Photo: Rudy Kimvuidi – Mercy Corps DRC, Beni, February 2019

LESSONS LEARNED

Lutter contre Ebola via l'Engagement de Communautés Redynamisées (LEVER), 720FDA20CA00001

OCTOBER 2019-JANUARY 2021

USAID
FROM THE AMERICAN PEOPLE

MERCY CORPS

Table of contents

List of acronyms

Acronym	French	English
AS	Aire de Santé	Health Area
CAC	Cellule d'Animation Communautaire	Community Action Cell
CAP	Plan d'Action Communautaire	Community Action Plan
CE	Engagement Communautaire	Community Engagement
CENI	Commission Electorale Nationale Indépendante	National Independent Electoral Commission
CPT	Tracker de Perceptions Communautaire	Community Perception Tracker
CSO	Organisation de la Société Civile	Civil Society Organization
ETC	Centre de Traitement Ebola	Ebola Treatment Center
EVD	Maladie à Virus Ebola (MVE)	Ebola Virus Disease (EVD)
FG	Focus Group de discussion	Focus Group
IT	Infirmier/ière Titulaire	Nurse Chief
MOH	Ministère de la Santé Publique	Ministry of Public Health
PNDS	Plan National de Développement Sanitaire	National Health Development Plan
PPE	Equipement de Protection Individuelle	Personal Protection Equipment
RCCE	Communication des Risques et Engagement Communautaire (CREC)	Risk Communication and Community Engagement (RCCE)
RECO	Relais Communautaire	Community Health Volunteer
SRP	Plan de Réponse Stratégique	Strategic Response Plan
WHO	Organisation Mondiale de la Santé	World Health Organization
ZS	Zone de Santé	Health Zone
/	Appel à manifestation d'intérêt	Expression of Interest
/	Chef de Quartier	District Chief
/	Chef de Cellule	Chief of Cell

Introduction

The 10th outbreak of Ebola Virus Disease (EVD) in the Democratic Republic of the Congo (DRC) started in August 2018 and was declared over in June 2020. It was the largest in the country's history and the first in an active conflict zone. The outbreak resulted in 3,481 (3,323 confirmed and 158 probable) cases, including 2,299 deaths and 1,162 survivors, with a 66% death rate.[1] This outbreak was declared a Public Health Emergency of International Concern by the World Health Organization (WHO), which required a coordinated international response. Conflict and displacement, poverty, limited access to basic services, and the mobility of the population impeded the response to the epidemic, and increased the risk that it could spread to other parts of the country and across international borders. At the community level, the main barriers to effective control of the epidemic included inadequate community engagement and inconsistent messaging that led to insufficient ownership and uptake of Ebola prevention practices, and deficiencies in basic Water, Sanitation, and Hygiene (WASH) and transport infrastructure that impeded adoption of basic prevention behaviors such as hand-washing.

From October 2019 to January 2021, Mercy Corps led the USAID/BHA-funded LEVER"[2] consortium in North Kivu (Goma – Beni corridor) to slow the spread of EVD by implementing community-based surveillance and prevention measures and by responding to basic water and infrastructure needs in affected zones.

I. Context

The 10th Ebola outbreak

One of the main challenges from the outset of the response was the local population's resistance to health workers, response partners (including NGOs) and response interventions. In the early months of the epidemic, the response focused mainly on medical treatment and primary care. It was essential to ensure that local health structures effectively treated patients to prevent the spread of the virus. However, a top-down response structure and messaging, as well as response activities that were not adapted to the local context and traditions, meant that communities felt alienated from decision-making. This led to mistrust and increased resistance in an area where decades of conflict had already instilled mistrust in the government, its armed forces, and international actors. In this specific context of the North Kivu and Ituri Provinces in eastern DRC, multiple factors contributed to mistrust towards response actors and existence of the outbreak, including the decision from the National Independent Electoral Commission (CENI) to indefinitely postpone the presidential elections for the territory of Beni and Lubero due to stated concerns about the potential spread of Ebola during the voting process. Further, the response also had a social and economic impact – an influx of non-local staff and significant injection of money spent for Ebola response interventions had disruptive and inflationary effects on prices for services. The negative effect of significant outside spending in these areas, a lack of local recruitment, and the exclusion of local organizations in Ebola response efforts worsened communities' perception of the response as "Ebola business." The outbreak ultimately came to be perceived as an artificial or otherwise invented front for humanitarian actors to make money.[3]

In short, these conditions served as a breeding ground for rumors and false information during the first part of the response. One such rumor was that the disease had been intentionally introduced to prevent affected populations from expressing themselves politically and to specifically harm the Beni and

[1] https://www.who.int/emergencies/diseases/ebola/drc-2019

[2] Lutter contre Ebola Via l'Engagement de Communautés Redynamisées

[3] International Alert, *Les violences communautaires durant la riposte Ebola, Leçons apprises de la riposte Ebola par rapport à Covid-19*, 2020.

Butembo populations and ethnic groups.[4] Ebola response efforts were thus met with violence, mistrust, mistakes in communication and weak community acceptance.

