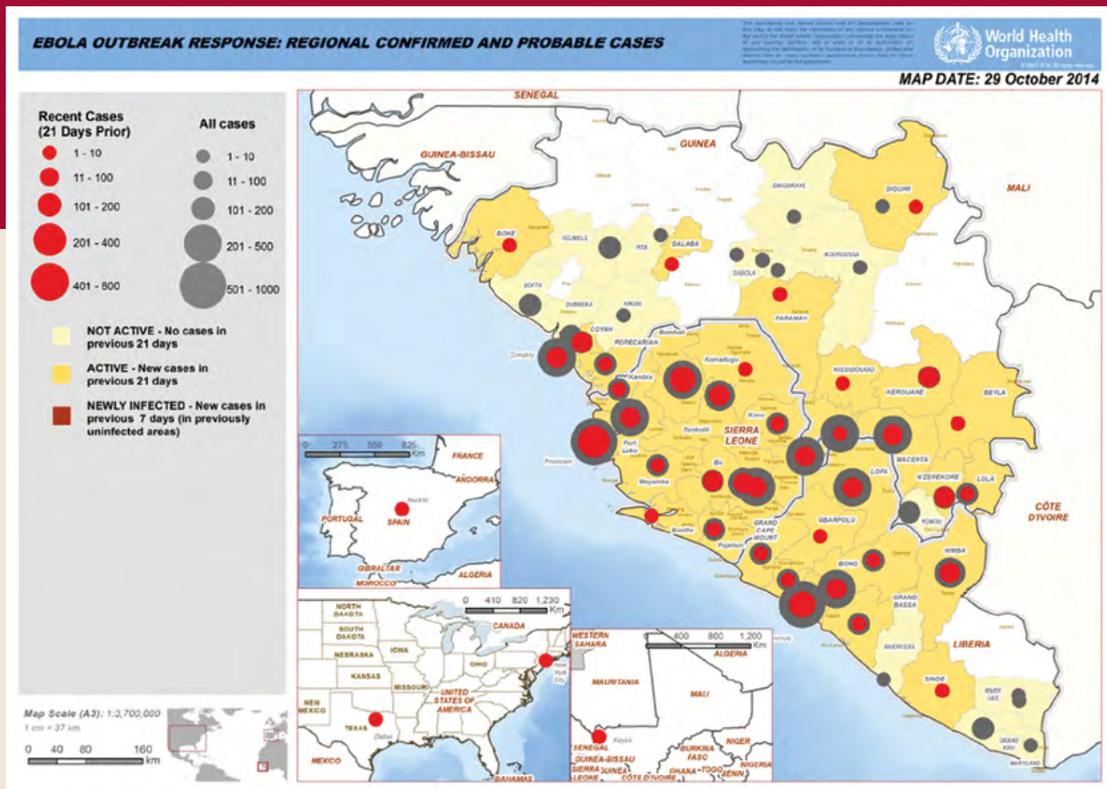


# Strengthening West African Health Care Systems to Stop Ebola:

## *Anthropologists Offer Insights*

Prepared November 18, 2014



AMERICAN ANTHROPOLOGICAL ASSOCIATION

# Workshop Recommendations

(November 5-7, 2014)

*co-sponsored by:*

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## Executive Summary

As of November 14, 2014, the current Ebola outbreak in West Africa had infected 14,413 individuals and killed an estimated 5,177 people. While the incidence of new cases seems to be slowing, fast-approaching seasonal changes and traditional agricultural commerce will increase the number of people traveling – opening new pathways for disease transmission.

In this crucible of crisis, an Emergency Ebola Response workshop was convened Nov. 5-7, 2014, in Washington, DC. The workshop participants were leading anthropologists who have dedicated their professional lives to understanding the societies and people of Liberia, Sierra Leone, and Guinea. Among professionals, anthropologists are well positioned to make a vital difference in stopping Ebola. These anthropologists have lived in these countries, researching and documenting societal and family structures, lines of respect and authority, spiritual beliefs, the region's distinct subcultures, mobility patterns tied to agriculture and seasonal changes, the impact of decades of war and poverty, and the history with former colonial powers that make many West Africans leery of trusting international help – even in a crisis of this proportion.

