Africa APPG inquiry: Call for written evidence on community led health systems & the Ebola outbreak

– Submission from Restless Development, 24th June 2015.

1. Restless Development – the youth-led development agency.

Restless Development is the global leader in youth-led development. Our mission is to place young people at the forefront of change and development. Our youth-led approach reaches over 450,000 young people weekly across nine countries in Africa, Asia and the UK. Since 1985, we have demonstrated that young people –half the world's population—are valuable actors in development, and can drive positive developmental change at community and country level in the areas of Sexual and Reproductive Health (SRH), Livelihoods and Employment and Civic Participation.

In Sierra Leone, Restless Development has been one of the lead agencies implementing community social mobilisation interventions during the Ebola emergency, reaching 54% of communities nationally.

2. Summary of Submission

2.1 Restless Development agrees that the role of communities is central to the spread and control of the Ebola crisis and is essential to the successful response to health crises. We also believe that community-led approaches should be central to the Ebola recovery period and within the context of any investment in health-system strengthening.

2.2 In regards to containment strategies and their implementation, these were unsuccessful in the early stages not only due to top-down and authoritarian approaches (as top-down messaging was an essential first step in disseminating general information about Ebola-safe behaviour), but also a result of delays in the international response and failure to heed early calls for action, a lack of coordination and capacity on the part of multi-lateral agencies and the Government of Sierra Leone (GoSL), political calculations in regards to the community reaction to quarantines in the early stages of the response and an emphasis on the medical/epidemiological response and lack of emphasis on the social mobilisation and behaviour change.

2.3 This submission refers to 'community-led' and 'social mobilisation' interchangeably to refer to activities where communities are supported and empowered to undertake their own analysis and take their own action on Ebola and other health-related issues. It also refers to interventions where communities are aware of, and contribute to, decisions that affect them and where feedback is provided on the impacts of these decisions.

2.4 This submission highlights the following lessons in related to community engagement and the Ebola response in Sierra Leone:

- Community engagement is often regarded as a 'soft' and relatively non-technical add-on to medical interventions. This is incorrect; social mobilisation and health education (demand creation) must be equally prioritised along with service delivery and resourcing (supply).

- Communities must be engaged with interventions at all stages; planning, implementation, decision-making, monitoring and evaluation.
- A strong Health Education Department within the Ministry of Health and Sanitation may have resulted in a more coordinated and responsive community engagement mechanism in the case of further outbreaks.
- There is a need for standard operating practices or technical standardisation of community engagement and social mobilisation.
- Young people have played a significant role across all pillars of the Ebola response in Sierra Leone; they have shown leadership, innovation, high levels of civic responsibility and determination.
- UK Government legacy investments in Sierra Leone have built a solid foundation and methodology for expanding community engagement with health and health-systems.
- UK Government policies and resourcing within the context of the Ebola crisis were commendable and contributed a hugely in addressing both the supply side of the response (a large proportion of treatment beds, support to burial teams and lab facilities) and the demand side (direct community engagement with more than 60% of all communities in the country).

2.5 This submission makes the following recommendations related to what Restless Development believes the UK should be doing to promote and enable the community engagement and ownership of health and health systems abroad particularly in African countries (with a specific focus on Sierra Leone):

- Capitalise on the large pool of youth that have been in the front lines of the Ebola and have had their skills and capacity fast-tracked; make them a focus of targeted programming
- Community engagement should be seen as a fundamental element of disease response and health-systems strengthening; UK Government strategy should be designed and funded with community engagement at their centre, not at their periphery.
- Standard Operating Procedures or community engagement strategies should be a requirement for all health interventions funded by the UK government.
- Take the opportunity of the unprecedented community-engagement infrastructure and large-scale behaviour change achieved within the context of the Ebola crisis to address other issues such as child marriage, teenage pregnancy and Female Genital Mutilation.
- That UK Government funding is targeted at 'traditional' development sectors that support community capacity to engagement with health systems such as maternal, adolescent reproductive, maternal, neonatal, child and adolescent health (RMNACH) services & service-seeking behaviour, livelihoods (such as vocational and technical training opportunities) and education.
- Prioritise women and girls across all interventions given the disproportionate impact the Ebola epidemic has had on this section of society.
- Reverse or rethink any planned funding cuts to Sierra Leone.

- Expanding working with consortia, the success of which has been demonstrated within the context of the Ebola emergency.
- When supporting the private sector, prioritising those industries that provider much needed infrastructure to the health system such as communications and energy providers.
- Continue to support the GoSL to develop its capacity, address corruption and ensure that Parliamentary Committee have the technical and administrative support to work effectively.
- Continue to support the GoSL with the process of decentralisation of the health sector to District Councils, including making up gain s reversed during the epidemic.
- Build the capacity of local NGOs, who often have comparative advantage in rural communities though longer term association and greater outreach.