In May 2019, the Ebola response started developing a more community-centered strategy and by July 2019, the "system-wide scale up" of the Ebola response had been adopted with the introduction of the Strategic Response Plan (SRP) 4.1. Advocacy and coordination work completed by a group of international NGOs, including Mercy Corps, played an important role in this overhaul. Several INGO meetings were held to harmonize community engagement across interventions, integrating anthropological research, such as that carried out by the UNICEF Social Science Analysis Cell (CASS). These efforts marked a change in the response, with more emphasis on community engagement as not only a means of gaining acceptance but ultimately as the means to end the outbreak. There was finally an understanding that the outbreak would continue to spread if communities did not have ownership of the response and if actions continued to be top-down rather than locally appropriate and based on local custom and norms.

With nearly a year between the initial outbreak (August 2018) and the adoption of a community-focused response (July 2019), changes were slow but were ultimately successful. The outbreak was finally declared over on June 25, 2020, 42 days after the last patient was discharged as a survivor from the Beni Ebola Treatment Center.

Photo: Katwa - Protection equipment washed and drying - Dee Goluba - Mercy Corps DRC, April 2019

[4] *Ibid.*

II. Mercy Corps' Ebola response

Mercy Corps was one of the first actors on the ground when the current Ebola epidemic began in August 2018; and over the course of the epidemic we adapted our intervention strategy according to the evolving context and community needs. Based on community feedback and the duration of the outbreak, it became evident that a health or clinical response alone was not a sustainable approach. Instead, an approach that was more attuned to community needs and adapted to the local context was needed. Under the scale-up, addressing the most pressing humanitarian and social issues and improving access to essential services became response priorities, rather than a narrow focus on Ebola response and containment measures. Accordingly, Mercy Corps and other response actors implemented community engagement approaches in line with the Community Engagement Commission led by the Congolese MOH and UNICEF.

In line with the multi-sectoral support to Ebola affected communities, Mercy Corps expanded its work in the response to address community needs around basic services, including access to water. By repairing existing or installing new water infrastructure (gravity-fed systems and new wells), Mercy Corps helped ensure that local communities had access to clean water – a benefit that not only supported Ebola prevention efforts, but also addressed a critical local need. Through this community-driven approach to address critical needs outside of Ebola (SRP4.1-Pillar 3), communities actively participated by identifying and expressing their needs via consultations and focus groups, and by creating Community Action Plans (CAPs). Local workers were employed on construction sites on a cash-for-work basis, and communities elected committees to take responsibility for construction and maintenance work. The LEVER program built capacity for epidemic prevention and preparedness by strengthening community engagement and improving access to essential WASH services, water points and to health centers by rehabilitating roads, bridges and other key infrastructure. Through LEVER, Mercy Corps (in partnership with four other organizations[5]) promoted community participation and ownership of awareness raising activities through working with the Community Action Cells (CACs) in the fight against the disease, reducing the risk of misinformation and rumors throughout North Kivu (Goma-Beni corridor).

Effective community engagement and mobilization meant that information about Ebola came not only from medical staff, international organizations or the government, but also from community leaders and individuals recognized and trusted by their community. By considering community dynamics, Mercy Corps has progressively laid the groundwork for a more decentralized response and better communication flows. Mercy Corps used evidence from the West Africa Ebola response (2014–2016) to demonstrate how critical a role community mobilization plays in curbing a disease outbreak.[6] Through a cross-cutting "bottom-up" approach, Mercy Corps improved affected communities' access to information about Ebola and to basic resources to effectively combat diseases with epidemic potential, while emphasizing community participation and ownership in order to further strengthen community engagement by working directly with pre-existing local organizations (including women associations, youth associations and even pressure groups). This and other Risk Communication and Community Engagement (RCCE) work needs to remain even after the end of this epidemic, as a means of helping communities develop their own strategies to prevent and fight future disease outbreaks and to effectively recover from this outbreak's social and economic consequences.

[5] LEVER (Oct 2019 – Jan 2021) has been led by MC and implemented with CARE International, Oxfam, International Alert and the local organization CORACON.

[6] Sheely et. al. "Community Mobilization: Essential for Stopping the Spread of Ebola." Mercy Corps. 29 May, 2019. See here

Mercy Corps' transversal and multi-sectoral approach

It is increasingly clear that resolution of complex global health issues requires interdisciplinary approaches and inter-sectoral expertise. Much like the 'One Health' approach[7], Mercy Corps looks for synergies across different sectors in order to improve communities' health and socio-economic resilience. This multi-sectoral approach aims at reinforcing transversal components such as WASH, IPC and community engagement to ensure communities' promptness in anticipating and managing future and current outbreaks and emergencies.