The workshop began with a meeting of policy makers, practitioners, donors, and NGOs active in the international response, examining their views on the quality of the knowledge base driving their response decisions. Over the next two days, the assembled experts gathered to: (1) share urgent information, practical guidance, and programmatic recommendations with partners working on the global Ebola response and (2) build a global emergency response network of anthropologists capable of rapidly deploying information and expertise to inform Ebola response efforts. A public forum was held on Nov. 7 to discuss the preliminary findings summarized in this report.

### Specific insights and recommendations are presented concerning:

- Care of the Sick
- Health Communications
- Health and State Systems Strengthening
- Streamlining Response Systems
- Risk Factors (Youth, Gender, Food Security, Mobility)
- Attending the Dead
- Identification and Diagnosis
- Surveillance and Quarantine
- Military Coordination and Security Issues
- Attending the Dead

A global Ebola Emergency Anthropology Network has emerged, drawing on experts from the U.K., U.S., Canada, France, Netherlands, Belgium, Germany, Senegal, Liberia, Sierra Leone, and Guinea. This network will continue to operate across a multilingual platform of websites, discussion boards, and listservs, which are available to all at the following web addresses:

- **Discussion Board:** <https://groups.google.com/forum/#!forum/ebola-anthropology-initiative>
- **Website:** <http://www.ebola-anthropology.net/>
- **Listerv:** <https://lists.capalon.com/lists/listinfo/ebola-anthropology-initiative>

Participants will also reconvene at the AAA Annual Meeting in Washington, D.C. (3-7 December 2014).

## Care of the Sick

A lack of treatment facilities and trained staff places the burden of healthcare on local communities. Patients have tended to seek treatment from family and community members rather than internationally sponsored facilities. Local culture shapes decisions about self-reporting to hospitals, reporting family members and neighbors, and about quarantine.

### Insights:

- **Multigenerational Families:** Care messages need to be refocused to address the multigenerational interdependence of households. To date, communications have recommended isolation and urged people to avoid contact with the sick, avoid sharing toilet facilities, exposure to bodily fluids, and. Family cohesion is a top value. Caretakers will not abandon their sick relatives even if it imperils other family members.
- **Palliative Care:** Basic medical ethics must be upheld, with palliative care available to all Ebola patients.
- **Risk Factor Data:** Social science observations are needed immediately on factors involving care-giving, care-seeking, and healthcare provision.
- **Rapid Review Cycle:** Solutions need to be revisited weekly to realign with evolving local perceptions and needs. Initially, Sierra Leoneans resisted homecare, preferring hospital care. They changed their minds.
- **A range of care options is needed,** including ETU's and hospitals, CCC's, and home-based care. Prioritizing one modality over another creates gaps in an already weak health infrastructure.
- **Home health care kits** need to be more widely available, including ORS, rehydration powder, fever medicines, thermometers, soap, and a cell phone/radio to help individuals make decisions about care.
- **Clarify the role of CCC's:** Are they for quarantining sick patients, regardless of their diagnosis? Asymptomatic people who have been exposed to Ebola? For transitional care?
- **Food is medicine.** Food should be provided to all at-risk communities. Severe impacts to agriculture, harvest, and food commerce are anticipated in the coming season. Unable to plant and harvest, seed stock will be consumed, thus adding famine to an already high-risk situation.
- **Evidence-based Interventions:** As the epidemic continues, interventions like IV-treatments should be based on evidence. IV treatments raise culturally sensitive issues among many patients.
- **Medical experimentation has a long, checkered history of abuse in the region.** Many local populations distrust foreign and state-supported medical experimentation campaigns. Their concerns must be taken seriously and addressed with sensitivity. This is also true in the context of medical care. In Mali, caregivers who arrived with food, medical supplies, and bedding rather than authoritatively taking family members away were better received.
- **Sexual transmission** poses a critical public health risk that could transform the epidemic into an endemic, region-wide presence. Experience with HIV/AIDS programs in West Africa indicates that basic communications will not suffice. Abstinence-only or condom-recommended messages will not work unless paired with grassroots programs on prevention, sexual behaviors, and response. Sexually transmitted Ebola could also create social stigma or shunning. Thus, education must be handled carefully.
- **Survivor Research:** Social science research is needed to understand the current conditions, experiences, and dispositions of survivors. Ebola response programs should not assume that survivors are willing to work on Ebola-related issues. They may want nothing to do with Ebola ever again. Clinically, we do not know enough about the duration of Ebola antibodies to position recent Ebola patients in caregiving capacities.

