The AAA/Wenner-Gren Ebola Emergency Response Workshop November 6-7, 2014

Preliminary Guidances and Recommendations

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Introduction

As of November 4, 2014, the current Ebola outbreak in West Africa is confirmed to have infected 13,268 individuals, with 4,960 total deaths estimated. The global Ebola response is evolving rapidly, and as it has evolved, it has become increasingly apparent that the causes of this epidemic outbreak result from the underdevelopment of local regional healthcare systems, and several initial errors in the global Ebola response that lead to an underdevelopment of emergency response capabilities, and resulted in complications with triage, treatment, community mobilization and engagement, and communications efforts.

To prepare for the event, on November 5th, the steering committee of the AAA-Wenner Gren Emergency Ebola Response Workshop convened a meeting with policy makers, practitioners, donors, and NGOs involved in the global Ebola response. The goal of this meeting was to consult with a range of partners about their needs and priorities for anthropological guidance. Attendees included: the U.S. Department of Defense, the Center for Disease Control, the Carter Center, the Open Society initiative, the World Bank, UNICEF, the Embassy of Sierra Leone, and representatives from the U.N. Mission for Emergency Ebola Response (UNMEER).

On November 6-7th, 2014, the American Anthropological Association and the Wenner-Gren Foundation convened the workshop at George Washington University to develop directed guidelines and recommendations for the global Ebola response informed by anthropological knowledge, experience, and information transmitted through current research and peer networks. The goal of the workshop was twofold: (1) to share urgent information, practical guidances, and programmatic recommendations to implementing partners working on the global Ebola response, and (2) to build a global emergency response network of anthropologists that would be capable of rapidly deploying information and expertise to inform planning and implementation of Ebola response efforts in short-term, mid-term, and long-term timeframes. This goal was achieved, and the preliminary report of findings and recommendations are documented within this report.

This event culminated in a public forum on November 6-7th, 2014 at George Washington University to present findings and recommendations. Approximately 100 members of the D.C. area community, policy-makers, practitioners, and media attended the forum. It is also linked to the emergence of a global Ebola Emergency Anthropology Network of social scientists in the following countries: U.K., U.S., France, Netherlands, Belgium, Germany, Senegal, Liberia, Sierra Leone, and Guinea (sub-networks in Canada, and of graduate students in the U.S., are in the planning stages). This network is working across a shared multilingual platform of websites, discussion boards, and listservs at the following web addresses:

- Discussion Board: https://groups.google.com/forum/#!forum/ebola-anthropology-initiative
- Website: http://www.heart-resources.org/ebola-response-anthropology-platform/
- Listerv: https://lists.capalon.com/lists/listinfo/ebola-anthropology-initiative

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1. Care of the Sick

The most prominent feature of the Ebola response has involved the lack of health infrastructure, and the lack of treatment facilities capable of managing Ebola patients while providing palliative care in a secure environment for healthcare practitioners. As a result, much of the burden of healthcare has fallen to local communities, and healthcare workers have been disproportionately affected by exposure to the Ebola virus.

When an individual becomes sick, neither that individual nor his/her family members knows that the person is sick with Ebola. (Moreover, even if the individual is aware of symptoms of Ebola, they may experience fear and denial as a result of the high rate of mortality, scare-messaging tactics, and concerns about family left behind if they should seek treatment.)

In recent months, under the phrase "Everything is now Ebola," communities have become more cautious about disregarding signs of illness, but the culture of health and the culture of medicine as it is practiced in local communities significantly informs the process of domestic concern, domestic diagnosis, triage, and subsequent healthcare seeking behaviors. These local cultures significantly inform decisions about self-reporting, peer reporting, and quarantine.

- Health care messages and requirements need to be refocused to address the multigenerational interdependence of Liberian households.To date, communications that address health care provision among local populations have advised avoiding contact with people who are sick, avoiding the sharing of toilet facilities, exposure to bodily fluids, and overall isolation. This strategy is not viable for most of the population, who are either involved in direct physical care for the very young (under 12) and the very old (over 40). It is unlikely that families will abandon family members who are unable to care for themselves, especially if doing so imperils the lives of the young, elderly, and handicapped who are vulnerable without there care
- Trust local communities to experiment and innovate, and to generate a variety of local and borrowed solutions. Support them in this process. Local populations are learning about treating Ebola rapidly, through trial and error. These processes need to be closely monitored and supported, and studied for healthcare innovations. For example, in Liberia, people are adopting a strict no-contact policy. Some are putting plastic on their house for protection.
- The situation is highly fluid. There was resistance to homecare in Sierra Leone, only wanting hospital care. Then they changed their mind. Solutions will need to be revisited every 2 weeks to realign with local perceptions and needs.
- Food is medicine. A rapid plan to provide widespread food support should be implemented in all at-risk communities. Research has demonstrated that hunger and malnutrition undermine biological immunities, and that a high nutritional profile facilitates both prevention of disease and recovery. We do not have data on this with specific regard to Ebola, but food support should be regarded as a critical aspect of care for the sick, and prevention for the healthy.
- Diversify the models of care. Communities should have support for a range of care options, including ETU's and hospitals, CCC's, and home-based care. Choosing one modality over another creates gaps in an already failed health infrastructure. Home-based care has been underinvested in in terms of training, research, and support. These gaps must be corrected, but other systems must be simultaneously sustained.
- The assets and gains offered by proposed CCC's need to be made clear. What, precisely, is the CCC supposed to do? Is it for quarantining the sick who have not been diagnosed with Ebola? Asymptomatic

people who have been exposed to Ebola? Or is it meant to be a transit unit between the community and the hospital?