3. Background to Restless Development's role in the Ebola response.

Restless Development has been working in Sierra Leone since 1995 and implements the country's largest volunteer programme for young Sierra Leoneans. The Volunteer Peer Educator (VPE) Programme recruits, trains and supports young people to live and work in remote rural communities for 8 months. VPEs work in schools and specially created youth centres to undertake peer instruction on issues focusing on sexual and reproductive health (SRH), life skills, civic participation, livelihoods, sexual and gender-based violence (SGBV) and peace-building. Core to the programme is the facilitation of linkages between existing structures in communities (for example between and across adults, adolescents and children, schools/teachers, health centres/staff, police/family support units, religious leaders, traditional leadership and local/district government).

When the Ministry of Health and Sanitation of the Government of Sierra Leone (MoHS) confirmed the first case of the Ebola Virus Disease (EVD) on Monday May 26th 2014, Restless Development was operating in all 14 Districts of the country and had an alumni of over 1,200 ex-volunteers. 50% of Restless Development staff in Sierra Leone were also drawn from this alumni.

Restless Development has been active in the national Ebola response since the first week of the outbreak, when 120 VPEs were trained to promote Ebola-safe behaviour in 20 communities across 9 districts through June and July 2014. Restless Development has continued to implement its traditional VPE programme, with 168 VPEs current living and working in 11 districts across Sierra Leone throughout the Ebola crisis.

Restless Development's primary Ebola response has focused on social mobilisation and community-centred behaviour change as part of the UK Aid-funded Social Mobilisation Action Consortium (SMAC).[1] Together as partners, SMAC have and continue to work directly with communities, through the radio and with religious leaders to address Ebola with a comprehensive social mobilisation approach that works from the community up.

[1] The Social Mobilisation Action Consortium consists of BBC Media Action, Centres for Disease Control, FOCUS 1000, GOAL and Restless Development: www.smacsl.org.

Restless Development's response draws on the decade-long VPE Programme and has trained more than 2,000 young Sierra Leoneans to act as volunteers and social mobilisers in rural communities across all 12 Districts. A mid-term review of the programme by staff, which informs much of this submission, is available here.

4. Response to Questions

4.1 What lessons can be learnt from the recent Ebola crisis in West Africa regarding the role of communities in response to health crises, and more broadly in relation to health systems at the local level?

4.1.1 Disease response and health-systems strengthening must be designed and funded with social mobilisation at their centre, not at their periphery.

A core lesson from the Ebola outbreak for the broader development community is community-led social mobilisation approaches are not easy, but are extremely powerful. Social mobilisation, community-led engagement, behaviour change or capacity building are often seen as 'add-ons' to interventions within the development sector. As a result, they are underfunded and based on modest community consultation that is often only undertaken at the front-end of any intervention; it may consist of community meetings to obtain permission to implement a project, requests for community volunteers to implement the project or to obtain from communities a list of the 'needs'.

Interventions based on limited consultation result in communities becoming 'beneficiaries', rather than participants themselves. It can exclude participation in elements such as design of the intervention, the stakeholders/community mechanisms used for delivery, the assets or items being built or provided, training and capacity building of community members themselves to lead on those elements of the intervention relevant to them, feedback loops and community reporting linkages to decision-making at District and National-level.

In the early stages of the Ebola outbreak social mobilisation was considered as a 'soft', non-technical intervention. The resultant mobilisation efforts often used health education (providing top-down health information to communities) and one-way communication to raise awareness among individuals and communities. This was often undertaken by volunteers with limited training, mediated through mega-phones and often in large groups. Although disseminating fundamental messages about Ebola in the early stages of the response was essential, this was also at the same time intimidating and created fear within communities.

However, this form of social mobilisation and community engagement does not provide the opportunity to learn and understand about the impact of Ebola (or other health and health-systems related issues) on communities through mechanisms that are accessible to them. It leaves limited scope for addressing misconceptions and rumours and does not provide linkages to the structures that support health-seeking behaviour. Table 1 compares, at a basic level, the differences between the two approaches.

Ensuring that social mobilisation and health education (demand creation) are equally prioritised along with service delivery (supply) is essential. A major lesson of the Ebola response is that community engagement should be seen as a fundamental element of disease response and health-systems strengthening, and UK Government strategy should be designed and funded with community engagement at their centre, not at their periphery.

Table 1: Comparison between Health Awareness and Community-led Approaches

	Typical Health Education/Information Approaches	**Community-led Approaches**
Unit of analysis	• Individuals	• Communities and families
Core Activities	• Educating households • Sharing information and 'key messages'	• Listening to communities • Inspiring self-realization and self-motivated action
Communications Approach	• One-way information sharing • Health educators are the 'experts'	• Facilitating dialogue • Community members are the 'experts'
Emphasis	• Top-down • Sharing biomedical facts, correcting erroneous local beliefs	• Bottom-up • Appreciative of other ways of understanding illness • Understands that it is possible to hold multiple framings for disease at the same time
Facilitation Style	• Teaching, preaching • House-to-house	• Listening, learning • Community-wide
Methods and Tools	• Information, Education & Communications (IEC) materials • Lists of 'Do's & Don'ts'	• Participatory Rural Appraisal (PRA) tools to enable communities to analyse their own situation
Typical Assumptions	• 'Traditional' beliefs and behaviours are the problem to be changed or solved • Communities must be convinced to use health services	• Communities have responses that are both health-lowering and health-enhancing • Health services must adapt to meet the needs of communities
Key Motivations for change	• Awareness of biomedical facts • Rational understanding of transmission routes, etc. • Self-preservation	• Urgency to protect each other, builds on social solidarity, cooperation and mutual support • Hope with early treatment • Trust in health authorities
Desired Outcomes	• Individuals seek external health services and follow the rules	• Communities feel empowered to protect themselves using local resources • Two-way dialogue results in better use of health services that respond to community needs