## Health Communications

Communications to date have largely involved one-way messaging delivered via posters, and not local dialogue, information exchange, and feedback via cell phones. Along with inadequate data centralization and identification, this communications approach has undermined efforts to respond to rapidly changing circumstances. Correcting this imbalance will build trust, share information, and streamline multiple systems of prevention and response. Two-way communication allows institutions to rapidly become aware of local rumors, so steps can be taken to dispel myths before they become fodder for conflict and resistance.

### Insights:

- **Problematic content:** Early fear messages drove Ebola reports underground. Ebola communications need to take an open, educational approach that explains why and how the situation is evolving. Local communities have rapidly learned and mastered a core set of messages about Ebola transmission, management, and treatment strategies. What they now need is detailed, specific, and relevant information that integrates local ideas of disease and misfortune.
- **Health beliefs:** People in the affected areas simultaneously pursue multiple healing strategies, and don't see a conflict between, for example, Christian healing, biomedicine, and traditional medicine. It is entirely reasonable that people accept sophisticated public health messages about Ebola causes, management, and transmission, while also accepting alternate explanations, such as Ebola is caused by sorcery.
- **Local views about symptoms** thought in terms of "small sickness" vs. "big hospital sickness" can lead to communications campaigns that help individuals undertake self-referral and quarantine behaviors in a timely manner.
- **Best practices:** Work through established community leaders, door-to-door campaigns, use social networks and "social learning", use hopeful, positive, empowering messages, encourage – but don't coerce – survivors to talk about their experiences, distribute free transistor radios and cell phones to facilitate the flow of information between local communities and response coordination, especially in remote areas.
- **Work with all religious communities:** Pentecostal and Seventh Day Adventist are the fastest growing religions among Liberians and Sierra Leoneans, and need to be better integrated into the Ebola response. In Guinea, the national network of Imams is a trusted voice of authority than can be better utilized.
- **Mixed messages:** Concern about "mixing messages" has created limitations. Information about homecare has not been emphasized because responders want to get people to the treatment units. The Ebola response should "meet people where they are" and provide information to caregivers where they are.
- **Develop longer-form communications outlets:** Take advantage of locally favored channels: call-in shows, fireside chats, radio trainings on home- or CCC-based healthcare, Q&A internet shows, and diaspora broadcasts. Multimedia can have great reach, like the video of a Liberian nurse who provided homecare to her family, which was shared on cell phones across Monrovia and reported even further by word of mouth.
- **The cultural concept of "home":** Home means, "Where are your people from" as well as "where do you live." Most people have many homes. When people hear "stay in your home" in Sierra Leone, they may think, "ok, I'll just go home to my grandmother's house in the village to wait out the lockdown."
- **Photojournalism:** Far greater photojournalist restraint is needed. Images of the sick and dying create a hostile, discriminatory perception of West Africans globally.
- **Emphasis on "care" not "war" imagery:** With war a recent memory in the region, metaphors for the 'fight' against Ebola can resurrect social conflicts and divisions. Messaging should rely on themes of caregiving and responsibility. A requested "gift" of blood will be more welcome than a demand for blood to fight a battle.

# Strengthening Health and State Systems

The current Liberian and Sierra Leonean health sectors were built just 12-15 years ago and were created by the international community. The model assumes epidemics are endemic and local urban and rural resources remain underdeveloped. As a result, in moments of crisis, enormous expenditures are needed to address health problems. A shift needs to occur that will promote an expanded health sector, greater stability, and long-term solutions. System strengthening should focus on improvements in health information systems, workforce training and development, facilities, equipment and supplies, and in the areas of planning and resource allocation decision-making.

## Insights:

### Health Information Systems

- **Data sharing arrangements need to be updated** immediately to make data more widely available for response planning and resource allocation decisions
- **Surveillance** – responders should investigate applicability of previous surveillance structures, e.g., community dispensary role in Guinea, which served as effective early warning system
- **Care and contact tracking** – aspects of Lassa fever, measles, HIV response in West Africa are transferable and will have immediate effect
- **Build a widespread identification system** that is not linked to citizenship. For example, the increased prevalence of childhood vaccinations provides opportunity for growing health database

### Healthcare Workforce

- Responders must acknowledge the validity and reliability of traditional local knowledge
- Specific steps should be undertaken to promote closer collaboration between the public health and clinical providers

