



COMMUNITY MOBILIZATION: ESSENTIAL FOR STOPPING THE SPREAD OF EBOLA

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The Ebola crisis in eastern Democratic Republic of the Congo (DRC) is worsening, and it poses a serious threat to the ongoing humanitarian response on which nearly 13 million people depend for lifesaving aid. As of May 27, 2019, **over 1,832 confirmed cases of Ebola have been identified in eastern DRC, and there have been 1,193 confirmed deaths.** Substantial **community resistance** to the response in many communities remains a serious obstacle, as indicated by persistent reports of individuals refusing the vaccine and avoiding treatment centers. In addition, since March there have been nearly 30 violent attacks on Ebola treatment centers and hand washing stations, including the April 19 murder of a WHO doctor during an attack on a hospital in Butembo. As a result of these dynamics, efforts to slow the spread of new infections have been seriously hampered, and there is a severe risk that the disease will spread further south along the main road towards Goma.

The purpose of this brief is to provide **donors, NGOs and technical agencies such as the WHO, UNICEF, and OCHA** with a snapshot of **what the evidence says about why and how to deploy community mobilization** in public health emergencies, using a synthesis of the existing literature and a reflection on Mercy Corps's evidence from a 2015 community mobilization campaign in Liberia. **Taking stock of the evidence about what works for community mobilization in Ebola response is crucial at this point in the outbreak, as decisive investments in community mobilization will be necessary to effectively reduce resistance and increase trust and community ownership of the response.**

Key Implications

...for Donors: Direct funding in 24-month cycles should be targeted to agile partners who are already on the ground in eastern DRC and in at-risk areas of neighboring countries such as South Sudan, Rwanda, and Uganda.

...for Technical Agencies (WHO, UNICEF, OCHA): There should be a senior community engagement lead appointed at the highest strategic level to ensure that effective community ownership is being achieved across the response.

...for NGOs: Fostering community ownership in a conflict setting will require the commitment of substantial personnel and resources that allow for ongoing learning and adaptation to local perceptions and politics.

Overview and Context

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

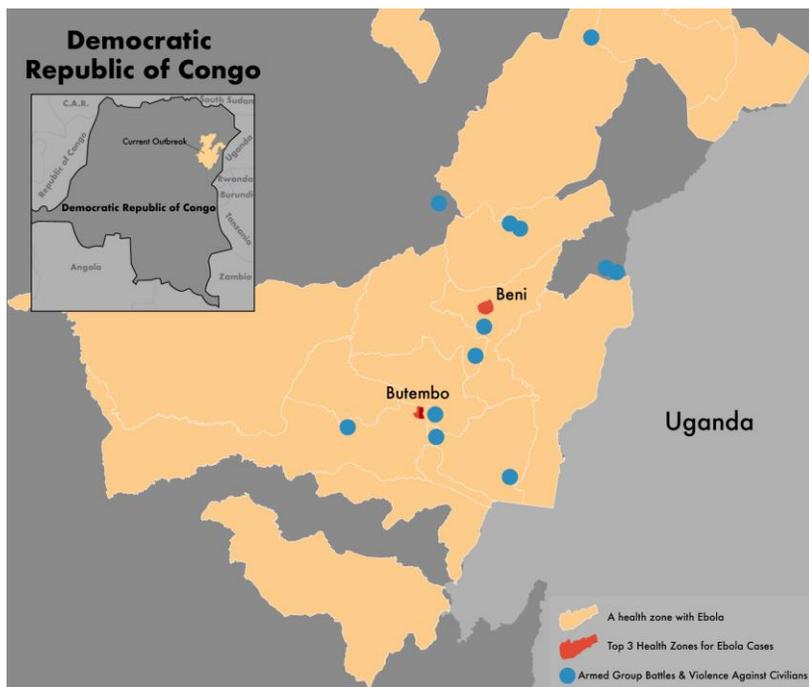


Image Credit: Sam Phinizy/Mercy Corps

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

What is Community Mobilization? Why Does it Matter for Ebola Response?

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

Mercy Corps and a number of other organizations operating in the DRC have made the case that addressing the roots of community resistance and



“Without bolstering efforts to improve community engagement and create community ownership of the response, the situation may spiral out of control. In that case, we will need to prepare ourselves for a radical rise in the rate of infections and deaths.”

— Whitney Elmer, Mercy Corps DRC Country Director

mistrust will require focused attention to **community mobilization**. Community mobilization campaigns **directly engage community members and trusted leaders in ongoing conversations** about the risks posed by the Ebola outbreak and the behaviors that can help to prevent the spread of the disease.

Community mobilization will be especially important in stopping the current outbreak in the Eastern DRC, due to the role of rumors and mistrust in driving community resistance to the response.

However, implementers have **limited shared knowledge** about how to design and implement such community mobilization programs so that they effectively address **the drivers of mistrust and misinformation in the midst of an ongoing conflict and contentious political environment**. Despite increasing emphasis on mobilization and communications, most **attention from donors and the government** has focused on medical treatment and care, and not on designing and implementing **grassroots-level mobilization campaigns** that are adapted to the unique aspects of the current outbreak.

