

Ebola, community engagement, and saving loved ones

The importance of community engagement in the control of an Ebola epidemic is often emphasised,¹ but how engagement occurs, and with whom, is not always straightforward. Do targeted populations act collectively, with shared values? If engagement means finding local interlocutors, who do they represent? Does linking them to an externally generated policy agenda compromise their roles or transform them into resented, externally empowered agents?

A danger in some locations is that exclusionary hierarchies might be enhanced, and resistance, including violent resistance, provoked.² At the very least, use of so-called customary or traditional institutions requires close monitoring. This point has been made in relation to Ebola responses in the DR Congo,³ where there are on-going calls to upscale the approach.⁴ Similarly, there are reasons to be cautious about a purported lesson learnt from the Sierra Leone epidemic. The role of paramount chiefs (whose positions are actually a legacy of efforts at indirect administration under British rule) has been highlighted as particularly important.⁵ Our research in Sierra Leone suggests other processes were occurring and are under-emphasised.

The experience of Ebola by those infected and their families is crucially a matter of moral choices. People are expected to give up their loved ones to be taken away, often by foreigners with whom they have no relationship, to treatment centres where they will likely die with strangers. This helps explain why people often do not cooperate, even in the face of demands by those deemed to speak for them or threats of violent enforcement.

Exploring how public authority worked in practice in Sierra Leone during the Ebola epidemic,^{6,7} we found that people with signs of Ebola virus

infection had been taken deep into the forest, where relatives would do their best to keep them hydrated, drawing on previous experiences of illness and information gathered from sympathetic contacts who were well informed about the disease. Those who died were buried in hidden places. After showing us the locations of these graves, one member of the group that did the burials proudly dressed up in the equipment they had made to protect themselves.

Those who performed burials were all members of one of the numerous secret societies that are pervasive across the region, and they explained how they evaded the instructions of their paramount chief and demands of medical staff to report cases. These people were not prepared to abandon their loved ones, and they were convinced that protecting and assisting them was the right thing to do. Many of those who were treated survived, and those who died were buried in places where their families could mourn them. The findings suggest that more people were probably infected with Ebola virus than official data indicate and that extensive unreported care was provided for those infected. Specifically, 58 Ebola cases were officially reported in Ribbi chiefdom.⁸ Meanwhile, in just one village in the same chiefdom, we collected information about 57 suspected cases, only eight of which were referred to chiefdom or district authorities.

People everywhere live in complicated social spaces. Engaging with communities necessitates a politically nuanced understanding of specific circumstances and awareness that local intermediaries are unlikely to represent the views of everyone.⁹ Also, their own understanding of what other people living in their area are doing might be limited.

Perhaps the most useful insight for Ebola policy from what happened on the ground in Sierra Leone is that treatment will occur within groups that feel responsible for one another, irrespective

of dictates to the contrary from their co-opted leaders, and there will be forms of accountability beyond family units that facilitate such arrangements. It might be challenging to identify and work with those involved, but alienating people who are perceived as acting morally is likely to be counter-productive.

We declare no competing interests.

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Photograph by Melissa Parker

Published Online
June 10, 2019
[http://dx.doi.org/10.1016/S0140-6736\(19\)31364-9](http://dx.doi.org/10.1016/S0140-6736(19)31364-9)

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