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CASE COMPETITION

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Collaborating, learning, and adapting (CLA) have long been a part of USAID's work. USAID staff and implementing partners have always sought ways to better understand the development process and USAID's contribution to it, to collaborate in order to speed and deepen results, to share the successes and lessons of USAID's initiatives, and to institute improvements to programs and operations. Through this case competition, USAID and its LEARN mechanism seek to capture and share the stories of those efforts. To learn more about the CLA Case Competition,

Rapid Collaboration, Learning, and Adapting: Community-Based Response to Ebola

David Humphries, Global Communities

What is the general context in which the story takes place?

When Ebola struck Liberia, USAID, Global Communities, and the Government of Liberia (GOL) were already collaborating closely on the Improved Water Sanitation and Hygiene program (IWASH). Since 2010, in Nimba, Lofa, and Bong counties, the partnership had implemented Community-Led Total Sanitation (CLTS), adapted to the local context, in 350 communities, and had supported 284 of these communities to become certified open-defecation free (ODF) by the Ministry of Health (MOH), one of the key goals of CLTS. Together, the collaboration had also developed the GOL's country-wide sanitation strategy.

From the first cases of Ebola in Lofa County in March 2014, USAID and Global Communities adapted the IWASH program, which was in its final stages, to include Ebola prevention education, and to provide sanitation equipment in those three counties. But when Ebola spiraled out of control into an epidemic in the summer of 2014, we were suddenly required to learn and adapt rapidly and collaborate more widely—and with new stakeholders—to come up with an epidemic-curtailling response. The partnership would expand to include traditional leaders and natural leader networks, and would put the county-level environmental health technicians (EHTs) and hundreds of volunteers at its core as it grew to cover all 15 counties of Liberia and deal with the grim challenge of dead body management and safe burials and, through community engagement, overcoming violent resistance of grieving communities that had been torn apart by a horrific disease.

What was the main challenge/opportunity you were addressing with this CLA approach or activity?

Our approach had to be adapted constantly to meet new challenges arising daily from the epidemic. The lethal speed with which Ebola spread, its far-reaching, devastating consequences for individuals and communities, and its prevalence in urban areas was unprecedented in West Africa and overwhelmed the few systems that were in place for dealing with sickness, death, and grief. Many of the affected also lived in rural areas that were extremely hard to reach, with no roads, no experience of outsiders, and no understanding of what was killing their families.

As clinical staff worked furiously to open and operationalize sufficient numbers of Ebola Treatment Units, and testing and transit centers, other priorities emerged as clear necessities required to stop the epidemic. According



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[to U.S. officials](#), it was rapidly becoming clear that dead body handling was responsible for 50-70 percent of infections.

Liberia faced significant cultural barriers with regard to established traditions and practices. Traditional burial rites involved close physical contact with the body. For example, family members wash the body then wash themselves in the same water, a lethal activity in the case of Ebola. As infection and misinformation spread, frightened people hid infected loved ones, conducted secret and unsafe burials, and traveled when ill to avoid being ostracized, thereby exposing more potential victims to Ebola. And long-time distrust of the government, stemming from decades of civil war, made it difficult to get people to adhere to practices that would best protect them and their families.

Because of our close existing relationship, the MOH approached Global Communities about the need for safe burials and body management, and asked if we could begin managing the process in Lofa, Nimba, and Bong counties. We gathered with county health officials, EHTs, community leaders, and USAID, and began to develop a strategy for safe burial and body management.

Describe the CLA approach or activity employed.

Our CLA initiative had a primary objective: massively reduce infection caused by unsafe burials and dead body management. It's secondary objective was to educate communities in Ebola-resistant behaviors. Led by EHTs trained through the IWASH program, Global Communities, with support now from OFDA, provided training, equipment, coordination, and payment to a partnership of government employees, natural leaders from CLTS training, and incentivized volunteers. Initially in Bong, Nimba, and Lofa counties, we began managing seven-person teams, body carriers, disinfectant-sprayers, and drivers who were able to enter communities and safely and respectfully remove the sick. At the peak of the epidemic, the partnership was able to remove 98 percent of bodies within one day of death. But this came through many adaptations, faced many challenges, and was aided by the extreme flexibility of USAID. Key challenges and adaptations included:

Traditional Leaders

When we expanded nationwide and moved into the southeast, we met violent resistance. Our people were attacked and vehicles damaged. Fear of outsiders was rife, the GOL was not trusted, and the communities had received no outreach from NGOs or the GOL to educate them. "Why do you only come when someone has died? Why do you not come to help when someone is sick?" they asked.

