kolahun Health Districts, Lofa County, Liberia (2014)," June 2015, Jean Meyer Capps and Haron Njiru http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report_081015.pdf

CLTS was pioneered by Kamal Kar in Bangladesh in 2000. Over the ensuing 15 years, it has become known as a powerful method of rapid behavior change for improved sanitation and hygiene. CLTS reduces morbidity and mortality due to illnesses that spread through feces, urine, and generally poor conditions and practices of sanitation and hygiene.

Although better sanitation and hygiene has long been understood as key for better health, the distinction with the CLTS method is to use participatory techniques that both increase awareness of disease transmission pathways and work through the pairing of emotional reactions with external monitoring. CLTS leads communities through a process that results in the identification of open defecation as a problem and then, without determining



the direction or correct localized response, provides continuous monitoring and encouragement as communities develop their own solutions to open defecation.

CLTS leverages social dynamics that exist in many human societies:

- Social networks of trust—using trusted local leaders to initiate the process of community engagement,
- Powerful human reactions—shame, disgust, pride, desire for social cohesion; and
- The inclination towards continuity of belief systems—the kinds of behavior change required through CLTS to ultimately improve health outcomes are not dependent on the adoption of new/different belief systems about the mechanisms of disease transmission but rather on social pressure and the emotional reactions of

disgust, shame or embarrassment at being shown the results of open defecation.

Global Communities recognized that these social dynamics could be improved to make the CLTS strategy more effective. With USAID support and in partnership with the Liberian MOH, Global Communities developed several key adaptations to the original CLTS strategy, including creation of the:

- **Natural Leader Network (NLN):** Natural Leaders are those people who, during the CLTS process, emerge spontaneously as the most passionate and influential to fellow community members. Although Natural Leaders are part of standard CLTS, Global Communities decided to form these Natural Leaders into local networks; working in pairs Natural Leaders are encouraged to move into neighboring communities to “trigger” them for the CLTS process. As the Natural

Leaders pair brings each subsequent community to ODF status—and graduate to become Community Champions—they receive cash bonuses and are eligible for training as WASH entrepreneurs. The NLN strategy is cost-effective, costing as little as \$130 per community, and makes use of micro-analysis for success: each pair of Natural Leaders will use their local knowledge and their own social networks to choose those communities they are most likely to be able to influence, leading to higher success rates as “insiders” take the process into their own hands.

- **Network Diffusion Model:** rather than launching CLTS wherever is most convenient, the diffusion model prioritizes launching the program in small, cohesive populations with high sanitation needs and demonstrated strong leadership; as ODF communities arise, the NLN—paired with technical assistance and consistent monitoring from government actors and the program—diffuses to neighboring communities in the cluster.
- **WASH entrepreneurs:** As Natural Leaders graduate to the status of Community Champions, the program provides training in business skills that will support the sustainability of improved water, sanitation and

hygiene, such as operation and maintenance for hand pumps or boreholes, soap manufacturing, and small business management for hygiene products. This training helps to both provide continuing livelihoods work for Natural Leaders once 100% of communities are triggered, and to meet the newly-created market demand for hygiene supply.

- **Integrated social marketing that leverages the NLN:** the Network Diffusion Model works very well to expand ODF through contiguous, relatively socially and culturally cohesive communities. However, expanding to new areas requires two strategies: triggering, scale-up, training and deployment of the local EHTs and community health volunteers—those government actors with existing mandates for sanitation—and sanitation marketing that, among other activities, incorporate Natural Leaders from nearby (or culturally similar) areas who stand in as CLTS/ODF “converts,” and training specialists for new local implementers.

Witnessing the success of this modified strategy, the GOL worked with Global Communities to develop a national CLTS strategy based on this adapted approach.





A student returns to his school after an outbreak of Ebola in his community



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