4.1.2 Health Education Management, Mechanisms and Strategies needs greater focus.

Health education in Sierra Leone is within the purview of the Health Education Department of the Ministry of Health and Sanitation (HED-MoHS). At the time of the outbreak, the HED-MoHS was under-resourced and with limited capacity for taking a leadership role in the outbreak, despite a large Cholera outbreak having occurred in 2012. As a result, Sierra Leone still did not have in place structures or strategies for adequately undertaking community behaviour change on a national scale.

The Social Mobilisation Pillar (SM Pillar) established as part of the broader response led by the National Ebola Response Centre (NERC) played an increasingly important role in coordinating the social mobilisation response, based on a *National Communications Strategy for the Ebola Response in Sierra Leone*.[2] However, the fact that the Strategy was not finalised until September 2014, five months after the first case, suggest that greater preparedness may have been possible at least in terms of target audiences, mediums of engagement, and strategies for community engagement and standard operating procedures for undertaking social mobilisation.

The unprecedented nature of the outbreak should be taken into consideration here in terms of preparedness. However, a strong HED-MoHS, supported by working groups of relevant agencies and with standing processes and strategies for community engagement and communications, may have resulted in a more coordinated and responsive mechanism in the case of further outbreaks, and also to ensure structured and consistent framework for those initiatives seeking to address ongoing health emergencies (for teenage pregnancy, child marriage or Female Genital Mutilation).

4.1.3 Need for Best Practice or Standard Operating Procedures for Community Engagement and Social Mobilisation.

As noted above, community engagement is often not subject to the same rigour as 'technical' interventions health and medical interventions. While this may be the result of the perception of community engagement and social mobilisation as amorphous undertakings, Restless Development strongly believes that core components of working with volunteers or Community Mobilisers in facilitating community-led responses can, and should, be subject to best practice and rigour that provides the guidance and tools for supporting communities to understand and engage with the health systems and participate in health seeking behaviour.

Poor social mobilisation and community engagement is often the result of:

- One-off activities that do not lead to and ensure impact on the ground, i.e. (1-day trainings) that discuss what but not how.
- Inappropriate methods for behaviour change, i.e. one-way communication activities such as megaphone rallies which don't allow for target group engagement and discussion.
- Lack of investment in mobilisers and incentive frameworks, including inconsistent and up-front payments.

[2] *National Communications Strategy for the Ebola Response in Sierra Leone*, Social Mobilisation Pillar/ Health Education Unit of the Ministry of Health and Sanitation, Government of Sierra Leone.

- Lack of sound monitoring and evaluation and feedback loops to communities, their representatives and duty bearers.

An example of this is from Port Loko District, when an attempt by the District Ebola Response Centre (DERC) in April 2015 to locate large numbers of community volunteers nominated by several leading agencies during a mapping exercise found that many were inactive, not adequately trained or were working for other agencies.

Community engagement that is not structured and supported by communication, monitoring and accountability can be ineffective or counter-productive. Community Mobilisers and Volunteers, Community Health Workers (CHWs) or community groups are effective if they receive sufficient training, commensurate incentive or payment (if working set hours), are linked into an overarching structure and are regularly monitored and supported.

Social mobilisation and behaviour change can result from processes and tools that are structured and monitored, to accompany every heath intervention. Introducing structure and accountability to community engagement is core to the Restless Development community engagement model, and provided basis upon which the Community-led Ebola Action methodology was designed in conjunction with our partners in the SMAC consortium.[3] The CLEA methodology and Community Mobiliser training outlines some core principle for ensuring community-led approaches are effective:

- Registration with authorities at all levels of government and traditional leadership.
- Consultation with coordinating bodies to avoid duplication/facilitate collaboration at community-level (as opposed to District or National-level);
- A clear recruitment and selection process and criteria for community representatives that draws volunteers from communities themselves and is agreed upon by community leadership.
- A minimum 5 days of training that covers not simply messaging or objectives but the mean to achieving this, including use of PRA tools, interpersonal communication, safety and security, communications, code of conduct and alerts mechanisms.
- For those community volunteers expected to work set hours and achieve prescribed targets, regular payments of a stipend at recommended government rates.
- A clear and consistent communications strategy – Restless Development utilises a Closed User Group allowing free calls with staff and outreach colleagues for daily check-ins.
- Community engagement protocols that takes into account local customs and traditions, supports communities to take ownership of any actions involving them, is not judgemental and based on listening and works through existing community structures.
- A clear and consistent monitoring and evaluation framework that engages and includes communities; for example weekly meetings for reporting; sign off and verification by community leaders for work completed; spot checks by staff of implementing agencies and government representative.