Our response was two-fold. We set up a social engagement strategy where we invited all parts of society to help us develop community-driven strategies. The traditional leaders—chiefs and tribal elders—came to us and offered their help. They became central to the response from then onward. Where the GOL was not trusted, the tribal chiefs were. They went into communities to provide education about Ebola, and accompanied our burial teams to peacefully overcome resistance. With OFDA's support, we purchased vehicles and adapted them into ambulances, and provided the first ambulance service in the southeast, so help would come for the living, not only the dead.

Muslim Burial Teams

All burial teams were composed similarly until Global Communities experienced resistance from Muslim communities. With advice from religious leaders, we developed and deployed special burial teams that were staffed by Muslim Liberians who had been trained to be compliant with Muslim burial traditions. The evident demand for these teams ensured that a Muslim-specific burial area at Monrovia's safe burial site was planned from the beginning.

Safe Burial Site

Monrovia's dense population made safe burials difficult. The high daily numbers of deaths and a lack of open land in surrounding Montserrado County had pushed the GOL in August 2014 to requisition a crematorium to manage all dead bodies. Unfortunately, this met with huge resistance.



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Global Communities, USAID, the GOL, and traditional leaders worked together to create a safe burial site for Montserrado County, and it was the efforts of the traditional leaders foremost that made it a reality. Greatly disturbed by the cremations, they sent out urgent calls to their associated communities in Montserrado County to find suitable land. Multiple possibilities were identified, and the participation of traditional leadership framed the search in a way that ensured local support for the location of the burial site. Eventually, teams identified an appropriate site for purchase by the GOL.

In November 2014, with more than 40 cremations taking place each day, construction began on the 25 acre plot of land, an overgrown plantation known as Disco Hill. Learning from previous experience, separate sections were developed for both Christian and Muslim burials, with the Muslim section positioned to face Mecca. On December 23, 2014, President Ellen Johnson Sirleaf inaugurated the opening of the Disco Hill site. In March 2015, the ashes of the cremated were moved to Disco Hill.

Were there any special considerations during implementation (e.g., necessary resources or enabling factors)?

The critical success factors were the close relationships with the GOL, traditional leaders, and an extremely flexible donor. This made it possible to engage the community at the grassroots level to overcome resistance, and to adapt the response rapidly according to needs identified by those closest to the epidemic.

Community Engagement

It is not possible to walk into a grieving village dressed in personal protective equipment and simply take the body of a loved one. Each safe burial—of more than 4,000 overseen by Global Communities—was the process of hours of engagement, dignified exchanges, and community education. At the core of the implementation was community engagement. Overall, we provided training and messaging support for more than 15,000 community leaders, and were supported by natural leader networks and EHTs from our earlier IWASH program, and traditional leaders in ALERT. By earning their trust, it was the community, the government, and the traditional leadership—those closest to the epidemic—who told us what they needed, and OFDA who provided the funding and flexibility to meet those needs. This enabled us to rapidly adapt to the changing dynamics of the epidemic.

Scale of Response

“It happened because America invested a billion dollars,” said [Rajiv Shah](#). Scale was essential. Through the ALERT program, we employed at its peak more than 500 Liberians in safe burials (not one of whom was infected) and had to rapidly procure 163 SUVs and 69 motorbikes to ensure that the burial teams could function. USAID’s willingness to fund a full-country implementation made the response possible. It also made other adaptations possible, such as contact tracing and surveillance across the whole Guinea-Sierra Leone border, which our partnership also undertook as these needs emerged.