At the community level, the main barriers to effective control of the epidemic include inadequate community engagement and inconsistent messaging that have led to insufficient ownership and uptake of Ebola prevention practices, and deficiencies in basic WASH and transport infrastructure that impede adoption of basic IPC behaviors, such as hand-washing. Government-led response strategies have created parallel structures and failed to employ local community members, and response actors have been militaristic when entering new areas. Official communications about the disease and the response have been inconsistent and sometimes contradictory; messages were not well tailored to different community contexts and not delivered by trusted actors. All these factors have served to increase already high levels of mistrust in the health system, and reduce willingness to adopt hygiene and disease prevention behaviors. This has been evidenced by significant under reporting of suspected cases, fear of health facilities, and hostility toward response actors. At the same time, many communities were unable to adopt critical prevention behaviors detailed in official messages because they faced extensive barriers to accessing WASH and health facilities and resources.

This is particularly crucial in a context such as the eastern Congo where substantial community resistance to the response remains a serious obstacle, with persistence of individuals refusing the vaccine, even though licensed, and recurring attacks on treatment centers. Addressing the roots of community resistance requires a multi-sectoral approach, including community mobilization campaigns and actions that directly engage community members and trusted leaders in ongoing conversations about the risks posed by the Ebola outbreak and which support the implementation of locally-owned actions to prevent the spread of the disease.[8]

The 10th Ebola outbreak in the DRC has taught response actors that it is not possible to reduce the duration of an outbreak solely through medical and health action. What can be achieved in terms or response and containing the spread of an outbreak depends to a large extent on the quality of social mobilization and the provision of clean water for hand washing (with hand washing stations, soaps and disinfectant/chlorine) in health care centers, schools and communities. A key indicator of the success of a response is when care providers and care receivers are seen to adopt certain behaviors in two areas: prevention and treatment. Mercy Corps provided the infrastructure to facilitate prevention and the means to allow behavioral changes to take place.

Linking Ebola response activities with contributions to community infrastructure and economic opportunities may yield a more receptive posture in resistant communities by demonstrating that the goal of Ebola response is to improve the health of the community, not simply to prevent spread of the Ebola. Investigational treatments and vaccination are no substitute for culturally appropriate, endogenous social

---

[7] 'One Health' refers to the collaboration of multiple disciplines, sectors and groups working locally, nationally and globally to attain optimal health for people, animals and the environment. Zoonotic outbreaks such as Ebola outbreaks are one of the biggest current challenges in which implementation of One Health strategies is crucial to ensure safety for the global community. The implementation of a well-planned One Health approach that brings together all stakeholders to address the interconnected factors responsible for enabling a pathogen such as Ebola to spread so successfully, including cultural practices, environmental conditions, and wildlife dynamics, can help address future and current Ebola epidemics. *(Degeling, Chris et al. "Implementing a One Health approach to emerging infectious disease: reflections on the socio-political, ethical and legal dimensions." BMC public health vol. 15 1307. 29 Dec. 2015, doi:10.1186/s12889-015-2617-1)*

[8] Mercy Corps, *Community Mobilization: Essential for Stopping the Spread of Ebola,* 2019. https://drive.google.com/file/d/1iorW8X3cL3Wde7Dx3knWIwSQ1HY6fZDB/view?usp=sharing

responses that support early detection and treatment. Even the best biomedical advances require social traction to work.

Mercy Corps' intervention was then not another case of "helicopter" intervention, but a longer-term commitment for humanitarian aid and to bolster communities' reliance and develop sustainable response strategies that can be deployed to other communicable disease outbreaks in the future. Building on local expertise and on existing local structures, Mercy Corps Ebola response pivots around communities, schools, and health facilities. This "bottom-up" approach avoided the standardization of Mercy Corps actions, while facilitating context-specific decisions based on existing needs and epidemiological developments.

Community Engagement

During this outbreak, Mercy Corps' community engagement work took various forms: working with pre-existing community partner groups (Care groups, local governance structures in and around Goma), with local organizations in Butembo and Katwa (community-based organizations) and with **Community Action Cells** (CACs) as recommended by the MOH. This Activity present these community engagement experiences and related lessons learned.

Engaging with CACs

The CAC is a multisectoral and multidisciplinary community structure that aims to coordinate community initiatives at the village level. The MOH recommended working through and with the CACs for Ebola prevention and surveillance. Most NGOs then started working with CACs, sometimes setting them up and sometimes by reinforcing their capacities and knowledge about their roles and responsibilities in the Ebola outbreak and response. The LEVER consortium collaborated with 1,106 CACs in 14 Health Areas across North Kivu, all of which developed CAPs and 959 developed Community Ebola Risk Reduction Plans (CERRPs).[9] For the set-up of CACs, the program used the methodology outlined by the Ebola coordination.

Recommended CAC structure and mandate

The CAC is normally led by the village/cell chief and should be made up of all the groups present in the cell: religious and opinion leaders, delegates from community-based organizations, water, hygiene and sanitation committees, RECOs, pressure groups, etc. There should be a balance of gender and ages.