Restless Development applauds the development of the Sierra Leone Standard Operating Procedures for Ebola Social Mobilisation and Community Engagement, by MoHS-HED and UNMEER as co-chairs of the Social

[3] SMAC, *Community-led Ebola Action Field Guide for Community Mobilisers*, Nov 2014.

Mobilisation Pillar (which draws greatly on the CLEA model).[4] A similar set of guidelines for all interventions funded by the UK government that requires community engagement is recommended.

4.1.4 Planning and implementation needs to be undertaken at community-level.

Sierra Leone, like all countries, is not a homogenous nation. It consists of sixteen ethnic groups, is mixed in its religious practice with approximately 55% Muslim and 40% Christian, has considerable urban and rural populations and has a broad political polarisation.

Community engagement and attempts at behaviour change, especially related to disease outbreak, that attempt generic or 'cookie-cutter' approaches may provide communities with the underlying messages, but are not sufficient. Communities were more willing and able to respond positively to Ebola regulations when they took ownership of the local level interventions such as leading social mobilisation, contact tracing and burial. In regards to community-led behaviour change in regards to health-seeking behaviour it is essential that the following is addressed:

- Each individual community's understanding of the issues related to the intervention be learned (such as specific health issues themselves, health seeking behaviour and obstacles to this, the role of health centres and health workers, traditional and cultural beliefs).Micro-planning, moving from regional/district-level understandings of community engagement to village level (taking advantage of the unprecedented community engagement undertaken for the Ebola response).
- Ensuring feedback to communities – the Ebola response has accelerated lessons on this front, whereby communities were often asked to listen, comprehend and change complex behaviour without reciprocal feedback loops.
- Communities should be heavily involved and integrated into the response from the very beginning. .
- Existing structures are worked through, based on an understanding that the creation of parallel institutions or groups undermine the legitimacy and effectiveness of communities.
- Religious and secret society groups play pivotal role in shaping the behaviours of communities. Making them central to the behaviour change communication models was very successful in Sierra Leone.
- Ensuring responders drawn from communities are part of the design process.
- Linking the local existing structure to the district health system not only through health personnel but also local leaders. This can bring sustainable resilience mentality for a systemic change.
- Establishing mechanisms for community-level accountability of health service provision.
- Reinvigorate community level accountability structures to be functional and effectively monitor health service provision at community level.

[4] MoHS-HED Govt. of Sierra Leone, *Sierra Leone Standard Operating Procedures (SOPs) for Ebola Social Mobilisation and Community Engagement*, March 2015.

4.1.5 Youth are integral to community engagement.

Just as with the rest of Africa, a large percentage of children and youth (0-35 years) in Sierra Leone are youth, where they make up 72% of the population. This active role of youth has not always been appreciated; since the end of the conflict in Sierra Leone in 2002, the youth 'problem' has been an issue ruminated on by government and civil society alike. The narrative has been that young people were the primary protagonists in the civil war, and are therefore volatile, untrustworthy, and prone to idleness. The youth response to the Ebola outbreak has done much to change this perception.

Young people have played a significant role across all pillars of the Ebola response in Sierra Leone; they have shown leadership, innovation, high levels of civic responsibility and determination. This has demonstrated something all those working with youth and in the youth sector understand; that the youth of Sierra Leone can be a positive force in the development of the country and addressing even the most difficult of challenges such as feelings of marginalisation, and disenfranchisement that Ebola may bring

The unexpected large-scale increase in the capacity, professionalism and skill-sets of an 'Ebola generation' of young people must be consolidated and built on during the recovery period. DFID has recognised this in recently supporting the 'Youth Leadership Forum: Ebola Response and Recovery' in Freetown. The UK Government should consider the recommendations for youth participation from the forum, including mainstreaming youth in all health sector development interventions including enabling youth representation in health system accountability at community-level

4.2 To what degree are the current policies, resourcing and programming of the UK Government promoting community engagement and ownership of health and health systems in low- and middle- income countries?

4.2.1 Sierra Leone – UK Government legacy investment has built a basis for health-seeking behaviour in communities.

UK Government policy has done much to promote community ownership of health systems in Sierra Leone. Restless Development believes that a relatively small percentage of the DFID health spend has (and can continue to have) a disproportionately large impact on the health-seeking behaviour of communities and ownership of their community-level health systems.