- The interaction between gender and age as a predictor of care-seeking behaviors remains unclear. This needs to be researched in the course of implementing community based programs.
- As the epidemic continues, interventions like IV-treatments need to become more evidence-based.
- When the epidemiological curves show that the epidemic is about to get out of control, there should be alternative models besides the very militarized health care delivery model. Community-based care support models should be seen as complements to, rather than competitors with, hospital-based care.
- Immediately implement an active and ongoing research program on the social factors involving care-giving, care-seeking, and healthcare provision. We need more research regarding social factors, care practices and outcomes.
- In the interest of upholding basic medical ethics, all individuals diagnosed with Ebola should be provided with palliative care to help them manage pain and discomfort, in addition to existing treatment modalities like oral rehydration solution.
- We need to provide better support for caregivers, from household caregivers, to caregivers in clinics and in hospitals. Home health care kits, including ORS, rehydration powder, fever medications, thermometers, soap, *and a cell phone and radio* can help individuals make decisions about care.
- In the context of a massive push towards the development of new treatments, it is important to recall that medical experimentation has a long and checkered history of abuses in the region. There are many good and rational reasons for local populations to distrust foreign and state-supported medical experimental campaigns, and these concerns need to be taken seriously and addressed widely.
- This is also important in the context of care, not only research. When caregivers arrive to communities that have been historically neglected, issues of mistrust might arise.
- The issue of STI's as a mode of transmission has been insufficiently addressed at the community level. This is a critical risk, as the sexual transmission of Ebola is likely to constitute a significant pathway for the transformation of Ebola into an endemic presence across the region. Practical guidances need to be widely disseminated about the fact that Ebola continues to be present in sperm for 90 days following Ebola. Based upon HIV/AIDS experience, it is unlikely that basic communications messaging practices will prove effective in addressing this issue. Instead, direct community engagement around issues of infection and sexuality is necessary. Abstinence-only, or condom-recommendation messaging will not be effective in the absence of a grassroots engagement with issues of prevention, sexual behaviors, and response. This must be undertaken carefully, as this is a critical area for the emergence of stigma and social isolation.
- Survivorship is key. We recommend the immediate implementation of a program of research to understand that current conditions, experiences, and dispositions of survivors in all three most affected countries, as well as issues of reintegration and stigma.
- Presently, survivors are being regarded as a "human resource asset" rather than as fragile individuals who have recently been extremely sick. Health interventions are accelerating towards institutionalizing the assumption that survivors will be able and willing to continue to work on Ebola-related issues, when in fact, individual survivors may want nothing to do with Ebola ever again. Furthermore, we do not know enough about the duration of Ebola antibodies to position recent Ebola patients in a caregiving capacity.

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2. Communications

At present, communications capabilities are focused on a unidirectional approach of getting messages out (ex. through posters), rather than creating a bidirectional pathway for information exchange and feedback (ex. through cell phones). Along with inadequate data centralization and identification systems, this communications structure has undermined efforts to respond rapidly to changing circumstances on the ground. Correcting this pathway can rapidly build trust, facilitate the sharing of information, and streamline multiple systems of prevention and response. Moreover, a two-way communication stream allows institutions to rapidly become aware of locally circulating rumors, and take steps to dispel them before they become fodder for conflict and resistance.

- Message Content: Early messages meant to instill fear in local populations about Ebola had the effect of terrifying people and driving reports underground. Subsequent messages about "Ebola has no cure" are going to be problematic if and when we do find a vaccine. In both cases, simplicity has the effect of undermining desired behaviors and outcomes. Ebola communications messaging efforts need to take a more open approach that seeks to educate in the context of an evolving situation, and explains to local populations why and how the situation is evolving.
- Myths and Beliefs: Liberians, Guineans, and Sierra Leoneans tend to be medically pluralistic, which means that they simultaneously pursue multiple healing strategies and beliefs simultaneously, without experiencing the different domains (ex. Christian healing, biomedicine, traditional medicine) as in conflict. It is entirely reasonable and sensible that local populations are capable of receiving sophisticated public health messages about Ebola causes, management, and patterns of transmission as a virus while simultaneously believing in alternative explanations (Ex. Sorcery).
- Learning Curves: Health communications follow learning curves. Effective communications campaigns will notice widespread misinterpretation and misinformation in the immediately implementation of the campaign, but will rapidly observe (with weeks) a widespread correction in the population, as the message is correctly filtered and absorbed. Ineffective messaging campaigns will show no such change. Present health communications campaigns are overly concerned with immediate acceptance and learning of the prescribed message, and need to offer greater information, and have tolerance for greater initial error.
- Health communications networks should be structurally integrated into case reporting procedures.
- Best Practices:
    - Work through established community leaders (not Ebola context self-appointed leaders)
    - Door-to-door campaigns
    - Use social networks, rumor, and "social learning"
    - Use hopeful and positive messages
    - Focus on empowerment
    - Encourage – but don't coerce – survivors to talk about experiences
    - Multimedia: We recommend a significant distribution of *free* one-way and two-way communications devices (transistor radios, cell-phones) to facilitate the unidirectional and bi-directional flow of information between local communities and response coordination. To date, multimedia messages have been tremendously effective in distributing Ebola information. The video of the Liberian nurse who provided homecare to her family was shared on cellphones across Monrovia, and was reported even further by word of mouth. Expatriate Internet radio call-in stations have been used to circulate Ebola-related information and messages.
- Work with all religious communities: Pentecostal and Seventh-Day Adventist populations are the fastest growing segment of Liberian and Sierra Leonean religious populations, but they have not been integrated

into the Ebola response in the way that mainstream Catholic, Methodist, and Episcopal communities have. This is regarded as highly suspect by local populations, and discredits Ebola outreach campaigns among a growing majority of Christian populations.