Size: 8 to 12 people (with a desirable minimum of 30% women)
Coverage: between 250 and 350 households
Hierarchy: The CAC is under the responsibility of the CODESA[10]
Composition: The CAC is directed by a four-person Executive Committee: a President, Vice-President, Secretary, and Treasurer.
Mandate:

1. Coordinate village / cell development activities
    - Conduct census of community members

[9] Not all CACs developed CERRPs for various reasons such as time constraint and cells being too close to each other to have separated CERRPs.

[10] CODESA is a community participation body, representing health areas and cells. CODESA, is a multidisciplinary body composed of, amongst others, delegates from the health areas CACs, with one member per CAC. Members have the responsibility to plan, co-manage and mobilize local resources for the revitalization of basic social services (Health, WASH, education, legal and social protection, etc.)

- Ensure the mobilization of local resources for the implementation of the Community Action Plan (CAP) and maintenance of village structures (example: maintenance of water points)
- Organize periodic meetings to monitor and evaluate the development of the CAP and then its implementation
- Develop and implement local risk identification and response plans in case of emergencies such as an Ebola outbreak.
- Ensure the safety of equipment and materials affected to villages/cells

2. Schedule consultation meetings with the population
3. Coordinate communication activities, promoting practices conducive to health, development and protection.
   - Schedule information awareness campaigns
4. Coordinate the activities of RECOs
5. Coordinate activities at the community level (health, WASH, protection, education, rural development):
   - Community distributions (for example: family kits, contraceptives, Aqua tabs, etc.)
   - Community Care Site Management (COGESITE)
6. Represent the village/cell in the management of basic social services (health/WASH, protection, education, etc.):
   - Compile village data and transmit them to higher levels (CODESA, Territorial Coordination, etc.)
   - Popularize decisions made by higher-tier structures, including priorities identified in the CAP

Table 1: CHANGE IN THE VILLAGE APPROACH WITH THE EBOLA RESPONSE

Change	Before Ebola	During / after Ebola
Scope	Exclusively Health	Multisectoral
Composition	RECOs	All groups present in the village
Hierarchy	Village/Cell Chief = President	Village/Cell Chief = hierarchically above in his role as Village Chief but no longer serves as President of the CAC
Representation	President of the CAC = CODESA representative	A CAC delegate = CODESA representative
Structure	RECOs report to the IT[11] (no direct link with the CAC structure)	RECOs report directly to the CAC
Accountability	Accountability of RECOs towards the IT	Accountability of RECOs and other CAC members towards the community
Target	RECO aims for individual change	CAC aims for collective change

Recommended procedures for CAC set-up

The following procedures are a mix of recommendations coming from the MOH and Mercy Corps' identified best practices.

1. Preparatory
   - Advocacy with local political-administrative authorities (mayors, district chiefs, village chiefs) in favor of the implementation of CACs.

[11] Infirmier Titulaire – Chief nurse of a health center

- Mapping of existing local organizations, social services and structures.
- Identification of local facilitators for the setup of CACs (mapping of local facilitation teams).

2. Initiation of community dialogue
   - Briefing of local facilitators and deployment in the different axes at the health zone level for community awareness raising.
   - Organization of an assembly at the cell level to proceed with elections of CAC members and RECOs.
   - Endorsement of the elected members by the village chief (formalization of elections with appropriate documents and minutes).

3. Development and implementation of Community Action Plan (CAP)
   - Training of CAC members on their roles and responsibilities.
   - Identification/prioritization of priorities by Focus Groups with men and women.
   - Development of Community Action Plans.
   - Validation of CAP by all members (with hierarchy in priorities – detailed below).
   - Implementation of CAP by CACs and community leaders, with potential support from NGO programs.

4. Support to the CAC on a continuous basis
   - Training/ capacity building of CAC members. Trainings covered the following topics as required by the Ebola response strategy: Pillars of the Ebola response, Ebola and promotion of prevention measures, community-based surveillance, community feedback, sharing with Ebola commissions and response to communities, vaccination, safe and dignified burials, etc.
   - Monitoring and evaluation sessions on the quality of implementation of plans by Focus Groups with men and women.
   - Training of the CACs on the maintenance of the WASH infrastructure and the appropriation of the project's achievements.

5. Validation and official handover of the WASH infrastructure and project achievements to the health and education authorities, the CAC and members of the Focus Groups.

Lessons learned

Within the process of setting up a CAC, Mercy Corps programming has identified the **training and capacity building of CAC members** as the major component in need of particular attention.

- An informed identification of social norms and power mapping are a prerequisite for initiating promising interactions in the set up or revitalization of CACs.
- While most CACs have been set-up or revitalized under the Ebola Strategic Response Plan, they have been a long-existing core component of the DRC's social structure. Now that the 10th Ebola outbreak is over, CACs should continue to function and support their respective communities in their multi-sectoral capacity. For this reason, the capacity building component of CAC members has become a crucial activity that must be tailored not just around the Ebola response but on the long-term and multi-sectoral needs that will allow the CAC structure to continue playing a central role in communities' health and socio-economic well-being, including but not limited to COVID-19 considerations. Mercy Corps therefore suggests expanding the portfolio of set trainings to be delivered to CAC members (as also outlined by the CAC strategy

in the Ebola response) in order to integrate, among others, the following transversal and technical components:

- Stress management and the creation of social safety nets.
- Non-violent communication and de-escalation of conflict.
- Project planning and management.
- Inclusion of a disaster risk reduction plan in the CAP.
- Safeguarding in conflict environments.
- Advocacy strategies and navigating governance systems.[12]
- Development and management of business plans for entrepreneurs.
- Selection planning and management of income generating activities.