Learning from Experience Against Ebola in West Africa

The 2014 West Africa Ebola outbreak was the **first mass deployment of community mobilization approaches in a rapidly evolving public health emergency**. There are no impact evaluations of effectiveness of community mobilization in Ebola response, but some implementing agencies and researchers have shared qualitative reflections on lessons learned. **Mobilization activities started well after medical response activities and quarantines were underway, which fed into mistrust**. Once communications and mobilization activities became part of the response, they were carried out by a variety of organizations and actors, who each used a wide array of approaches across the three countries involved in the outbreak. Many of these early approaches to communication and mobilization relied either on mass media or on top-down dissemination of information via social mobilizers as opposed to ongoing grassroots-level discussions that actively solicited community perspectives. Later in the response, there were many innovations in community mobilization that used technology, anthropological insights, and community-based research. However, **there was a lack of coordination in use of systems across responding agencies and a failure to pursue an integrated approach to mobilization**. As a result, there was a limited ability of data to keep pace with the evolution of the outbreak, and many implementers were unable to feed data and analyses back into programmatic adaptations.

Learning from the challenges of the early phases of the West Africa Ebola response, Mercy Corps implemented a community mobilization program called the **Ebola Community Action Platform (ECAP)** in Liberia from December 2014- June 2015. The program was funded by USAID's Office of Foreign Disaster Assistance (OFDA). Population Services International provided technical expertise in the community mobilization and communications methodologies and trainings. IREX worked with community radio stations to complement the face-to-face mobilization with mass media messaging.



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

》 **WA-NYEBO NEUFVILLE- ECAP COMMUNICATOR, MARYLAND, LIBERIA**

“One of the major challenges we were facing was about the Ebola Treatment Unit (ETU)...They saw it as a government attempt to bring Ebola in Maryland. It was hard to convince them. We taught them about the ETU... We even encouraged some of them to go around the ETU and see what happens there and ask questions. We didn't take one day or one moment to pause... Now, I can say about 80% of the people see the ETU as important. You see, we all agree and are willing to kick Ebola out of Liberia....and when I see people changing their behaviors like this, it gives me more strength to continue and want to do more.”

Photo Credit: Laura Keenan/Mercy Corps

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

As part of the mobilization campaign, Mercy Corps implemented **a technology-based monitoring and learning platform and a rapid social science research team**. Partners conducted **monthly random-sample surveys on knowledge, attitudes, and practices** in villages using smartphones donated by the Paul Allen Foundation. This allowed the program team to track the evolving attitudes of a sample of over 7,500 people reached by the community mobilization. Data and graphs from the monthly surveys were

shared with partner organizations using an online dashboard, which allowed them to adapt their mobilization approaches and content in real time. The Mercy Corps rapid research team led a number of studies exploring issues emerging from the surveys. This team also led a **qualitative socio-anthropological assessment** of the intervention in April and May 2015 in 40 ECAP communities and a comparison group of 20 communities in which ECAP had not been implemented.

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

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

Image Credit: Sam Phinizy/Mercy Corps



“It helps us to understand the messaging because they sit with us to discuss and make us understand that Ebola is real.”

—ECAP Focus Group Participant



Photo Credit: Laura Keenan/Mercy Corps

The qualitative case studies support these findings by comparing patterns of discourse and behavior in ECAP communities and non-ECAP communities. The qualitative analysis reveals several key insights. First, **ECAP’s use of repeated, ongoing mobilization by community-based communicators** set it apart from other behavior change communications that communities experienced. A focus group participant from an ECAP community described their experience of the program by saying that “It helps us to understand the messaging because they sit with us to discuss and make us understand that Ebola is real.” In contrast, participants described that they learned less well from other mobilization approaches that relied primarily on broadcasting messages through loudspeakers or mobilizers who were moving from village-to-village. A participant in a non-ECAP community described mobilization by a different organization by saying that “We

did not get the message well because the people used to be in rush to go to another community, we were not able to ask questions to get clarity.”

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

Finally, ECAP communicators **helped community members to understand the linkage between knowledge, behaviors, and**



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— Focus Group Participant in a Non-ECAP Community, describing a different organization’s education campaign

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

Implications for Ebola Response and Preparedness

For Donors: Committing urgent flexible funds for community mobilization

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

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

For Technical Agencies: Integrating medical, communication, and mobilization efforts

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



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

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

Photo Credit: Rudy Kimvuidi/Mercy Corps

For NGOs: Adapting mobilization approaches to address conflict dynamics

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

However, the same conflict and political dynamics that necessitate community mobilization in the current Ebola outbreak in Eastern DRC also pose severe operational challenges to designing and implementing effective grassroots campaigns. Given the sheer number of armed groups operating within the area where the outbreak is most intense, the deep roots of distrust, and the wide array of local variation

in the nature of the outbreak, **simply replicating mobilization models that worked in the West African Ebola response will not work.** Instead, successful community mobilization in a conflict setting will require the commitment of substantial people and resources that allow for **flexible, context-specific adaptation and learning.** NGOs need to be aware of how **local perceptions** shape community acceptance of response activities and should ensure that community mobilization initiatives **model good governance principles such as transparency, fairness, inclusion, and accountability.** For Mercy Corps's own activities in the current outbreak, this has meant **recruiting and making purchases locally** and paying careful attention to **tailoring framing and communications** to local dynamics. Organizations implementing community mobilization in the current outbreak should **continue to assess and adapt their mobilization approaches using a variety of data sources and methods,** including surveys, data visualization, socio-anthropological participant observation, political economy analysis, and local case studies.

Conclusion

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



Photo Credit: Rudy Kimvuidi/Mercy Corps

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