- Mixed messages: Concern about "mixing messages" has inhibited a robust Ebola response. For example, although healthcare has been managed principally at the community level, health-messaging campaigns have been hesitant to share information about how to manage homecare because responders are concerned that it will undermine the ETU and Hospital model of care. These concerns should be set aside. The Ebola response should take rapid steps to "meet people where they are," and provide information and support to caregivers *where there* are.
- Develop longer-form communications messaging outlets: Call-in radio shows, Fireside chats, radio-based trainings on home or CCC-based healthcare, Q&A internet shows, internet radio broadcasts from the diaspora
- The concept of "Home": Be advised that the concept of home does not mean the same thing in West Africa that it mans in Europe or the United States. When people hear "stay in your home" in Sierra Leone, for example, they may think to themselves, "oh, I'll just go home to my grandmother's house in the village to wait out the lockdown." Home means, "Where are your people from," as well as "where do you live." And given the wide degree of cultural heterogeneity, most people have many homes.
- Overly Simplistic Messages: Evidence suggests that local communities have rapidly learned and mastered a core set of messages about Ebola transmission, management, and treatment strategies, and that communities are not dealing with a lack of basic information, they are trying to manage Ebola with a lack of sophisticated, detailed, and relevant information (ex. How to clean up Ebola-infected fluids in a household with a cement or dirt floor; how to safely perform a burial when burial teams do not arrive; How to provide resources to quarantined individuals and families under complex conditions. Community messages need to become more sophisticated, more relevant, and more detailed, but must also integrate local conceptions of disease and misfortune (ex. "Swears" - SL).
- Photojournalism: We recommend the exercise of far greater restraint in the photojournalism campaigns deployed in this epidemic, for both fundraising and reporting purposes. Current photojournalistic representations of sick and dying Liberians, Guineans, and Sierra Leoneans are uncompassionate and inhumane. Individuals who are suffering, in extreme pain, and are writhing on the ground fighting for their life are not being granted their dignity when their images are splashed on the cover of major news mediums, websites, and fundraising material. Such images are also contributing to the perception that all Africans are carriers of disease, and are creating a hostile and discriminatory environment for African expatriates globally.
- Avoid "war" imagery: While fighting, attack defense, and war are all powerful images for mobilization, the application of war imagery to the fight against Ebola can have the effect of supporting social conflicts, sedimenting social divisions, and making people feel like they have to physically mobilize or flee. Remember your audience. Perhaps shift to a soccer metaphor instead?
- Ebola as Political Critique: Communications around Ebola messages can (and have been, in the past (Gabon)) been effectively to attack national governments, with the consequence of delegitimizing the Ebola response. Backstage political interventions may be required to prevent or divert this kind of action. When deployed by diaspora communities, it can discredit Ebola-related messages that are concurrently offered.
- Emphasis on "care," not on "war": The focus on war imagery may lead to distorting effects downstream. It is imperative to focus on widely resonant conceptions of caregiving and responsibility, rather than on

resistance and battle. This will become particularly important if and when blood plasma transfusions are adopted widely for treatment of Ebola patients. The "gift" of blood will be more gracefully acceded to than the demand for blood to fight a battle, which has negative resonance with how occult conceptions interacted with the practice of war.

Group 3: Mary Moran, Gwen Heaner, Mark Nichter, Robert Hahn, Doug Henry, and Barry Hewlett

3. Health and State Systems Strengthening

The current models of the Liberian and Sierra Leonean health sectors are just 12-15 years old, and are a creation of the international community. The model, as designed, has created a system in which *epidemics are endemic* and the capabilities of local urban and rural resources are underdeveloped. There needs to be shift from current patterns of underdevelopment, decentralization, and enormous expenditure in moments of crisis to a pattern that promotes greater stability, long-term health sector development and expansion. This will assure better overall minimum health and health surveillance standards. In order to achieve this goal, certain minimal criteria for a functional health system will have to be attained:

Recommendations For Stability:

- **Increase mobility within the health system, and add a capacity to react systemically to localized events, and prepare a response.**
- Expand and fund health system. Pay for additional salaries.
- Increase mobility within health system. Take advantage of trained yet unemployed medical personnel.
- Remobilize former systems that addressed other diseases, such as Lassa Fever.
- Assure that the supply chain is working and is properly funded. (Many systems are funded perfectly when built, and then supply chain bottoms out.)
  Create widespread identification system that is not linked to citizenship. (Perhaps utilize existing structures of identification, like Guinea dispensary information, community based surveillance – see Section 8)
- Increased vaccinations for children provide opportunity for growing health database.
- Respect and utilize local health knowledge
- Respect the role of local herbalists and healers as providers of psychological/cultural comfort, support, and conflict resolution. Integrate them as community leaders into training and surveillance activities, as well as community healing responsibilities.

Recommendations for Emergencies:

- Strengthen infectious control disease facilities.
- Create the capacity for the centralized collection and analysis of data so that interventions can be taken based on the epidemic curve before hospitals are at saturation.
- Emergency response cannot focus on one single disease. Epidemic response must sustain a system of healthcare for co-morbidity issues, or mortality and co-morbidity will increase across the board.
- Support the widespread implementation of rapid testing mechanisms. Engage in frank and open dialogue with local populations about the meaning and prevalence of false positives and false negatives to avoid discrediting of testing mechanisms.

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4. Streamlining Local, National, and International Response

- **Create a chain of command to link various multilateral, national, bilateral, and local efforts. Create capacity for chain of command to endure after the dismantling of UNMEER.**
- **International:** Different countries need to coordinate approaches to caregiving. A lack of coordination at the multi-national level is resulting in the perception at the local level that "better medicine" may be available elsewhere (i.e. from Liberia to Guinea, or from Guinea to Sierra Leone). Inconsistency across national boundaries can induce treatment-seeking mobility and local distrust of available healthcare systems.
- Prepare for a transition from US involvement to international takeover. The response is gradually learning from past mistakes and existing challenges. This learning curve is likely to be interrupted if there is insufficient preparation for a transition from U.S. involvement to international authority within the next 3-6 months.
- Examine specific aspects of aid conditionality that are impeding nimbleness in epidemic response.
- **National:** In order to coordinate national and international responses, coordination meetings need to take place daily or several times a week, rather than once a week. Once-weekly meetings make it impossible to feed local situations into national and international responses, and places international and national systems in a status of "reaction" rather than proactive pre-emption of emerging problems.
- Examine existing systems for bottlenecks, and create bypasses. County medical officers are poorly trusted in both Sierra Leone and Liberia. The position is not an autochthonous position with local legitimacy. It was created as part of an effort to promote local accountability and decentralization in the healthcare sector, but the effect has been the opposite. County medical officers are seen as intentional bottlenecks in the flow of money and medical resources, and as prominent diverters of resources. The status of CMOs in any epidemic management system needs to be carefully revisited.
- **Local: Communities** have high historic and current capacity for prevention and response, but there is a lack of coordination and integration among local communities.
- Maximal efforts should be made to redistribute aid to the local level, rather than aggregating it at international, national, and institutional bottlenecks. Instead, A "capillary approach" should be taken to ensure that cash, supplies, and resources are made available to micro-social units of community organization. This will be relevant for food and medical resource distribution, and for implementing alternative patterns for a two-way flow of information.
- In all three countries, the current Ebola crisis has lead to a catastrophic impact on economic activity. Food prices are skyrocketing, and food insecurity is about to rise. Therefore, all forms of local labor should be compensated, and no form of labor should be requested or sought as "voluntary." This constitutes a form of economic abuse.
- **Data Bottlenecks:** Currently, the inaccessibility of existing data (i.e. registries and case tracking) is impacting coordination. The current system of data collection is as follows: Teams go out with detailed case intake forms (age, occupation, etc.), and information collected is aggregated at the Ministry of Health level. Data is sent and stored in Western academic institutions for the writing of reports; and the actual raw data then disappears/becomes inaccessible. This is impeding the use of existing data for comprehensive

analysis and response by the scientific community, and is creating barriers between practitioners and their own information.

5. Risk Factors (Children, Food Security, Gender)

Food Security

Right now, all three countries are entering the dry season, and approaching the harvest phase of the agricultural cycle. Due to the epidemic, it is likely that farmers will be unable to mobilize sufficiently large agriculture support teams, and harvests are projected to decline by nearly 50%. If this happens, the consequences of food shortages are likely to be felt much more rapidly over the coming year. The hungry season will be likely to begin in March or April, rather than months later, and people will eat their "seed rice," or the rice that has been set aside for planting for the following year, leading to a collapse of next year's agricultural yield. Therefore, the impact of the Ebola epidemic is likely to head to large-scale, region-wide food insecurity for nearly 24 months from the time of writing.

- Due to pending disruptions of two consecutive agricultural cycles, plans should be set into place immediately to provide supplemental food support across the region for the next 24-months, as well as see rice for the next annual rice planting. This is relevant for food supply in both rural and urban areas.
- If Ebola-related precautions require the discouragement of mobility within and across regions and national boundaries, food support will need to be provided locally across the region for 24 months.
- Food and income-seeking mobility is bidirectional – moving from urban-to-rural, and rural-to-urban. This can result in the transmission of Ebola into previously unaffected areas, including remote rural areas, and unaffected regions like Western Cote d'Ivoire.
- There needs to be a clear differentiation made between mobility for income and food-seeking purposes, and mobility that is due to sickness. Sickness-related mobility may need to be quarantined, while income and food-seeking mobility should not be discouraged, unless systems are established to offer local alternatives.

Relatedly, as the rainy season ends and the dry season begins, there's going be a rapid acceleration of male mobility. As the roads dry and become passable, young and older men will start to do what they have always done in this region – they will take to the roads, and move across the region, and across borders, to engage in wage labor in the mines, woodcutting in the deep forests, artisanal diamond digging, and work on the cocoa plantations. This poses a direct risk for the spread of disease into currently unaffected areas.

These factors need to be taken into account when considering epidemic management and care-giving models. Food security has an impact on immunity, and reciprocally, food access is having a direct impact on compliance with recommendations for Ebola diagnosis and management. This is but one example of the varied ways in which international, national, and local level coordination is need in order to effectively respond to the crisis.

Orphans and Youth

Local communities have strong traditions of fosterage that are presently under strain, and need to be supported with financial and food resources. While many communities reported in August and September that they would be willing to take responsibility for children orphaned be Ebola, they noted that they would be able to absorb 2-3 children with existing resources, but not 12 or 20. Communities are enquiring about the psychosocial and grief counseling needs of orphans. They want to know these issues are being addressed, or they would like to be trained to address these issues themselves.

As time has passed, it is increasingly apparent that stigma is playing a role in children's community reintegration, and the problem of stigma is undermining community support for fosterage. Local communities are shunning

children who have recently lost family members. When children are unable to reintegrate into communities, they require a central point of shelter where they can seek care during an interim period. Post-conflict “family tracing” systems should be revived to help children locate extended family members.

The epidemiology of child survival is a mystery in the context of the Ebola epidemic. It remains unclear why children are not forming a greater proportion of reported cases. Why are a relatively small proportion of children being infected, or being reported to facilities to testing? These issues require further investigation.

Gender and Age

Both gender and age are presently having an unknown impact on the spread of Ebola, the course of Ebola, and patterns of Ebola healthcare trajectories. Based on our ethnological experience, and our review of the current public health and medical literature, we believe that gender is a risk factor for Ebola infection, but that there is a strong likelihood that the risk is impacting to modalities and pathways of infection, rather than overall rates of infection – which are appearing to balance out. While women, for example, are more likely to be infected through basic caregiving and household activities, men are more likely to be infected through their roles as transporters and porters, and as workers on burial and healthcare teams. While for women, risk principally derives from household contact, for men, risk appears to derive from their greater mobility. We also have concerns about how gender is impacting *when* in the course of disease hospital or ETU care is sought. We suspect that men are more likely to seek care earlier in the course of illness, possibly improving overall health outcomes, while women are more likely to defer seeking healthcare. To echo a point made previously in this report, our concerns about differences about the speed and patterns of healthcare utilization after the onset of sickness supports the provision of a range of treatment options in the household, at the community-level, and in hospitals and ETUs.

The role that gender has as a predictor of healthcare services utilization, health outcomes, and caregiving practices remains unknown. Very little data is available that has been disaggregated by gender, but we are in agreement that hospital and ETU admissions data is a poor criterion for analysis, because men, who tend to have more disposable income, have disproportionately higher rates of access to hospitals and ETUs. We are also concerned that hospital and ETU admissions are a poor criterion for analyzing patterns of child morbidity and mortality because we suspect that children are less likely to be brought in for care, and are more likely to die before receiving treatment.

Gender and age are co-factors that predict highly varied social roles and responsibilities. Due to the significance of highly structured gender and age roles, it is of vital importance that all data collected be disaggregated by gender and age, as gender/age cohorts have highly distinctive sociological profiles.

The transmission of Ebola through sexual transmission also requires further virological, public health, and ethnological investigation. Substantial lessons can be gained from our recent experience with HIV/AIDS.

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6. Attending the Dead

The recent development of the WHO Guidelines for a safe and dignified burial mark a significant step forward in addressing funerary practices and the management of corpses in the context of Ebola, but more work remains to be done. Participants highlighted the fact that there is considerable sub-regional variation in funerary practices and priorities, requiring local and anthropological consultation. They also noted that any alternative burial modalities have existed in local cultures to accommodate the deaths of individuals who have died in unusual circumstances,

and when their bodies have not been able to be recovered (ex. While doing agricultural burning practices, drowning). Moreover, participants noted that burials exist in the context of a large informal and formal network of part-time burial and funerary experts in every locality. Part-time and full-time practitioners involved in mortuary ritual practices need to be engaged as skilled and knowledgeable colleagues who are capable of modifying ritual practices, rather than as uninformed audiences.

- As in the context of other Ebola crises, the local community has received the public health message that corpses are a potential source of transmission of Ebola. While this message may need to be extended further into rural communities, the next path of communication needs to address the *specific* needs of local communities for the management of dead bodies, especially in contexts in which it may not ever be known if individuals have died of Ebola.
- Guidances regarding burials need to accommodate the fact that requesting the assistance of healthcare teams or burial teams is unpractical in many contexts. Alternative guidances need to be shared, and an ongoing open forum needs to be created for local communities to engage in specific questions and answers with local experts.
- It is unlikely that the Ebola response will be able to identify a "one side fits all safe burial" set of practices. Instead, core recommendations should be made that can be integrated into diverse ethnic, religious, and regional communities.
- Family members want a way to see the body after death. Options include photographs, cell-phone photographs, and personal witnesses. This will alleviate concerns about bodies disappearing, and address fears that family members' bodies are being used for ritual mutilation and dismemberment.
- Communities and families need a more complete explanation of what is happening to bodies after death. Transparency and visibility is key to resolving existing distrust issues.
- The location of buried bodies or cremated bodies needs to be made widely known and highly public. In all three countries, the recent conflict has created a legacy of populations who have been separated from family members, never to find them again. Some have reported that it is highly disquieting to walk on the landscape without knowing of the bodies of their loved ones are beneath them. The current situation should not contribute to these existing anxieties. Families need a burial location, and a site of memorialization. Local consultation will need to be taken to determine if sites of memorialization should be combined, or separated by religion or ethnicity.
- There is considerable religious diversity within families, and burial practices need to address the religious requirements of the deceased. This cannot be inferred from the religion of close contacts or relatives.
- Local communities are innovating alternative burial practices, and have historically done so, as well. For example, once West Africans began migrating abroad, it was not possible to convey the body to a home village for burials. Alternative practices were implemented that involved practices like touching a stone or wood to the skin of a corpse, and sending the stone or wood home. Communities that have innovated new practices should be credited for having done so in public campaigns to replicate these practices elsewhere, as this is a mark of prestige and local legitimacy, and can function as a community-based endorsement of the practice.
- Sylvain Landry Faye has considerable experience working with local communities in Guinea to adapt funerary practices to the Ebola context. His efforts should be scaled up and circulated widely.

- A national day of memorialization should be created in countries where local communities desire it. Furthermore, resources should be made available to support local communities in existing days of mourning, as with the annual "Cleaning the Graves" day in Liberia, forthcoming in Spring 2015.

The most prominent feature of the Ebola response has involved the initial lack of health infrastructure to identify individuals at risk of Ebola, identify symptoms of Ebola in newly infected individuals, and the lack of treatment facilities capable of managing Ebola patients while providing palliative care in a secure environment for healthcare practitioners. As a result, much of the burden of healthcare has fallen to local communities, and healthcare workers have been disproportionately affected by exposure to the Ebola virus.

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7. Identification and Diagnosis

A critical, and widely recognized barrier to effectively stopping transmission of the Ebola virus is the failure to identify and track new cases of Ebola patients. Each new case of Ebola requires prompt identification, early intervention, and supportive treatment. Efforts to provide these are expanding. However, Ebola is, in many respects, a disease that is transmitted through the social interactions of physical contact, caregiving, burial, and normal human social interaction. Therefore, the identification of individuals who are at-risk for contracting Ebola, and the identification and surveillance of those who have been exposed to Ebola is imperative. These relations track along commonly shared patterns of interaction, social engagement, and social relations of care.

Identification at every juncture in the Ebola-disease pathway is complicated by the absence of formal institutional structures for identifying individuals in each of these three countries. In the absence of formal identification systems, the responsibility to engage in surveillance devolves to local communities, which are trusted, are the only institutions scaled to engage in individual tracking, hold community's trust, and are aware of local residents' vulnerability to disease through their familiarity with their daily movements and contact networks. In the recommendations below, we offer guidance for implementing community-based surveillance and identification systems.

Engaging local communities in identification of individuals is a crucial line of defense against Ebola, but it should not be regarded as the best line of defense. While community-based surveillance can be effective at containing Ebola in the short-term, the absence of formal systems of identification and reporting like birth registries, death registries, and the provision of international health identification numbers makes the emergence of an epidemic on the scale of this Ebola outbreak likely in the long-term.

Local: Instead of sending teams to collect data, implement low-cost and more reliable alternatives: **Community-based surveillance**. Hand off surveillance duties to local village nurse practitioners, traditional care givers, midwives, etc. Local community leaders also hold a high level of trust. They can and should be collaborated with to engage and lead local communities in all issues pertaining to surveillance, identification, and reporting.

- Local communities should assume responsibility for surveillance. Local community leaders can serve as a two-way communication source for the transmission of needs, concerns, problems, and innovations in the community, and the reporting of cases of infection and death to health authorities.
- At the community-level, previous systems implemented under governmental authority can serve as a template for community surveillance and identification. For example, in Guinea in the 1960's-1980's, every community had a local dispensary, and the manager of the local dispensary kept track of the health status of individuals in the community on a daily/weekly basis. If any individual showed signs of unusual or atypical symptoms, the dispensary would note the fact that someone was sick on a chalkboard or in a

notebook, and the information would be sent to sub-regional health offices, which would respond with further investigation and treatment protocols. This is a system that can be implemented.

- Heightened community-level surveillance in the absence of careful community guidelines for doing so can result in negative consequences. Increased reporting might lead to an increase in locals concealing contact with someone who has had Ebola, or deferring informing someone about symptoms of illness, out of a fear of shunning or being reported.
- Heightened community-level surveillance can also lead to scapegoating. Perceptions that someone has Ebola can result in the scapegoating of individuals in the community who have moved in or arrived from outside the community or from other countries; as well as marginalized individuals, and individuals who appear to be symptomatic or sick for any reason. This can result in the loss of jobs, sources of revenue, and isolation as well as mob violence towards specific individuals.
- If the consequences of reporting are seen as excessively punitive, fearsome, or disrespectful (see Sierra Leone model vs. Mali model in Section 9) community members can revolt, or undermine local authorities.
- Community-based trust must be supported at all times. Local leaders must be able to retain their role as legitimate stewards, allies, and representatives of their local communities, and not seem to be allied state or the international community against the local community.

National: More human, information and IT resources need to be invested in identification practices and systems. The lack of effective identification and surveillance systems are resulting in fundamental challenges for the Ebola response. For example, a lack of information about ID and case tracking has made it impossible to explain recent shifts in the epidemic trends. This is untenable for continued epidemic surveillance and response.

- Large-scale systems of rapid and distinct identification have been successfully deployed in the region during the recent conflict. We recommend that mechanisms like those used by UNHCR should be deployed to issue identification rapidly. Identification information can be documented locally through local leadership groups and local institutions, and changes in health status can be tracked and reported. This would also facilitate the accurate reporting and tracking of all deaths – not just deaths due to Ebola – that can help identify other emerging epidemics. This also constitutes a critical aspect of health systems and governance strengthening.
- In contexts in which there is a low level of trust between state governance institutions and local populations, identification systems can be used for various nefarious purposes. They can be used for to extend state authority through abuse or coercion, and they can be used as a method for excluding or persecuting individuals from other regions, ethnicities, religions, or nationalities. As the recent example of tbe Cote d'Ivoire conflict demonstrates, national and international identification systems have been used to prevent individuals from receiving services, holding or using political or economic rights, having legal recognition, and can be crude mechanisms of exclusion. These factors should be taken into account when considering the design and implementation of any national or regional identification system.

International: the existing system for the international reporting Ebola-related deaths needs to be revisited, as there is widespread public grumbling in Africa and abroad about the perception that the only deaths that appear to "count" are Ebola deaths. This appears as callous and indifferent. In a context of extremely high mortality rates due to a wide range of epidemic and endemic diseases, **the international community's concern with global health in the region would be better demonstrated by demonstrating that all deaths really do count by counting all deaths.**

- Additionally, local community leaders should have a capacity to report mistakes, missteps, and errors by international actors in order to improve local accountability.

- Programs set in place in the immediate post-conflict period to assure that international/local flows of resources arrived at their destination (ex World Bank) should be reinstated.

Group 7: Annie Wilkinson, Adia Benton

8. Surveillance and Quarantine

Quarantine must be retained as an effective intervention to prevent transmission. However, we advise that robust and widespread community-based and community-run quarantines are a superior option to state-run quarantines. At the same time, we are aware that not all communities are comfortable self-imposing quarantine, and prefer to defer to the authority of the state.

It remains unclear whether or not the Sierra Leonean experience of large-scale quarantine was effective at slowing the spread of Ebola. On the one hand, quarantine may increase intra-household transmission while decreasing inter-household transmission. On the other hand, some evidence suggests that the lock-down may have accelerated community-based learning about Ebola through household-to-household visits by health workers conducting home-based sensitization.

Quarantine

- Facilitate local and self-diagnosis by providing more detailed guidance regarding the symptoms of Ebola, and the symptoms of other diseases, as well.
- Help local populations differentiate between Ebola and other sicknesses by providing basic medical education about endemic diseases and injuries within the community.
- Ask individuals within local communities where they go and what they do when they perceive symptoms. Specifically, are their symptoms that they regard as “big hospital sickness,” or symptoms that they recognize as “small sickness?” Realigning local assumptions regarding symptomatology can help individuals undertake self-referral and quarantine behaviors in a timely manner.
- Provide guidance and resources to individuals to help transport Ebola patients to healthcare facilities safely. At various times in the recent epidemic, taxis delivering Ebola patients to ETU’s have been asked to remain until they have been sprayed with disinfectant, so as to prevent the surface-to-skin contact of bodily fluids with a future passenger. Precautions like these need to be made more widespread, but guidance also needs to be communicated to taxi drivers, bus drivers, motorcycle drivers, and porters (patients are carried to health facilities) about how to remain safe. Porters, in particular, are highly vulnerable.
- Nearly all of the transporter populations have unions or other organizations, which can serve as a crucial point of contact for community engagement with the Ebola response.
- Due to issues of distrust between local populations and governments, we recommend community-controlled quarantines rather than state-run quarantines. A widespread system of local community quarantines, along with a system of restricted mobility, can effectively contain the disease without requiring the more drastic steps of shutting down international borders.
- We recommend supporting community-based quarantines, but we feel that a new approach must be taken to the process of quarantine. Individuals should be able to choose if they wish to be quarantined in their households, at CCC’s, or in ETU’s and hospitals. They should receive assurances that their children and families will be provided for throughout their period of quarantine with food, bedding, adult supervision, and access to family, social support, and education, and these commitments should be upheld so as not to lose trust.

- Communities should be provided with the means to provide for and monitor individuals in quarantine safely, and without incurring costs to already fragile local household and community economies.
- Communities require ongoing delivery of complex information and guidance for managing community-based quarantines in order to resolve challenging systematic issues, like how to quarantine a household of children with no adults. This can be delivered through secondary communications mechanisms, especially radio and cellphone.
- Communities require training to provide palliative care to people who are sick in their households.
- The initiation of quarantine constitutes a very important and very sensitive moment in shaping community response to Ebola intervention and support. **Responders should always anticipate that quarantine would be met with resistance, and take steps to defuse confrontation** rather than induce it. The use of military and police forces to initiative quarantines in communities, or "the Sierra Leone model," should be avoided at all costs, as it is regularly leading to physical, and sometimes deadly, confrontations between police and security forces and local populations mounting resistance. Instead, the "Mali model" for quarantine should be adopted. In the "Mali model," families that are being approached to engage in quarantine are approached with fuel, food, blankets and bedding, cleaning materials, and medical supplies from the outset, and are assured that they will have all of their needs provided for while they undergo a 21-day quarantine.
- Steps need to be taken to reduce stigma for individuals who have undergone quarantine.

Mobility: Checkpoints and Roadblocks

- The international community should recognize that local populations are very invested in controlling flows [both visible and invisible] in and out of their community. Given the invisible nature of the Ebola virus, local communities are reactivating practices they used in warfare, including mounting checkpoints and roadblocks in and out of local communities. Checkpoints and roadblocks are a highly visible tactic being deployed by local communities to address the spread of Ebola to keep strangers out – including the international community.
- We advise that the global Ebola response take an agnostic attitude towards checkpoints, and to consider them as an important site of engagement with local communities. We advise that interventions regard roadblocks and checkpoints as an important point of entry and egress for all kinds of material coming in and out of local communities – viruses, medications, food and medicine, rumors, and humans.
- Young men often man checkpoints and roadblocks. This can result in a situation in which local elders lose control over young men, and the possibilities for violence and indiscipline rise. We recommend addressing this problem in a proactive manner by establishing guidances and regulations for the conduct of local roadblocks and checkpoints. An emphasis needs to be placed on avoiding economic or physical abuse, on community leadership control over roadblocks, and on the use of non-violent conflict resolution mechanisms when conflicts around roadblocks emerge.
- When engaging with checkpoints, we recommend the deployment of respected individuals who can serve as representatives of the state, like nurses, community health workers, and local leaders, rather than police and military forces. Caution must be taken when imposing limitations on mobility. Wealthy and elite citizens can often move around freely and easily, and marginalized populations may be able to slip through, but most people in the middle can be unduly burdened by limitations on mobility.
- There are different reasons why people engage in mobility. As the dry season progresses, people will be moving across the region for burials, for work, to visit family, to engage in agricultural and artisanal labor, and even to participate in the Ebola economy. People will also move because they are sick, and are seeking treatment. Different types of mobility require different standards of intervention. If people are moving to find food,

provide food to them in situ. If people are moving to find treatment, help them locate treatment closer to their point of origin. If people are moving for labor migration purposes, it is vitally important to understand the economic impacts of limiting this form of migration.

Group 8: Catherine Bolten

9. Military Coordination, Militarization, and Security Issues

The current epidemic has three significant characteristics of militarization that are likely to have a substantial impact on current and emerging aspects of the Ebola response. Military coordination refers to the fact that multiple countries are using military forces and capabilities to address the Ebola response. In some cases, as in the United States, this is one of the first times those militaries have ever been used in a global health emergency deployment, and the preparedness of the personnel is in question. Militarization refers to the activation of the Liberian, Sierra Leonean, and Guinean national armies and police in the Ebola response, but it also references the fact that networks of community self-defense are being mobilized in many local urban and rural communities, bound together through conventional local institutions, and through ex-combatant networks that remain in place from the last conflicts. By the term security, we refer to the capacity for the current situation to devolve further through the emergence of civil unrest, conflict, force migration, and protest and resistance, and the possibility for the emergence of violence.

Presently, bilateral aid, including military involvement, is closely following historic patterns of colonial presence – with Guinea receiving aid principally from France, Sierra Leone receiving aid from the U.K., and Liberia receiving aid from the United States. This is creating significant discomfiture in local populations, as it appears to be a rebirth of classical colonial patterns of occupation. There is the potential that, amidst emerging political tensions around Ebola, there lies a risk that “mission creep” could emerge, especially of foreign military forces are called upon to prop up a challenged government, or could be caught up in confrontation with local populations engaging in resistance, protest, or other kinds of mass actions. We note here that military involvement and militarism are not the same thing.

- **Local histories of colonization need to be taken seriously**. There are reasonable and valid reasons for local objections to multi-national military involvement in the Ebola response.
- The multi-nationalization of the Ebola response in each country can go a long way to alleviating **concern about progressive colonialist ambitions**. The integration of even small units of trusted African multi-national forces (ex. Namibia, Kenya) and African military forces with experience with Ebola (ex. Uganda) can go a long way to avert local concerns regarding the international use of the epidemic as an excuse for recolonization. This multi-nationalization is not restricted to African forces, however. In Guinea, for example, local populations are often highly distrustful of the French military due to its specific historical relationship, but have warmer memories of U.S. military involvement with the vaccination campaigns of the 1960s.
- **Clear and public statements** should be issued regarding military activities, contributions and plans of all military presences, with specific details given regarding their roles in the Ebola response, the contributions they are making.
- **Local communities should be made aware of military chains of command**. Contact information should be provided for reporting suspect issues or perceived abuses in order to avoid the possibility for confrontation. It may not occur to military forces to disseminate this information, so government and non-governmental agencies should actively seek this information and make it available. Since there may be a number of different service

elements in an area and individuals rotate, this may mean trying to get both a local contact – by billet, as well as name – and a contact much further up the chain at a point where somebody is responsible for multiple elements.

- There needs to be **public discussion regarding what will happen to the infrastructure** that is being built by international military forces on the ground, including hospitals, ETU's, and CCCs. Who will own and operate these resources over the next three months? Six months? 12 months? How will these resources be transitioned to local operators? Will material and resource supply chains and staffing continue to be supported through transitions? Who will have authority over them after the Ebola response? These questions need to be addressed, as they are an ongoing source of public anxiety.
- Despite the recent post-conflict professionalization and restructuring of police and military forces in Sierra Leone and Liberia, these processes should not be regarded as complete. While some discrete police and military units are regarded as trustworthy and collaborative, like the family support units in Sierra Leone, **local populations often regard police and military units as predatory and dangerous.** The current epidemic can expand their reach in ways that induce confrontations with local communities, especially when military or police forces are used to support healthcare teams or burial teams trying to remove the sick or dead from communities.
- **Support should be provided to all existing local organizations currently involved in the monitoring of abuses among police, military, and governmental forces.**
- The global Ebola response is introducing a **vast supply of finances and resources that is effectively building a new "Ebola economy."** It should be expected and anticipated that there will be struggles and competition for resources between parties operating at the local level. Local economic conflict is going to be inevitable, but now is the time to review the best-practices for conflict resolution that were deployed in the aftermath of the Sierra Leonean and Liberian conflicts. These can be rapidly adopted and implemented widely.
- Seek opportunities to push information about military and militarism considerations to both local and headquarters elements of involved military organizations. While some military personnel may have received culture-related pre-deployment training, many will arrive unaware of how they and local security forces are perceived and how their actions may exacerbate situations.

Group 9: Susan Shepler, Fredline M'Cormack-Hale, Vinh-Kim Nguyen, Catherine Bolten, Anita Schroeven

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