Other lessons learned through the course of this process include:

- The lack of understanding of CACs' work by some leaders sometimes led them to oppose the volunteering of CAC members. Their involvement at the beginning of the activities had a positive impact on the acceptance of project activities and breakdown community reluctance.

- Collaboration with local authorities and influential groups and the involvement of health providers helped to reduce community resistance encountered during the implementation of activities. For example, during the implementation of the awareness raising activities and home visits in LEVER, CAC members faced difficulties in overcoming resistance from community members on the existence of Ebola and COVID-19 which has improved with collaboration with influential actors.

- The quality audit made to assess the process of setting up CACs was a necessary activity even though it was time consuming. This process revealed that some partners had not taken into account national standards of 250-300 people per CAC. The lack of demographic data was also a defect in defining the number of CACs necessary in each health area.

- During CAC elections, it was especially important to ensure that not only there was a gender balance, but also that all groups and religions present in the community were equally represented (identified during the formative research – mapping of actors, religions and groups present in the cell/village).

- As most of the Ebola implementing partners worked with CACs, a harmonized approach of their roles, responsibilities, and the financial or material support they receive would have been useful. The harmonization of payment of RECOs and CACs was a major issue during this Ebola epidemic, as partners applied different practices (some organizations paid them 300 USD per month, others paid them a single lumpsum of 300 USD for the group, some did not give them any financial support). Mercy Corps was among actors emphasizing the volunteer nature of CACs and chose to incentivize these groups with training.

- Mercy Corps contributed with other organizations to an advocacy effort to unify payments, but this did not result in guidance that was sufficiently aligned with our approach and came late in the implementation process. To ensure ongoing sustainability of CACs, LEVER ultimately developed a strategy focused on the long term operating plans of CACs, which integrated income generating activities to cover ongoing expenses. In support of the CACs' business plans, the program provided a

[12] Since they represent different layers of their community, CACs are not meant to represent a specific political opinion and, as far as possible, should not become a political tool.

one-time cash or material transfer (valued at 300 USD per CAC) to help launch their pre-identified income-generating activities to enable them to sustain their action and ensure their continued operation.

Community Perception Tracking

Clear communication to better engage with communities needed to be adapted and changed according to communities' needs and the outbreak itself. Along with LEVER partners, Mercy Corps developed a community feedback mechanism – the **Community Perception Tracker** (CPT) – to collect perceptions, rumors, questions and change communication accordingly, based on needs. This system was led by trained field that that visited the CACs and attended other community meetings on a weekly basis, where they collected rumors, questions, and feedback from the community on issues related to Ebola and COVID-19. These rumors were then shared with the LEVER partners on a weekly basis and weekly reports were shared externally. This information was then categorized par Health Zone and common concerns that emerge from the community. For example, questions on (i) The origins of EVD and COVID-19, (ii) The coordination of the COVID-19 response, (iii) The sanitary structures. It was then analyzed on the frequency and trends per Health Zone. This information was needed for the Community Engagement teams to decide which rumors to respond to, by what medium and in what language. They also identified which rumors required additional engagement and how they could systematically address them within the community.

Lessons learned

The main lesson learned regarding tracking perceptions, questions and rumors is that this information is useful only if it leads to concrete responses and program/intervention adaptation. It took a considerable amount of time for the response coordination to take into account this collected data and to take concrete actions to respond to it. Rather, it was the organizations themselves that in their programs attempted to respond to it and to adapt their interventions accordingly. However, this has not been sufficiently rapid or systematic, which has contributed to a certain fatigue and lack of confidence in the response.

Community Action Plan development

Objective: Orient and empower people to identify and address the root causes of their vulnerability in order to address adverse socioeconomic, health and political realities. The process of CAP elaboration, if inclusive and representative, improves social cohesion and sense of citizenry and also informs the aid sector on investments to be made to respond to key needs.

- The development of a CAP should foster a participatory approach that produces wide-ranging benefits;
- Communities can and should determine their own priorities in dealing with the problems they face;
- The important depth and breadth of collective experience and knowledge in a community can be built on to bring about change and improvements;
- In addition to being better able to identify their needs and resource gaps, communities are more aware of the resources and assets they *do* have to contribute to local responses;
- When people understand a problem and its causes, they will more readily act to solve it;
- People solve their own problems best in a participatory group process.

It is essential that during the development of a CAP, all communication is a two-way process. By asking for and listening to people's needs, opinions, suggestions and complaints, the humanitarian community can adapt its response to their specific situations and concerns.