Prior to the Ebola crisis, UK Government direct support to community engagement as a component of health systems strengthening was targeted, but relatively small. For example, community engagement and demand-side health interventions are included as an element of the *Improving Reproductive, Maternal and Newborn Heath (IRMNH) in Sierra Leone Programme*, which is one of several funded by DFID to strengthen the health system and service provision under the overarching Free Health Care Initiative. The most recent evaluation of the programme found increases in health seeking behaviour in communities supported by a VPE community structure.[5]

[5] A review of the first five years (2007 – 12) of Restless Development's UK-Government-supported VPE Programme found that 63 communities were still implementing youth-focused sexual health activities without direct Restless Development support following the exiting of VPEs. A recent DFID external review of the national UNFPA-implemented *Improving Reproductive, Maternal & Newborn Health (IRMNH) Programme* also highlighted the sustainability of community

The UK Government has supported this and Restless Development's wider VPE Programme since collaborating on an initial pilot in 2005. Support by the UK Government in the resourcing, development and evaluation of the VPE Programme model resulted in a legacy that is directly responsible for the capacity of the large-scale SMAC implementation during the Ebola outbreak; what Restless Development believes is one of the largest social mobilisation campaigns ever in support of a disease outbreak.

Between 2005 and the beginning of the Ebola outbreak the legacy of UK policy and resourcing of volunteer-led community engagement included:

- A recognised and valued volunteer model for young Sierra Leoneans that is acknowledged by the Government of Sierra Leone;
- 50% of chiefdom authorities nationally with direct experience of the programme and its role in supporting community engagement with the health sector, especially for children and youth;
- An alumni of more than 1,200 ex-volunteers nationally;
- Repeated evaluations that demonstrated sustainably community engagement with health systems and in supporting health seeking behaviour.

The Ebola crisis has however demonstrated on how a larger (yet relatively small) investment in social mobilisation can have a considerable impact on changing entrenched and long-standing cultural practice *at scale*.

4.2.3 Sierra Leone – UK Government and community engagement in an Ebola context

UK Government policies and resourcing within the context of the Ebola crisis were commendable and contributed in addressing both the supply side of the response (a large proportion of treatment beds, support to burial teams and lab facilities) and the demand side (direct community engagement with more than 60% of all communities in the country).

In terms of community engagement with health and health systems, the UK Government through DFID were the first partner to identify and support large-scale social mobilisation through the funding of the Social Mobilisation Action Consortium, and recognising that deep community engagement at national scale was essential to decreasing the supply side/demand creation component of the response. For an initial investment of just over £3,100,000 million GBP to the SMAC Consortium over six months, the following was achieved:

- Design of an entire Community-led Ebola Action methodology, including a community-led design, testing and 5 day training for volunteers;

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engagement activities in exited communities as a major success of the programme. It found that: *"The involvement of Restless Development was reported in one community even three years after the organization had closed their programme in that community. The school continued training and encouraging young girls for the uptake of family planning services, with positive results.* "Girls in the school ask us even in class for family planning" *(Link teacher in one secondary school). Anecdotal evidence supplied to the review team suggests (*during visits to exited Restless Development communities*) that this support is well received by communities and is improving school performance and lowering teenage pregnancy levels, with activities continuing once Restless Development has exited sites."* External Evaluation Report of Restless Development Sierra Leone's Youth Reproductive Health Programme (2007 – 2012) and *DFID Mid-term Review of the IRMNH Programme* 2013.

- 2,366 Community Mobilisers were recruited, trained and provided with necessary resources. They worked fulltime for 6 months, drawn from and embedded directly in communities. Approximately 40% were ex-volunteers from the UK Government-funded VPE programme;
- More than 10,000 communities (approximately 60% of all the communities in the country) were supported to development and implement 'community-action plans', often strengthen by being written into community by-laws;
- More than 1,989 religious leaders trained, supported and monitored and Christian and Islamic networks revitalised;
- National coverage of 36 radio stations producing and broadcasting local content.

Communities planned to make their own change, resulting in the following outcomes:

- An average 9% increase in communities reporting safe burials;
- An average 25% increase in communities reporting referral of sick cases within 24 hours.

This large scale mobilisation and engagement would not have been possible without previous UK Government investment in and support of the Restless Development VPE Programme, which provided the template and infrastructure for implementation.

While there remains to be clarity on DFID priorities for the recovery period in Sierra Leone as it pertains to health and health systems strengthening, and the role of communities in this process, Restless Development argues that for a relatively small investment, the Ebola crisis has proven that large-scale behaviour change and health seeking behaviour can be achieved. This should provide for a paradigm shift in thinking in terms of what can be achieved when the supply-side element of health systems strengthening (health sector staff, training, supply chains, equipment) is matched by increased and proportional investment in demand-side.

4.3.3 Note on working through multi-lateral agencies.

Current policies relating to work though multilaterals agencies such as the UN and EU can at times limit accountability and efficiency, increase costs, delay implementation and undermine quality. It can add another layer of bureaucracy and institutional priorities that contribute greatly to community voices being lost during planning and implementation.

In Sierra Leone, many mid- to large-size International NGOs have higher technical capacity than UN agencies ostensibly providing technical support, sometimes leading to unnecessary conflict and competition at District level. UN agencies have a distinct comparative advantage in coordination, supporting Ministries, monitoring and identifying and resourcing gaps in the response and UK Government multi-lateral funding responsibilities would be higher value for money if channelled in this direction, while identifying consortia for technical funding.