- Developments in formal training apparatus may include:
  - \* Revise training to distinguish between urban and village settings
  - \* Reexamine the conditions that international organizations place on the support they provide for workforce development
  - \* Provisions are needed for converting the many unemployed but trained healthcare workers who have been volunteering their services in the past several months
- Incentivizing workers to do their job
- Respect and utilize local health knowledge, include herbalists and healers as providers of psychological and cultural comfort and conflict resolution. Integrate them as community leaders into training and surveillance activities as well as community healing responsibilities.
- **Facilities, Equipment, Supplies:** Assure that the medical equipment and supplies storage and delivery system is working and is properly funded (many systems are funded perfectly when built, and then supply chain bottoms out)

### Governance, Planning, and Resource Allocation Decision-making

- Immediate attention must be paid to the anticipated transition from short-term military to longer-term service delivery
- Support is needed for increasing the availability of rapid testing mechanisms. Engage in open dialogue with local populations about the meaning and prevalence of false positives and false negatives to avoid discrediting testing mechanisms.
- Emergency response cannot focus exclusively on one disease. Healthcare systems must be sufficiently strong and flexible to handle multiple and ongoing co-morbidity issues, or mortality will increase.

# Streamlining Local, National, and International Response

We have a chance to benefit from the wisdom of experience gained from previous responses, where the urgency of responding often trumps coordination and collaboration among response organizations, and between response organizations and those local authorities responsible for delivering ongoing public services. Now, attention should be directed to creating a clear scheme for linking multilateral, national, bilateral, and local efforts. This will help assure continued capacity that will endure after the dismantling of UNMEER.

## Insights:

- **International:** A coordinated approach to caregiving is needed, as the lack of organization and consistency is creating a perception at the local level that “better medicine” may be available in neighboring countries thus far not infected (i.e. from Liberia to Guinea, or from Guinea to Mali). This will worsen the epidemic.
- Anticipate and prepare for a transition from U.S. involvement to international takeover in the next several months.
- Assess whether conditions tied to international aid (e.g., supply sources) are facilitating epidemic response.
- **National:** To coordinate national and international responses, coordination meetings need to take place daily or several times a week, rather than once weekly. 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. Nationally appointed county medical officers are poorly trusted in both Sierra Leone and Liberia, as they do not have local legitimacy. The positions were created to promote local accountability and decentralization in the healthcare sector, but the unintended effect has been quite the opposite. County medical officers are seen as intentional bottlenecks, often diverting essential money and medical resources. Their role and status in any epidemic management system needs to be carefully revisited.
- **Local:** Communities have high historic and current capacity for disease 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. A “capillary approach” should be taken to ensure that cash, supplies, and resources are delivered to micro-social units of community organization. This is needed not only for distributing food and medical resources, but also conveying information.
- In all three countries, the current Ebola crisis has led to a catastrophic impact on economic activity. Food prices are skyrocketing and food insecurity is about to rise. 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:** A significant impediment to healthcare coordination is the inaccessibility of existing data, including registries and case tracking. The current system of data collection is as follows: Teams go out with detailed case intake forms (age, occupation, etc.), and data are aggregated at the Ministry of Health level. Data are sent and stored in western academic institutions for the writing of reports; and the actual raw data then disappear/become 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.

# Risk Factors

## (Food Security, Children, Gender and Age)

### Food Security and Mobility

In November, all three countries are entering the dry season and approaching the harvest phase of the agricultural cycle. Due to the epidemic, many farmers will be unable to mobilize sufficiently large agriculture teams to plant and tend crops. Harvests are projected to decline by nearly 50 percent. The resulting food shortages are likely to be severe. The hungry season will likely begin in March or April, and people will eat the seed rice they have set aside for planting for the following year leading to a collapse of next year's agriculture. In this way, the Ebola epidemic is likely to generate large-scale, region-wide food insecurity through 2016. Nutritional assessments will be necessary to evaluate the need for mid-term interventions.

#### Insights:

- **Farming Disruptions:** 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 seed rice for the next annual planting. This is relevant for food supply in both rural and urban areas.
- **Food Support:** If Ebola-related precautions require discouraging normally itinerant farmers to travel within and across regions and national boundaries, food support will need to be provided locally in their absence.
- **Multiple Mobility Patterns:** People move in search of income and subsistence in multiple patterns from urban-to-rural, and rural-to-urban. This could result in Ebola transmission into previously unaffected areas, including remote rural areas and unaffected regions like western Cote d'Ivoire.
- **Food-related Mobility Restrictions:** A clear differentiation needs to be made between mobility for income and food-seeking purposes and mobility 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.

- **Moving for Work:** As the rainy season ends, and the dry season begins, male mobility will rapidly accelerate. As the roads become passable, young and older men will do what they have always done in this region. They will move across the region, across borders, and 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 Ebola into currently unaffected areas.
- **Nutrition and Immunity:** These factors must be taken into account in managing the epidemic management and creating care-giving models. Lack of food reduces immunity, and reciprocally, food access directly impacts compliance with recommendations for Ebola diagnosis and management. This is one example of the kind of international, national, and local level coordination needed to the crisis.

### Children

It is unclear what is happening with children and Ebola. Relatively few children are brought to facilities for care; perhaps they are dying before they can receive treatment. What is known is that Ebola is orphaning many children. Local communities have strong traditions of fosterage, but are presently under strain and need financial and food resources. In August and September 2014, many communities reported that they would take responsibility for children orphaned by Ebola, noting they could absorb 2 to 3 children with existing resources, but not 12 or 20. Communities are concerned about the psychosocial needs of orphans. They want to know how these children are being helped and want to be trained to address these issues themselves.

#### Insights:

- **Stigma:** It is increasingly apparent that stigma affects children's community reintegration and undermines fosterage. Local communities are shunning children who have recently lost family members.
- **Family Tracing and Stability:** These children need a place where they can receive care until homes are found. "Family tracing" systems developed after the war years should be revived to help children locate extended family members outside of their communities.

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## Gender and Age

With the lack of sex-disaggregated data there are only educated guesses to guide an understanding of the gender dimensions of Ebola.

### Insights:

- **Gender and Patient Care:** Women provide the bulk of hygiene work and care for the sick in households, but their ailments are usually under-reported and under-treated.
- **Health-Seeking for Women:** Families across the region are more likely to seek medical care for men than for women.
- **Gender and Nutrition:** Compared to men, women are often less nourished and have higher morbidity rates due to other infections and exposure to hygiene challenges, which affects women's resilience to viral infections.
- **Gender and Patient Transport:** More men than women transport those afflicted with Ebola. More men than women work as nurses, doctors, and other medical personnel.
- **Gender and Mobility:** Men tend to be more mobile, traveling at times long distances. In the wake of the civil wars, this comparative absence of men has even increased, in some regions leading to an under-representation of young and middle-aged men in the local population. Statistical estimations about infection rates may be skewed, unless this disproportion of sex is considered.
- **Gender and Data Reliability:** Hospital and ETU admissions are poor criteria for analyzing patterns of child morbidity and mortality; we suspect that children are less likely to be brought in for care and are more likely to die before receiving treatment.
- **Better Data Needed:** Gender and age are factors that predict highly varied social roles and responsibilities. Data collection needs to carefully attend to gender and age of individuals.
- **Sexual Transmission Pathway:** As mentioned earlier, transmission of Ebola through sexual relations also requires further assessment.

## 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 resulting from Ebola, but more work remains to be done. Funerary practices and priorities vary considerably across the region. Local cultures have developed alternative burial practices when individuals have died in unusual circumstances and their bodies could not be recovered, such as when people have drowned or died while conducting agricultural burns. Moreover, burials are conducted and supported by large formal and informal networks of part-time burial and mortuary experts in every locality. These practitioners serve an important role in communities and should be engaged as skilled, knowledgeable professionals capable of modifying ritual practices, creating situation-appropriate solutions that are also sensitive to needs of surviving families in the communities.

### Insights:

- As with other Ebola crises, local communities now understand that corpses can transmit Ebola. While this message may need to still be conveyed to rural communities, the next path of communication needs to provide information to local communities so they can manage their dead, especially if they may not ever be known whether the individuals actually died of Ebola.
- Guidance regarding burials needs to accommodate the fact that requesting healthcare teams or burial teams is often not practical. Communities need specific information and an ongoing open forum so they can ask questions and obtain answers from local experts.
- Developing a “one size fits all safe burial” set of burial practices is unlikely. Instead, core recommendations should be identified that can be integrated into diverse ethnic, religious, and regional communities.
- Family members want 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 to know where their family members bodies and cremated remains are buried. This should be made widely and publicly known and could become a memorialization site. Community leaders should determine if sites 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. For example, once West Africans began migrating abroad it was not possible to convey the body to a home village for burial. One way of commemorating their death involved touching a stone or piece of wood to the skin of a corpse and sending the stone or wood home. Communities that have innovated new practices should be credited in public campaigns to encourage these practices elsewhere.
- Sylvain Landry Faye has considerable experience working with local communities in Guinea to adapt funerary practices given the challenges Ebola poses. 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.

# Surveillance, Identification, and Diagnosis

Identifying and tracking newly diagnosed patients is a key challenge to stopping Ebola transmission. Each new case of Ebola requires prompt identification, early intervention, and supportive treatment. Efforts to provide essential healthcare are expanding. However, in many respects Ebola is a social disease. It is transmitted through the social interactions of physical contact, caregiving, burial, and normal human interaction. Identifying individuals who are at-risk for contracting Ebola and providing surveillance of those who have been exposed to Ebola is imperative. But in each of these three countries, and at every point along the healthcare pathway, the challenge is heightened by the absence of formal institutional structures for identifying individuals. In the absence of formal identification systems, the responsibility to engage in surveillance devolves to local communities, which 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. Engaging local communities in identification of individuals is a crucial line of defense against Ebola; centralized systems are needed as well. In the recommendations below, we identify ways to implement community-based surveillance and identification systems.

## Insights:

### Community-based surveillance.

- We recommend that surveillance responsibilities be shared with local village nurse practitioners, traditional care givers, and midwives, among others. Local community leaders also hold a high level of trust.
- 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. 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 with the state or the international community against the local community.
- At the community-level, previous systems implemented under governmental authority can serve as a template for community surveillance and identification. For example, in Guinea from the 1960s to the 1980s, every community had a local dispensary, which had sensitive and specific knowledge of new diseases and could refer sick individuals

for further assessment and treatment. This is a system that can be recreated.

- Careful guidelines are needed to avoid an increase in locals concealing contact with someone who has had Ebola, deferring informing someone about symptoms of illness, out of a fear of being shunned or reported, and to anticipate the potential for scapegoating, especially individuals who have arrived from outside the community, or from other countries. Surveillance can also marginalize individuals who appear to be symptomatic or sick for any reason, with accompanying loss of work or even mob violence.
- If the consequences of reporting are seen as punitive, fearsome, or disrespectful (see Sierra Leone model vs. Mali model under Military) community members can revolt, or undermine local authorities.
- Response organizations can facilitate local and self-diagnosis by providing more detailed guidance regarding the symptoms of Ebola, and the symptoms of other diseases, as well.

### National:

As noted, more human resources and IT expertise must be invested in central identification systems and practices.

- Large-scale systems of rapid and distinct identification have been successfully deployed in the region in the past, for example, by UNHCR. This constitutes a critical aspect of health systems and governance strengthening for all infectious diseases, not just Ebola.
- Design of identification systems must acknowledge the history of abuse, preventing individuals from receiving services, holding or using political or economic rights, having legal recognition, and can be crude mechanisms of exclusion.

### International:

The international community's concern with global health in the region would be better demonstrated by counting all deaths, not only those attributable to Ebola.

- International response organization performance should be reported in a timely and transparent manner, and programs set in place in the immediate post-conflict period to assure that international/local flows of resources arrived at their destination should be reinstated.

# 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 should be available as a superior option to state-run quarantines, acknowledging that not all communities are comfortable with self-imposing quarantine and prefer to defer to the authority of the state. The effectiveness of large-scale quarantine in Sierra Leone is uncertain. While quarantine may decrease inter-household transmission, it may increase intra-household transmission. Some evidence suggests that the lock-down may have accelerated community-based learning about Ebola through household-to-household visits by health workers.