Lessons learned

In the short-term CAPs should foster community-generated solutions to immediate problems. In the long-term CAPs should remain with CACs, be regularly updated to become a development plan and an advocacy tool for the community, notably to hold targeted service providers accountable. In order for CAPs to be even more sustainable in the long term there is a need to create a channel of communication that facilitates the sharing of CAPs with bodies that go beyond the Ebola coordination structure and actors. Examples may be the *bureau du développement,* the Health Zone and Health Area offices.

Throughout the development of CAP, two steps have been identified as in need of particular attention:

1. **Feasibility assessment of the CAP**
    - When reviewing the sites / structures and interventions identified by the community:
        - **i.** Adopt a Do No Harm approach, to ensure that activities benefit the greatest number of community members while addressing unique needs of different groups, as appropriate, without showing preference for certain groups over others.
        - ii. Community WASH Infrastructure is WASH infrastructure that contributes to preventing transmission of diseases and improving the quality of life of the entire community through improved access to basic services.
        - **iii.** No WASH community infrastructure should be built on private land in order to avoid appropriation of the infrastructure by individual parties and avoid that the actions carried out by Mercy Corps are not neutral or impartial.

2. **Review and validation (between Mercy Corps and community) of communities proposed sites / structures and interventions by the IPC/WASH commission**
    - The schools and health centers where Mercy Corps constructs WASH infrastructure and implements its IPC activities must be identified by communities themselves during day 2. Involving the IPC/WASH commission at this stage was crucial in order to align Mercy Corps intervention with the national Ebola response strategy.

Suggestion: In order to facilitate continuous and effective program adaptation an indicator should be added to measure community participation and satisfaction in similar programs. This would help measuring success in the following aspects:

- Information sharing on the project – technical details, roles and responsibilities in the process clearly communicated and understood;
- Involvement of communities in the design, site selection, construction of the WASH infrastructure;
- Involvement of communities in the selection of priority structures (health centers and schools) targeted by the project;
- Feedback mechanism available for communities to share suggestions and concerns;
- Satisfaction of MoU between local authorities, CAC and infrastructure committees to set rules about maintenance and roles and responsibilities.

Pedagogical activities

In parallel to trainings and capacity building of CAC members (continuous throughout the whole course of programs), educational activities, including participatory demonstrations on Ebola response and prevention activities, were organized in health centers and schools for all community members of the cell. The targeted structures were structures identified during the CAP and where Mercy Corps was intervening in IPC/WASH (to ensure acceptance and collaboration of the structures).

Aim: Improve people's perception, acceptance, and knowledge of the Ebola response through guided tours and educational activities of the health centers and schools.
Approach: having a pedagogical scope, activities were designed to encourage learning processes (memory, attention, observation) and cognitive skills (reasoning, comparing and contrasting, classification), as well as the acquisition of specific information. Participants' active interaction and exploration of materials and structures remained central to all activities in order to facilitate the understanding of concepts and skills through experiencing.
Facilitators: Mercy Corps staff, CAC members, medical personnel of the health centers and teachers of the schools concerned by the activities.

Facilitating similar activities is an opportunity for CAC members to disseminate the knowledge acquired through the trainings and capacity building received. In the long-term, their involvement also ensures ownership and sustainability of this community engagement approach.

In **health centers,** activities included the explanation and demonstration of:

- Functioning and purpose of a pre-triage including the isolation procedure in case of a suspect Ebola case;
- Decontamination and Personal Protection Equipment (PPE);
- Basic IPC measures adopted by medical personnel;
- Preparation of the chlorine solution;
- Use and importance of hygiene kits;
- Healthcare waste management.

These activities aimed at reducing people's distrust in health centers that collaborated with the Ebola response and accepted the construction of pre-triages on their facilities. They also contributed to reduce the risk of misinformation and rumors about the Ebola and the response more generally.

In **schools,** activities included explanation and demonstration on the use and importance of:

- Latrines and safe excreta disposal;
- Impluvium (system for collecting and conserving rainwater, usually it is a water tank – for handwashing purposes mainly, not to drink water);
- Hygiene kits and hands washing.

These activities promoted positive hygiene practices and reduced the risk of transmission of Ebola and waterborne diseases.

Lessons learned

Lessons learned highlighted the urgent need for the integration of activities where community members themselves bridged the gap between communities, healthcare practitioners and the Ebola response through the application of a participatory approach. The complementarity of these three components IPC, WASH and community engagement should be further explored not only to increase community

acceptance of the Ebola response, but to more sustainably (re)shape the socio-economic and health fabric of communities.