4.3.4 Economic growth and health systems strengthening

In 2013 UK policy towards the delivery of international aid experiences a significant shift to economic development and growth within the context of the '*Economic development for shared prosperity and poverty reduction, a strategic framework'*.[6] While this emphasis on growth and economic development is welcome, this should not be at the risk of what be seen as traditional sectors of health and education. Both of these sectors

[6] DFID, Economic development for shared prosperity and poverty reduction, a strategic framework.

are also core drivers of growth and provide communities with the tools for engaging with development. While the strategic framework recognises the need to need to be inclusive and benefit women and girls, the strategy does not describe how support to health and education will contribute to the broader growth strategies.

Restless Development does on have a position at this time on the extent to which an economic focus will deliver on health outcomes in countries such as Sierra Leone and how communities engage with them, however we hope that the following will be taken into account within the context of future policies that both directly and indirectly:

- To maintain a focus on youth, especially initiatives related to:
  - *Maternal, adolescent reproductive, maternal, neonatal, child and adolescent health (RMNACH) services & service-seeking behaviour:* A rapid assessment recently published by UNFPA and funded by DFID found the Ebola outbreak has a significant decline in visits to clinics for RMNACH services; a 33% increase in estimated maternal deaths; a 35% increase in new born deaths and a 29% increase in unplanned pregnancies, representing an estimated 29,034 pregnancies.[7]
  - *Livelihoods:* where vocational and technical training opportunities are almost non-existent and a lack of livelihoods opportunities leads away from health-seeking behaviour and high risk behaviour especially related to the sexual health outcomes of young women and girls;
  - *Education:* Given the closure of schools for more than 12 months during the Ebola crisis, primary and secondary education should be included a high priority for future funding. Education accounted for approximately 8% of planned spending for Sierra Leone within the 2011 – 2015 operational plan. Given the contribution education makes to health outcomes for young people, especially young women and girls, prioritising this sector is essential.
- Restless Development also endorses the following findings of the House of Commons International Development Committee Report *Recovery and Development in Sierra Leone and Liberia*[8]:
  - To reverse or rethink any planned funding cuts to Sierra Leone and Liberia.
  - Expanding working with consortia, the success of which has been demonstrated within the context of the outbreak of the SMAC and Ebola Response Consortium). This increases efficiency and coordination, ensures working to comparative advantage and allows leveraging UN agencies for technical support (where it exists) rather than funds management where NGOs have a comparative advantage compared to UN agencies in Sierra Leone.
  - Continue to support the Government of Sierra Leone to develop its capacity, address corruption and ensure that Parliamentary Committee have the technical and administrative support to work effectively. Concerted capacity building of government agencies and ministries – often this is done in name only, but close mentoring and shadowing is often not undertaken.

[7] UNFPA, (May 2015), *Rapid Assessment of Ebola Impact on reproductive, maternal, neonatal, child and adolescent health services and service seeking behaviour.*
[8] UK Government House of Commons International Development Committee (2014), *Recovery and Development in Sierra Leone and Liberia.*

4.4 What are the principal challenges and gaps in responding to the Ebola crisis in rural and interior areas? What actions could be taken by the UK Government to improve that response?

- Lack of infrastructure – roads, communication and health assets. We advocate for the UK Government to make the link between services delivery and access to these services. A road or mobile link to an average clinic may be more effective than no access to top level clinics in district towns.
- Supporting government to more effectively map the work of both international and local NGOs at all times, so area of coverage and comparative advantages are known prior to crises.
- Maintaining links at local level – understanding those parts of DFID's Ebola response at district level that may be sustainable, localised and supported (for example the DHMT which has been undermined within the context of the local response).
- Limitations in availability of infrastructures internet and electricity at community level undermines the efficacy of the health system. Support to private sector enterprise related to communications (mobile and internet) and energy (particularly renewables) will support expansion to harder to reach rural communities.
- Insufficient health personnel within district and at community level to provide the needed health support to the people. In Sierra Leone, the educational system does not generate the needed students on health or sciences, while a significant number of the country's health workers work in the UK. This is an area that needs promotion, for example working with the GoSL with scholarships programmes for schools focusing only on the sciences, an area that private educational institutions could not invest.

4.5 What, if any, are the barriers to successful and sustainable engagement of communities in health crisis response?

4.5.1 Limitations of decentralisation and community participation.

One of the primary issues readily identifiable during the Ebola response is the capacity and resources of District authorities and their accountability both upwards towards the national government also to the rural and communities at chiefdom and section level which they serve.