## Insights:

- Due to widespread local mistrust of national government, we recommend community-controlled quarantines preferred over state-run quarantines. Local quarantines can effectively contain the disease without requiring the more drastic steps of shutting down international borders. However, response organizations should expect resistance.
- Individuals should be able to choose if they wish to be quarantined in their households, at CCC's, or in ETU's and hospitals. Assurances are needed that their children and families will receive food, bedding, adult supervision, access to family, social support, and education.
- Communities should have 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 issues. This can be delivered through radio and cell phone.
- Individuals helping transport Ebola patients to healthcare facilities need guidance and resources to do so safely. Taxis delivering Ebola patients to ETU's sometimes take necessary precautions, but guidance needs to be communicated as well to bus drivers, motorcycle drivers, and porters (patients are sometimes carried to health facilities) about how to remain safe. Porters, in particular, are highly vulnerable. This can be done through unions or other organizations.
- Community workers require training to provide palliative care to people who are sick in their households.
- The use of military and police forces to initiate quarantines in communities, "the Sierra Leone model," should be avoided at all costs. It regularly leads to violent confrontations.
- The "Mali model" for quarantine should be adopted instead. Families 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

- Local populations are very invested in controlling flows, both visible and hidden, in and out of their community. Practices used in war times are being reactivated to address the spread of Ebola to keep strangers out – including the international community.
- Checkpoints should be regarded as an important site of engagement with local communities, as they serve to control all kinds of material coming in and out of local communities – viruses, medications, food and medicine, rumors, and humans.
- Checkpoints and roadblocks are often operated by young men, accompanied by a breakdown in traditional lines of authority. Community engagement in establishing guidance for the conduct of local roadblocks and checkpoints will help reduce conflict and abuse while involving community elders in decision-making.
- Deploy respected state representatives, like nurses, community health workers, and local leaders, rather than police and military forces when engaging checkpoints. It must be recognized that mobility limitations disproportionately affect people in the middle, as wealthy elites often move around freely and easily, as do marginalized populations.
- There are different reasons why people are mobile – e.g., work, family visits, burials. People will also move because they are sick and seek treatment. A range of appropriate interventions are needed.

# Military Coordination, Militarization, and Security Issues

The Ebola epidemic has three significant characteristics of militarization that are likely to have a substantial impact on current and emerging aspects of the response. “Military coordination” refers to the fact that multiple countries are using military forces and capabilities to address the Ebola response. Proper preparation for deployment in a global health emergency is essential. “Militarization” refers to the activation of national armies and police in the Ebola public health response and also the mobilization of community self-defense networks, bound together through conventional local institutions, and through ex-combatant networks that remain in place from recent conflicts. “Security” issues could arise if current circumstances devolve further due to civil unrest, conflict, force migration, protest and resistance – all of which could create the conditions for 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. For local populations it appears to be a rebirth of classical, colonial patterns of occupation. Amid increasing political tensions around Ebola, there lies a risk that “mission creep” could emerge, especially among foreign military forces called upon to prop up a challenged government, or soldiers 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.

## Insights:

- 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. Clear statements should be issued publicly about military activities and plans with specific details about their roles, such as how long they’ll stay.
- Messages should emphasize the multi-national Ebola response efforts in each country to alleviate concern about colonialist ambitions. The integration of even small units of trusted African multi-national forces (e.g., Namibia, Kenya, Uganda, DR Congo) can help reduce local concerns about using 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.
- Local communities should be advised of military chains of command. Militaries should provide this information, updating as necessary to ensure current contacts, but as needed, government or non-governmental agencies should serve as a conduit so that should issues arise, local people can report suspected problems or perceived abuses. 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.
- Public discussion is needed about what will happen to the infrastructure that is being built by international military forces, including hospitals, ETU’s, and CCCs. Who will own and operate these resources over the next three months? Six months? Twelve 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?
- Despite the recent, post-conflict professionalization and restructuring of police and military forces in Sierra Leone and Liberia, and the Security Sector Reform in Guinea, these processes should not be regarded as complete. While some discrete police and military units are regarded as trustworthy and collaborative, local populations often regard police and military units with mistrust. Support should be provided to local organizations monitoring police and military performance.
- The global Ebola response is introducing a vast supply of finances and resources, a new “Ebola economy.” It should be anticipated that there will be local competition for resources. 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.
- Ongoing cultural sensitivity training is advised. 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.

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## Summary and Next Steps:

- Until there is a vaccine, community mobilization and community involvement are the fastest, most effective, and least expensive ways to resolve this crisis.
- The key to supporting community mobilization is understanding the local context in the three, most affected countries. This context is nuanced, but it is not unknown. This knowledge base is well documented and accessible. It is well documented, and this knowledge base is accessible.
- For community mobilization to succeed, these regions and peoples need to be engaged.
- Communities are already mobilizing local resources including family support and caretaking networks, women's networks, and other community-based institutions to address this response.
- Some large-scale interventions can effectively complement community mobilization. Development and implementation of centralized information and reporting systems will facilitate rapid epidemiological analysis for planning, prioritization, and resource allocation decisions.
- Communications channels must not be one-way channels from those implementing the response to the affected communities. They need to be two-way. There needs to be a rapid way for communities to report what they are dealing with and how they are managing, so they

can receive support in real time from the international response.