- Community engagement is the backbone of WASH programming within the framework of the Ebola response (and other similar outbreaks): access to water in sufficient quality and quantity, safe excreta disposal, positive hygiene practices are all critical factors for risk reduction and disease prevention. However, the simple provision of infrastructure does not necessarily ensure that populations will use them effectively (due to social norms, perception of risks, availability of resources, etc.). Preventing and reducing disease risk means people may have to change their current behaviors and practices or adopt new ones. Associating IPC/WASH activities with reinforcement and extension of existing community-based mechanisms for Behavior Change Communication (BCC) and community engagement for health promotion and social mobilization is important. In some places, this work can be done with a robust network of trained community volunteers and governance structures to enhance awareness and uptake of behaviors that prevent Ebola transmission and negative impact through community-led social engagement activities, while supporting the setup of a community-based alert system to increase effectiveness of the urgent response.
- SBCC activities include messaging, and the community's ability to access accurate, trustworthy and relevant information is critical in a public health emergency context. By enlisting communities to contribute to the development of BCC messaging, starting this messaging early, and establishing a system and structure that connects communities to the response and monitors developments, the response is able to tailor its activities to different zones and needs. Messages and information can inspire behavioral adaptation and one of the main lessons learned from this Ebola outbreak is that messages must be communicated in a locally-appropriate language that people can understand. Implementers should select media channels (radio, WhatsApp group, churches) based on what community members usually use to get information. Images are also important as they convey information for illiterate people. Images must be accurate, appropriate to local norms, and respond to people's questions (posters at the beginning of the response showed people bleeding when vomiting, crying, or having diarrhea. However, in most cases, Ebola disease does not lead to major hemorrhage and presents with malaria-like symptoms. The message around symptoms was therefore confusing and limited the up-take of messaging around other issues).
- Another key lesson from the communication effort was to avoid the use of technical and unfamiliar vocabulary and to support communications in local languages. As seen with this response, failure to adopt these measures can create misunderstanding, confusion, and mistrust[13]. The pedagogical approach that Mercy Corps recommends helps clarifying information and can support an increased acceptance of referrals to ETCs, safe burials and vaccinations.
- Clear communication also needs to be adapted and changed according to communities' needs and the outbreak itself. The more local the communication and people who convey it were, the more impactful it was (further indicating the importance of using local dialect). Working through traditional and religious leaders,

[13] Cellule d'Analyse en Sciences Sociales (CASS), Social Science Support for COVID-19, *Lessons Learned Brief 3, Humanitarian programme recommendations for COVID-19 based on social sciences evidence from the DRC Ebola outbreak response,* May 2020.

as opposed to outsiders, and hiring local staff to convey messages and trainings supports buy-in and builds trust.

Translators Without Borders conducted research during this 10th Ebola outbreak that highlighted best practices and what to avoid in terms of communication. Reports from that effort are available here.

WASH infrastructure in public spaces

Community WASH Infrastructure *is WASH infrastructure that contributes to preventing transmission of diseases and improving the quality of life of the entire community through improved access to basic services.*

As Ebola is a disease that can be transmitted by both sweat or through the fecal-oral route, an investment or a response that includes WASH activities was essential, to improve hygiene conditions as well as to provide sufficient water for hand washing. This helps prevent the incidence of diarrhea, which can be interpreted as Ebola symptoms and weakens the immune system, reducing the risks that a patient is taken to an ETC unnecessarily or is less able to recover with a later infection with the virus.

Before any construction started, a Memorandum of Understanding (MoU), containing details of all the planned infrastructure, specifications of what is meant by public infrastructure and details of the roles and responsibilities of all parties, was signed between Mercy Corps, the CAC members, and the chief of the cell.

This MoU stipulates the following four elements:

1. Infrastructure built by Mercy Corps serves the whole community by remaining accessible and properly maintained;
2. No single party appropriates itself the infrastructure;
3. The chief of the cell is responsible to ensure that infrastructure maintenance committees properly work, respect opening and closing hours, and clean the infrastructure;
4. The CAC members are responsible to ensure that infrastructure maintenance committees do not run out of the necessary equipment/products necessary to clean the infrastructure.

During the construction, there was a need for continuous community sensitization on the purpose and usefulness of the infrastructure. To achieve this, community engagement team members needed to be present on construction sites at all times. This alllowed them to engage with and respond to any questions raised by community members passing by.

After completion of the infrastructure work, the relevant authorities, CAC members, and the entire population of the cell was gathered for the official restitution. In this same occasion, the purpose, use and proper maintenance of the WASH infrastructure was communicated to the whole community and if needed, questions are answered. This approach helped to ensure community buy-in and facilitate long-term maintenance of all infrastructure.

Infrastructure maintenance committees

In each cell, infrastructure maintenance committees were set up and trained by Mercy Corps WASH and community engagement teams on the proper maintenance, use, and accessibility of infrastructure. The ideal ratio is one committee per piece of infrastructure. If more than one piece of infrastructure is found in the same area/public space, then they can fall under the responsibility of the same committee. The

number and composition of committees must in all cases be discussed with community members and CACs to find a system that makes sense to them.

Composition: community members (ideally living around the concerned infrastructure) and one or two CAC members.[14]
Responsibilities: opening and closing hours, cleaning and maintenance and continued sensitization of the community on the proper use of each piece of infrastructure. They also can define water payment conditions, in collaboration with the CAC members, chief of cell, and community representatives.