There has been significant momentum in the post-war period to bring government closer to the people through the decentralisation of key government functions to re-established local councils. The decentralisation process, began in 2004 and presented an opportunity for all citizens, including young people, to engage more effectively with local governance at council and sub-council level. While decentralisation was rolled out with impressive speed, the realisation of full, meaningful participatory governance has been slower to progress. A DFID-commissioned report from 2011 found however that, *'(e)nhancing the voice of poor people in local government can also be more apparent than real. Local councils' diligence in public consultation continues to be monitored and assessed at the centre, but enhancing the voice of the poor in local government has little intrinsic value unless it leads to concrete action'.* [9]

[9] Fanthorpe.R, Lavali.A & Sesay.M.G, (2011), *Decentralisation in Sierra Leone, Impacts, Constraints and Prospects*

In addition, research undertaken by Restless Development in 2013 (and funded by the FCO in Sierra Leone) found that the key challenges to *youth* participation in governance – the largest constituency nationally - identified legal and policy constraints, funding constraints, a narrow vision of youth needs, limited capacity of councillors and partisan politics.[10]

The Ebola outbreak brought into sharp relief some of the challenges that remain in terms of decentralisation and the management of government in terms of capacity, resourcing and capacity. It is arguable that establishment of centralised management of the outbreak through the NERC and its District branches (the DERCs) was necessary given early unsuccessful efforts on the part of the MoHS in addressing the response; however, this side-lined the existing structures such as the District Health Medical Teams (DHMT). In addition, the fact that administrative powers of chiefs remains strong has (as was pointed out in the 2011 research) made it difficult for local councils to develop a social contract with rural communities. The Ebola outbreak, especially in the early stages, highlighted that mistrust still remains between much of the traditional leadership and District councils, often resulting in a competition for resources.

4.5.2 Lack of trust and competition for resources.

This lack of a social contract, as demonstrated through the on-going community perception that Ebola interventions are largely driven by cash flowing into the hands of both locals and international players, has led to the perception that interventions were intended to exacerbate the outbreak, resulting in a huge barrier to successful sustained engagement of communities in the health crisis. There has been examples off communities attacking their own chiefs.

Competition for resources is also a significant barrier – causing wasting of resources at all levels, especially UN agencies and governments at national and local levels. This competition for resources created mistrust in communities and the belief that local authorities perpetuated the crisis for personal gain.

4.5.3 Consultation not extending beyond traditional leadership.

Reinforcing this, there is a tendency on the part of NGOs and multi-lateral agencies to limit community inclusion and engagement at the level of local traditional authorities (i.e. Paramount/Section Chiefs). While engagement with chiefs at all levels is an essential and fundamental element of working with Sierra Leonean rural communities, it is a first step only in both gaining permission, support and contributions to any health-related interventions in communities. However, consultation with chiefs should not be seen a proxy for community engagement, but as a part of the overall process. Effective community engagement works with traditional leaders and local councils to support them to better understand community understandings and needs in regards to issues that may be new to their communities. The UK Government should request all partners to be able to demonstrate plans and outcomes for community engagement for any intervention that it funds.

4.5.4 Lack of mechanisms for community monitoring.

Lack of mechanisms for communities to directly engage with the health system; for example in supporting how communities hold health providers accountable. Funding directed at supporting community reporting

[10] Restless Development Sierra Leone (2013), *Youth Participation in Local Council Decision-making.*

mechanism, for health would do much to increase community engagement and better inform local councils and support their decision-making.

4.5.5 Lack of funding and capacity of local NGOs.

The expansion of funding to local NGOs is essential to overcoming barriers to reaching more rural and remote communities. INGOs are often working in easier to reach areas to keep costs down and maintain spheres of influence. During the Ebola outbreak, local agencies working in some of the harder to reach areas were overlooked in the rush for scale during the initial stages of the outbreak. However, capacity is lacking amongst many local NGOs to manage funds at any scale. The UK Government should support capacity building for agencies or developing agencies that are more willing to work directly through partners, while providing funds for capacity building of local NGOs themselves.

4.5.6 Lack of involvement of women and girls.

Women and girls are subject to exclusion during planning at community level. However, at the same time they have been disproportionately impacts both directly and indirectly by the Ebola epidemic. Their involvement is key at all the stages from planning to implementation and monitoring and accountability.

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ANNEXES

CASE STUDY 1: KPETEMA, BO DISTRICT

Kpetema Community was one of the initial hot spots of Ebola transmission in Bo District. The community registered its first case when a person unknown to the community arrived and was hosted by a local okada (motorbike) rider.

Within four days, the stranger started showing signs and symptoms of Ebola and was asked to leave the community. On his way out, the stranger fell on the road side close to the community check point and died. The Section Chief of Kpeteme, Chief Francis Jabbie, recalled, 'We did not treat the incident with seriousness. All we did was to call the burial team, but failed to report the okada rider who hosted the stranger'.

Less than a week later, the okada rider fell ill and died as well. Several people were in contact with the sick person and Ebola then spread in the community, including Chief Jabbie's son. Almost every house was quarantined, including that of Chief Jabbie.

'When I was told that an organisation wanted to bring its people to stay among us and talk to us about Ebola, I asked myself what kind of organisation would do such a thing - bringing people to a place where most people would leave the if they had the opportunity?', Chief Jabbie said.

According to Chief Jabbie, Restless Development was not the first organisation to visit the community. Many others did. He said the difference was that other organisations mounted mega-phones on vehicles and would not even alight from their vehicles, while Restless Development actually recruited one member of the community and another from Bo City as SMAC Community Mobilisers.