Support from Leadership

Support from Leadership within Liberia and the United States was essential, but that support went beyond the usual levels. Despite everyone acknowledging the need for a safe burial site for Monrovia, there were significant delays in its opening while the land-owners awaited payment for the site. The land was quickly identified and prepared, but regulations dictated that the GOL needed to purchase the land, not USAID/OFDA or Global Communities. It was in response to the advocacy of U.S. Senator Chris Coons, the only member of Congress to visit Liberia during the epidemic, that the GOL stepped up to purchase the land so that that safe burials could proceed.

What have been the outcomes, results, or impacts of the activity or approach to date?

[Rajiv Shah](#) also said, “It happened because an NGO we had supported—not just for the Ebola fight, but for five years prior—called Global Communities was already working in Ebola-affected communities and they came up with the concept of trusted burial teams that could remove dead bodies from the setting very quickly and



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efficiently and respectfully. And you saw the main vector of transmission just caused the disease to go straight down. No one expected that.”

Monitoring and evaluation played a vital role in tracking the impact of the burial teams. We were asked for daily reports on safe burials, and we were determined to provide the most effective data. We focused on speed of burials. Very quickly, we were burying 93 percent of Ebola victims within a day of death; we were ultimately able to achieve 98 percent. Combined with care provided by medical teams and logistical assistance from U.S. servicemen and women, we saw the transmission rates rapidly decline.

But we also tracked unintended outcomes. During the peak of the crisis, we received informal reports from the 284 ODF communities from IWASH that they were also Ebola-free. This anecdotal evidence demanded scrutiny. We worked with USAID to employ Global Health experts to study 551 households in Lofa. The results showed that a representative sample of the ODF communities (98 of 284) were, indeed, Ebola-free, and that those that had even begun the CLTS process were 17 times less likely to experience Ebola infection. This is a statistically significant correlation between the IWASH CLTS activities and Ebola resistance. We used this learning to fortify border communities with CLTS training and to integrate CLTS into our emergency Ebola response activities. Today, we are seeking to enlist more experts to examine this correlation to help inform future community-led preventative health approaches.

What were the most important lessons learned?

CLA is an iterative process. In an emergency situation, the process is drastically accelerated. Here is some of what we learned.

Do Not Replace Local Systems—Enhance Them

Emergency responders frequently replace local systems, but it is better if they work through indigenous systems, whether community, traditional, religious, or through county and national governments. By working through these structures, responders can gain local knowledge and simultaneously build the capacity of the people who will be in place to deal with future crises.

Flexibility

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

Preventative Health through Water and Sanitation

Safe burials were extremely effective in reducing the rate of infection in Liberia. But the most effective method of overall prevention, in Global Communities’ experience, was our prior work in CLTS. Because disease spreads at the community level, it must be combated at the community level. Clinical infrastructure is extremely expensive; community-led sanitation initiatives are not. Any curative health system-strengthening work must be complemented by preventative approaches.

Stopping Epidemics Requires Effective Community Engagement

Infectious diseases follow the patterns of daily social movements and interactions, so stopping the spread of disease requires the development of strategies to engage communities in *willing* rapid behavior change. Attempts to force behavior change will almost certainly result in widespread resistance, decreasing the capacity for central control or monitoring the spread of the epidemic.

Is there any other other critical information you would like to share?



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The CLTS study emerging from IWASH is an important document supporting our work. It is available here:
http://www.globalcommunities.org/publications/Global-Communities-Ebola%20Study%20Report_081015.pdf.

One of the most significant demonstrations of the strength of the collaboration with traditional leaders came in April 2014 when our country director, Piet deVries, who had implemented IWASH and overseen the Ebola response, was made an honorary chief by the traditional leaders' council:
<http://www.gnnliberia.com/articles/2015/04/14/liberia-traditional-leaders-honor-global-communities-head-fight-against-ebola>.

In June 2015, Global Communities' Liberian project director, George Woryonwon, a former EHT and employee of the MOH, received the International Humanitarian of the Year Award from InterAction. Mr. Woryonwon represents the many Liberians on our project and the closeness of our collaboration with the GOL. He also played a central role in building relationships with the traditional leaders: <http://www.interaction.org/forum-2015-awards>.