- The local situation is rapidly changing. As one colleague said about this epidemic, every week is like a year. The epidemiologic conditions are moving quickly. The social conditions are moving quickly. Even the climatic conditions are moving quickly, with the impending end of the rainy season, and its associated increase in mobility, timing of the agricultural cycles.

In the next few weeks, we will hold additional discussions at the AAA Annual Meeting, guided by the principles of remaining fast, focused, international, interdisciplinary, open, and transparent. Among our next steps, we will aim to:

- Extend an organizational network that supports international collaboration
- Build and circulate an expertise database
- Plan for Publications - Open access, aim for policy and public health readership as well as anthropologists
- Work with universities and with UNMEER on overcoming hurdles for visiting consultations
- Build concrete approaches for engaging the governments, including military services

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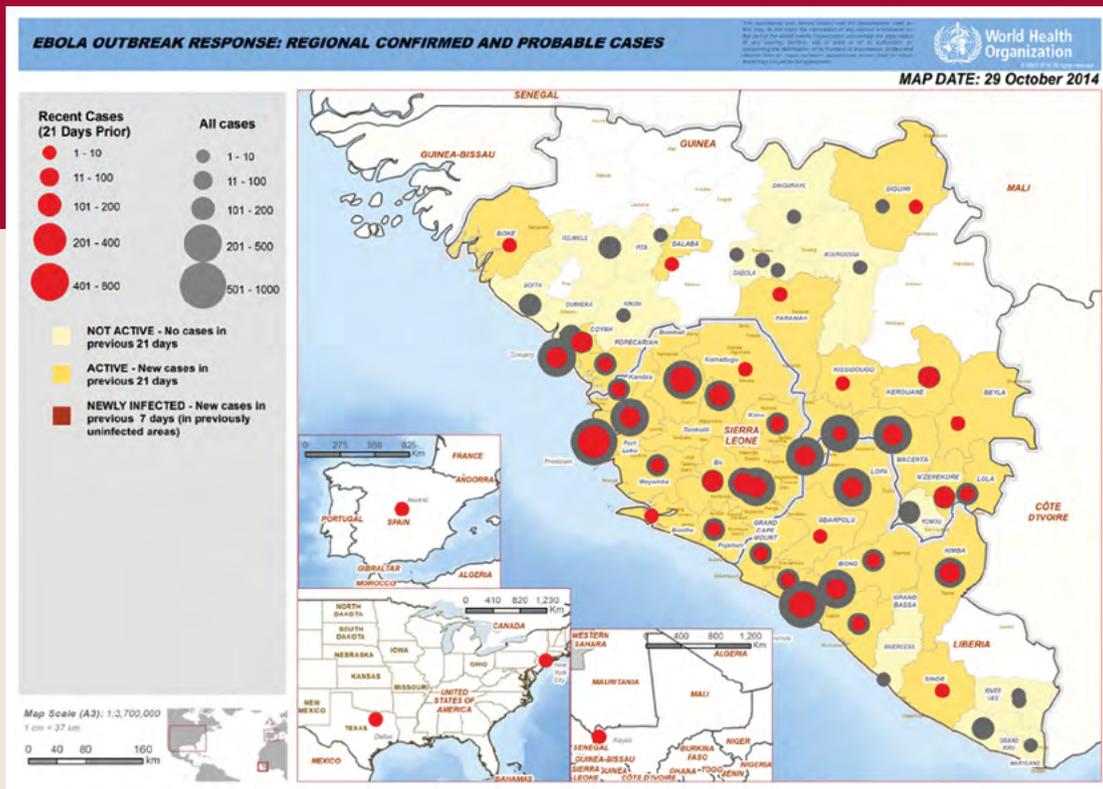
**Document published by:**

The American Anthropological Association, 2300 Clarendon Blvd., Suite 1301, Arlington, VA 22201  
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## *Anthropologists Offer Insights*

Prepared November 18, 2014



AMERICAN ANTHROPOLOGICAL ASSOCIATION