'During our first meeting (*what SMAC calls 'triggering'*) with the Mobilisers, people started accepting the fact about the existence of the virus when they saw a member of the community (*as a SMAC Community Mobiliser*) talking about the sickness', remembers Chief Jabbie, 'They encouraged us to set our own by-laws to protect the community against Ebola. We established a village surveillance team to check on each household every morning for sick people'.

The Chief said the work of SMAC Community Mobilisers during the outbreak was highly effective. He said they did all kinds of work; ranging from social mobilisation to assisting with surveillance and contact tracing.

At first we thought they were sent into the community as spies, to monitor our activities and report to government or the police. Most people were scared of them, but as time progressed and their interaction and integration into the community increased, they started gaining our trust. I appreciated the work of SMAC Community Mobilisers in my community. I am happy that we succeeded in kicking out the sickness out of this section and the other sections as well'.

CASE STUDY 2: ROBUNG, BOMBALI DISTRICT

Robung is in Bombali, one of the districts with the highest rate of Ebola transmission. One day in December 2014, with permission from the district and local leadership, two SMAC Social Mobilisers arrived in Robung. Mamusu and Ibrahim had been recruited and trained by Restless Development to undertake a 'triggering' discussion using the CLEA methodology.

The triggering was conducted with a large group of community members, including the chief, and the activities that formed the basis of conversation included Ebola risk ranking and a burial role play. As a result of the discussion, the SMAC team learned that issues of major concern in Robung included denial of the existence of the Ebola virus, as well the hiding of sick and dead bodies. The Mobilisers thanked the community for their participation and promised to return at a set date in the next couple of weeks.

Between the triggering and the next visit, a Community Champion had emerged in Robung, Mr. Conteh. Working with the SMAC mobilisers, Mr.Conteh took the lead in the development of a community Ebola action plan. It was agreed in the action plan that: *Nobody should hide the sick or dead bodies* and *anyone who fall sick should go to the treatment centre.* These two action points were closely monitored by Mr.Conteh along with the Robung community.

In 11 other neighboring communities, Mamusu and Ibrahim provided support and encouraged their Champions to maintain neighborhood watch strategies in order to properly monitor and implement their own action plans.

Before the Mobilisers visited again, a man fell sick in Robung and went into hiding. Mr.Conteh contacted the SMAC Mobilisers, and with their support the Champions in surrounding communities agreed to assist in the search for the man. As a result of the community effort, the sick person was located by Mr.Conteh, who safely guided the patient to the treatment centre.

CASE STUDY 3: MOYAMBA JUNCTION, MOYAMBA DISTRICT

Musa Ngonie Bangura was born and raised in a Mende family headed by a traditional leader, the Paramount Chief, in Moyamba Junction.

Moyamba Junction became a centre of Ebola transmission in October 2014, spurred by the movement of numerous traders and visitors coming to the market located at Moyamba Road Junction. As the result of an unsafe burial of a well-known community member, Moyamba Junction became one of the most serious ‘hot spots’ during the worst stages of the Ebola outbreak.

The hardest experience for Musa has been to protect himself and his family. As a member of a small and close community he has social, traditional and personal duties, amongst which is to support anybody who needs help. Musa has had to forgo some of these responsibilities, and keep away from certain friends and family members who felt unwell.

This is the context into which two SMAC Community Mobilisers named Princess and Mohamed, recruited and trained by Restless Development, arrived in Moyamba Junction at the end of November 2014 to begin working with the community. By then Musa had joined the Youth Coalition (youth chiefdom group) as a volunteer. His father, the Paramount Chief welcomed and thanked the SMAC Mobilisers for coming to work in his community.

The role of Princess and Mohamed was to facilitate the community through the Community-led Ebola Action (CLEA) approach. This initially involved a community meeting whereby stakeholders discussed the issues related to Ebola transmission in community and developed an action plan to prevent further transmission. Musa’s father played a leadership role in supporting the action plan and instituting further by-laws to make the community safe.

The youth community, led by Musa, also teamed up with the Princess and Mohamed. Their role has been to join the Mobilisers in supporting his community’s activities, including following up with Ebola action plans, supporting

the household community engagement activities and supporting surveillance and contact tracing of suspected Ebola cases. His leadership has been crucial in reaching 60 days without a single Ebola case in his Chiefdom.

According to Musa, before Restless Development and SMAC arrived in his community, sick people were being hidden, and that there was limited understanding of Ebola, its risks and the ways of avoiding contamination. Musa has also become Princess and Mohamed's close friend. He visits them several times a week to know how the activities are evolving, he makes sure that they are aware of events in the community, and he gives them moral support. 'They are living away from their home place, so I try to make them feel at home by offering conversation and trust', Musa says.

Musa finds that the CLEA approach is very successful, as every member of his community understands and participated in the initial awareness-raising session. Musa is aware that the Ebola situation is changing, and recognises the need to adapt the response to the upcoming needs. He suggests that mobilisers should be trained in contact tracing and encourage communities to avoid strangers, being supported with communication facilities. In this regard, Restless Development has learned to foresee challenges and opportunities, and has already put in place mechanisms to cover these needs.

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