Lessons learned

- Above all, a successful WASH activity must have strong community engagement teams to work with community members on their needs and the best approaches to adopt before WASH teams intervene.
- CAPs developed with Mercy Corps highlighted water as one of communities' greatest and most widespread needs. In fact, with few exceptions, water appeared first on the list. In addition, during an Ebola outbreak, the need of water is increased to respond to hygiene and prevention needs. Responding with simple water sources and impluvium has not only proven insufficient both in terms of liters of water provided and number of people reached, but it has also proven difficult to realize following the scarcity of available water sources in the targeted communities. Consequently, programs that Mercy Corps developed later in the outbreak reinforced the response in communities by integrating the construction/rehabilitation of boreholes as well as the construction of gravity-fed systems.
- Infrastructure maintenance committees should be created and trained before the completion of the WASH infrastructure. This will allow them to help Mercy Corps community engagement team with the sensitization of community members on the purpose, use, and maintenance of all WASH infrastructure.

[14] If a block of latrines is next to a school or church it would be advised to insert in the committee a member of the school being that the users of the public latrine will mainly be the students of the school.

III. Looking forward: Mercy Corps Vision for post-Ebola recovery

Mercy Corps' mission in eastern Congo is to *support vulnerable communities through crises, while fostering strong relationships and partnerships across government, civil society and the private sector to deliver programs that build resilience and promote sustainable change*. Our post-Ebola strategy emphasizes the importance of improved public health outcomes as essential to long lasting, positive development. We understand the importance of addressing the root causes, immediate drivers and effects of protracted humanitarian and development needs in eastern Congo through a triple nexus vision - a response that considers and emphasizes the interlinkages between humanitarian, development and peacebuilding efforts. A more integrated, agile and complex approach must be adopted and put into practice to address structural causes of interconnected crises in eastern DRC, respond effectively to future outbreaks that fuel vulnerability to Ebola and other public health shocks, and to ensure that positive outcomes and progress are sustained through long-term development approaches. This includes investments in other sectors to reinforce overall economic, WASH and governance systems.

The origin and proliferation of an outbreak is the result of the many aforementioned complex drivers, including environmental degradation, unsustainable development, food insecurity and poor nutrition, social practices, climate change, weak public health infrastructure and governance and inequitable access to information. These drivers affect the health and wellbeing of individuals and communities differently due to their specific vulnerabilities that are personal and social. Health in North Kivu is, among others, undermined by the lack of availability, access and utilization of food, low economic opportunities, weaknesses in access to water, sanitation and hygiene and recurrent conflicts. This has led to recurrent outbreaks of diarrhea, cholera and other diseases and nurtured a vicious feedback loop with poor health conditions driving food insecurity and undermining economic opportunities. Mercy Corps understands food security, WASH and peaceful co-existence as pillars to improve public health. Although Ebola can affect anyone and be fatal in most cases, people who are healthier, and therefore have better nutritional status, are more able to fight off the virus and then recover if they survive.[15] It is also key in the COVID-19 context, in addition to ensuring that people have access to care to reduce the risk associated with co-morbidities.

Mercy Corps' overall goal for this post-Ebola phase is to improve public health outcomes by reinforcing resilience capacities across key sectors including food security, economic development and WASH with a focus on local peacebuilding efforts and good governance that reinforce inclusivity of women and youth. Mercy Corps post-Ebola strategy is designed to complement the essential work of health actors by combining expertise across sectors. Our approach will promote inclusive community participation and ownership that facilitates access to resources and increases households' resilience to shocks/stresses either induced by the outbreak or that exacerbate vulnerability to future outbreaks, targeting affected systems for transformative change and community preparedness.

[15]There is also a link between food insecurity and diseases that increase vulnerability to COVID-19, such as type 2 diabetes, hypertension, cardiovascular disease, mental distress and general ill health. Vozoris NT, Tarasuk VS. Household food insufficiency is associated with poorer health. J Nutr. 2003;133(1):120–6

IV. Bibliography

Degeling, Chris et al. “Implementing a One Health approach to emerging infectious disease: reflections on the socio-political, ethical and legal dimensions.” BMC public health vol. 15 1307. 29 Dec. 2015, doi:10.1186/s12889-015-2617-1

DRC National Health Development Plan (PNDS) 2016–2020

Essential Environmental Health Standards in Health Care (WHO, 2008): https://www.who.int/water_sanitation_health/publications/ehs_hc/en/

International Alert, Les violences communautaires durant la riposte Ebola, Leçons apprises de la riposte Ebola par rapport à Covid-19, 2020.

Kristen Devlin, Kimberly Farnham Egan, and Tanvi Pandit-Rajani. 2017. Community Health Systems Catalog Country Profile: Democratic Republic of the Congo. Arlington, VA: Advancing Partners & Communities.

National Research Council. 2000. How People Learn: Brain, Mind, Experience, and School: Expanded Edition. Washington, DC: The National Academies Press. https://doi.org/10.17226/9853.

Sample size Calculator. https://www.surveysystem.com/sscalc.htm

Waldman et al., IDS Bulletin Vol. 49 No. 2 March 2018: 'Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage