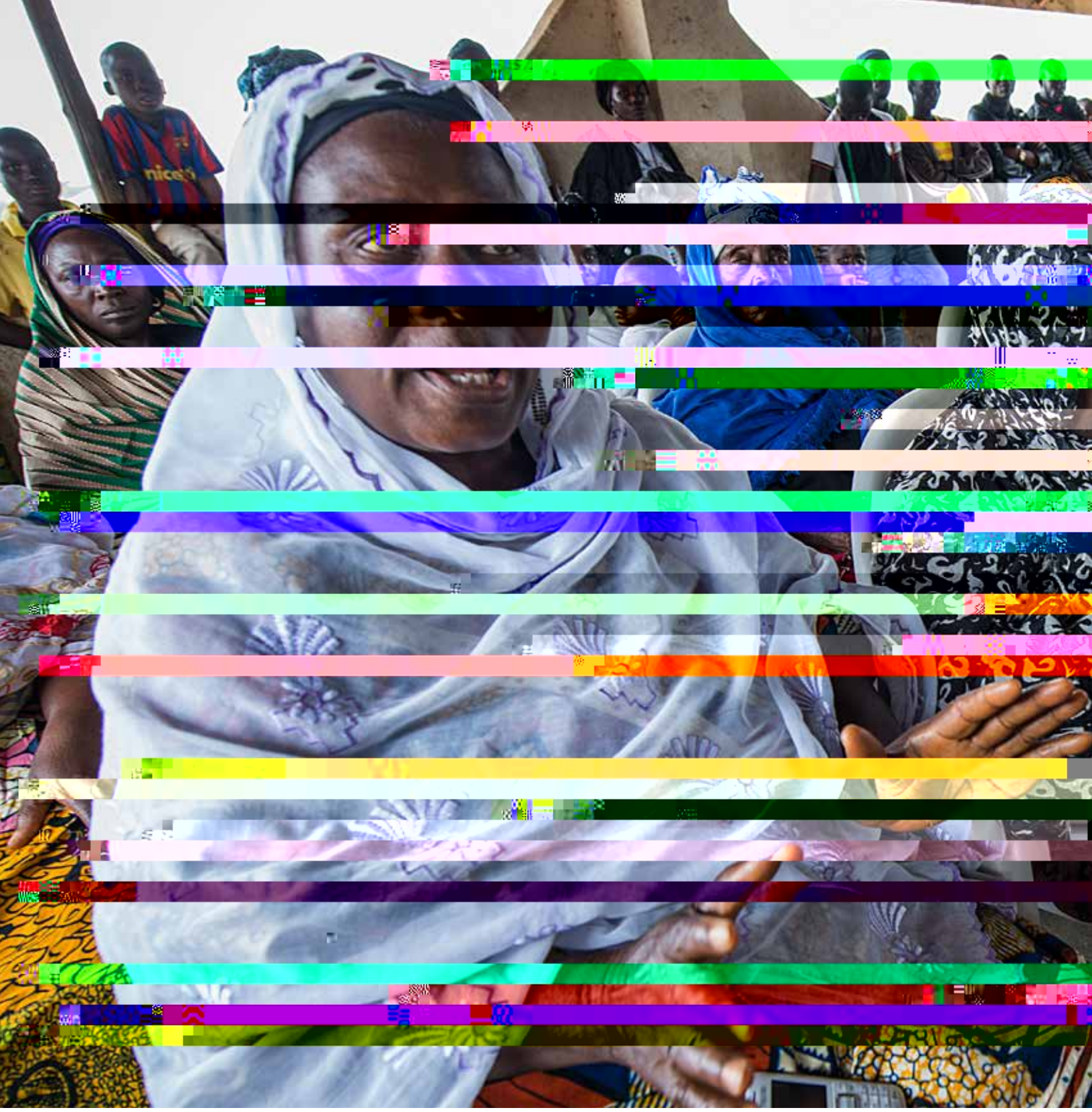

A Different Kind of Army

INTERNATIONAL RESCUE COMMITTEE

A Different Kind of Army

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FRONT COVER: A woman speaking in a community meeting about Ebola in Lofa County, Liberia, October 2014.
BACK COVER: Road to Foya, where the Ebola virus first crossed into Liberia from Guinea, October 2014.
OPPOSITE PAGE: Community meeting about Ebola in Lofa County, Liberia, October 2014.

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INTERNATIONAL RESCUE COMMITTEE

The IRC's Ebola Reponse

The International Rescue Committee (IRC) is leading a large-scale response to the Ebola epidemic in the most affected regions of Sierra Leone and Liberia. The IRC is involved in all major areas of Ebola control and mitigation, including case identification, lab testing, treatment of Ebola patients, contact tracing, burial, infection control, data management, coordination, and support for primary health care clinics.

These factors are also linked with each other. Changing cultural norms is difficult under any circumstances but especially so when institutions advocating for the changes do not have the trust of communities.[6] The starting point for any planning and action must be an understanding of the distrust of authority, the trauma of war, the inherently frightening nature of Ebola, and cultural priorities. The relative importance of each factor varies from community to community, but they have one common point: they are best addressed by restoring a sense of control to communities and individuals alike.

> “We even prefer war to this Ebola war. Because if you hear that war is coming to the area, you can run. But with this Ebola, you don’t know who is who.”
>
> —MAN FROM LIBERIA

Communities in control

If this epidemic is to be stopped, community engagement must not be limited or undervalued. Community leadership must be placed at the heart of the global response.

What is a Community?

Community health has become a cornerstone of global public health. Many public health schools have community health departments, and many ministries of health in Africa have community health units. There is agreement that policy makers and health workers must focus on communities, since that is where the majority of infection prevention measures must take place.

Many policies, however, have put communities in limited roles to implement models designed by others. Community members employed by organizations often deliver messages developed far from the communities they serve. Messages have not always been tested for their acceptability or effectiveness. More recently, community health workers have been trained to provide treatments for common illnesses, but often under careful supervision and under instruction to follow procedures.

Arnstein's ladder of public participation (*see below*) demonstrates that these types of approaches fall in the middle of the scale and short of community empowerment. The ladder illustrates the range of potential for incorporating communities in response efforts. We must understand the crucial distinction in terms of approach, activities and outcomes between tokenism and citizen power.

The International Association for Public Participation has developed another scale (*see p.7*) that is helpful in distinguishing between different levels of community engagement.[7] The scale classifies community action from ones in which the communities are passive, such as being informed about actions taken by others, to ones in which they are most active, including collaboration between equals. The scale culminates with communities taking the lead in determining priorities, and

deciding how those priorities can be implemented. The general trend in global community health has been a rise from the lower end of the scale towards the middle.

By both measures, the global Ebola response is positioned in the middle of the scales, offering opportunities for improvement. A number of strategy documents developed by U.N. agencies

Where community leadership is working

Individuals and groups in Liberia and Sierra Leone show what can be achieved when communities are in control, and why support for this type must be scaled up.

as well. I knew I had to go visit my village."

Tamba returned to his village, Gbandu, near the border with Sierra Leone and Guinea — close to epicenter of the West African Ebola outbreak. To his surprise, he was greeted not with hostility, but joy and relief. Villagers had been waiting for someone trustworthy and informed to talk to. They immediately

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or community member."

Many of the responses detailed the difficulty of reconciling Ebola control measures with traditional customs, particularly burials.

"We do not like it that way at all," a leader said. "It has not been our culture and tradition to do so, and it is very painful."

Changing such behavior has proven to be an intense challenge in both Sierra Leone and Liberia. Despite these challenges, community leaders in Kenema expressed a willingness to

he was also starting a non-profit Refuge Place International clinic. As he was in the process of graduating the first batch of public health technicians in March 2014, he was quickly confronted with the spread of Ebola. Fortunately, he had the trust of senior officials at the Ministry of Health and of neighborhood groups.

Dr. Fallah quickly came to realize that there was a disconnect between the residents of Monrovia and health authorities. Many individuals did not believe official information about Ebola, and many people did not believe that the disease existed. As a consequence, many individuals were not referring suspected cases of Ebola for treatment or notifying authorities of the disease's spread.

Dr. Fallah initially began working on a small scale in Wv ao8(s)-11.4(t)]TJ0 -1.368Pe

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COMMITTEE