Chapter 10
Partnering with Communities for Effective Management of Health Emergencies: Four Case Studies

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10.1 Introduction

During recent public health emergencies, health authorities have run communication campaigns, as well as tailoring messages and risk communication strategies aimed at responding to infodemics in order to engender social and behavioural change from individuals and communities. This is despite the fact that those messages do not always correspond to the expectations of specific communities. Evidence from research and lessons learnt from health emergencies such as the COVID-19 pandemic (2018–2021) and the Ebola outbreak in West Africa and Central Africa (2013–2016) have proved that effective social and behavioural change solutions are co-constructed through a partnership between communities and health authorities (Anoko et al. 2020). This chapter presents a review of 4 case studies for the co-construction of effective solutions for social and behavioural change.

Several key lessons derive from considerable marketing, marketing communication, and social marketing experiences, and show that people agree to change their behaviour when they perceive an advantage in making that change. Thus, health

All ideas and opinions expressed in this chapter are those held personally by the authors.

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authorities must consider communities as 'customers' to whom a product – in this case public health messages – is sold in order to convince them to 'buy it' for their own benefit and thereby change their behaviour (#case study 1, Sect. 10.2). Through personal engagement within a community in India during the COVID-19 pandemic lockdown, popular alternative narratives challenged the policies of pandemic programmes, as well as raised questions surrounding drastic uncoordinated biosecurity protocols and humanised the solutions on offer (#case study 2, Sect. 10.3). Built on socio-anthropological research, community dialogues, coupled with COVID-19 vaccinations, have led to the acceptance of the vaccine and increased appreciation of its value in Cameroon (#case study 3, Sect. 10.4). The final case study (#case study 4, Sect. 10.5) shows us how health authorities and communities re-established trust by working together to rebuild a Treatment Centre that had been destroyed by arson in an active armed conflict zone in the Democratic Republic of the Congo during the Ebola outbreak.

10.2 A. Schneider: Lessons from Social Marketing (Case Study 1)

Social marketing has been practised for over 50 years and has taught us many valuable lessons about how to influence health behaviours. The question now is whether it is still able to teach us anything that can help deal with contemporary public health emergencies such as COVID-19. Social marketing has become embedded in a larger discipline we now call social and behavioural change. In addition to social marketing, this area includes a broad array of tools and approaches, including behaviour change communication, social change, risk communication, human centred design, behavioural economics, and community engagement. In this section, I focus on some of the key lessons that can inform our approach to public health emergencies.

10.2.1 Voluntary Exchange

Central to the social marketing construct is the notion of voluntary exchange. It is understood that in the commercial marketplace, we trade something of value in order to obtain something else of similar or perhaps even greater value. The fact that the commercial marketplace has been modified throughout history, yet has endured as a central feature of human existence, suggests that it is a core element of who we are as humans. We have to ensure this concept remains front and centre in our public health interventions. Marketers have become experts in encouraging customers to engage and purchase goods and services without the use of coercion. An exploration of how they have been able to do this could provide some useful lessons that could be applied to health emergencies.

The four P's of social marketing highlight four of the core strategies:

- *Price*

Reduce all costs. We have learned that costs are measured not only in monetary terms. Making behaviours easier, or less of an effort, is an age-old technique that has been applied to public health interventions. It requires innovative thinking and knowledge of community behaviours and preferences. For example one of the best ways to make behaviours easier and less costly during the COVID-19 pandemic was through the provision of free vaccinations and handing out free masks at the entrance to shops and places of business. Considering price provides an opportunity to be creative and innovative by answering the question, "How might we reduce the barriers to adoption of the desired behaviour?"

- *Place*

Address the 'where' of obtaining the product or service or enacting the behaviour. As with price, convenience is a key factor. Bringing services to customers is preferable to requiring them to go out of their way to engage in them. For example bringing vaccination services into the workplace (ideally, also free of cost) proved effective. The expansion of access should be among the first targets to maximise utilisation of services and/or adoption of behaviours.

- *Product*

Be clear about what is being asked of people. In commercial marketing, the products and services are skilfully packaged/repackaged and positioned based on consumer preferences. In public health, the look and feel of products and services is often packaged in the equivalent of an unappealing brown paper and what is on offer may be quite unclear. Appealing to individuals and groups to adopt something new continues to be a struggle that must be approached with respect for community preferences and values. When Apple launched its newest MacBook, for example, they appealed to user values and aspirations, and did not focus solely on product features. We need to do our best to go beyond an explanation of features, safety, effectiveness, and cost, and consider (and appeal to) user values and aspirations such as security, group identity, and freedom of choice.

- *Promotion*

Utilise all appropriate means to promote the product or service. This is the area that is the most visible aspect of marketing. It includes advertising and the full range of marketing communication, such as PR, social media, public service announcements, TV appearances, panel talk shows, shopping channels, hotlines, promotional tours, and street dramas. Utilising the full range of promotional tools and approaches is arguably one of the most important roles undertaken by those involved in public health. Research has shown that the more public exposure to carefully crafted messages, the better. The caveat is that those messages have to be harmonised and free of internal contradictions. In all of our promotional efforts, we must be smart marketers; look beyond the immediate, and seek to build and maintain long-term relationships with our clients. That means being respectful, even (or especially) when customers say 'no' to what is being offered.

10.2.2 Factors Influencing Behaviour

We all know there are many ways to influence behaviour. For clarity, behavioural scientists often group these into three categories: structural factors, social factors, and individual factors. Individual factors might be considered the classical factors of behavioural change: for example, knowledge, skills, and attitudes. Over time, however, we have found that knowledge is often overrated as a critical factor influencing consumer choice. We have found that factors such as attitudes and skills – often considered necessary predecessors to behaviour – can follow the behavioural choice rather than precede it.

Human-centred design and consumer journey mapping are specific tools that have been used to identify points at which consumers make critical decisions. These tools can provide us with valuable insights into where along the consumer pathways we can most effectively intervene to affect change. Marketers have reduced consumer pathways that in the past may have seemed insurmountable; for example ATMs replacing bank branches and online shopping displacing retail shopping behaviour. In both cases, marketers focused on assessing the core behaviour and cutting down the 'friction' between the consumer and the desired behaviour, allowing 'information' and 'attitudes' to follow the service experience.

Social factors include some of the most powerful influences on human behaviour. Fear of social rejection is one of our most primal fears, and many of our actions are guided by the actions of others and driven by social influence. We are all shaped by the need for recognition, acceptance and by the fear of rejection. Notably, social factors are often specific to social groupings, so our appeal to social influence must be community specific. We have seen social factors utilised successfully in community programmes that engage community leaders. These may be celebrities, religious leaders, or other influential members of the community. Engaging fully in the needs of constituencies and communities involves talking to them, listening and understanding concerns, and then helping them to best meet the needs of their communities.

The last group of factors are structural. In essence, this group of factors encourages us to find ways to make behaviours easier for our consumers. For example bringing services to local communities, providing mobile clinics, extending clinic hours, leveraging private sector outlets for services or referrals, and increasing the availability and visibility of services. We can better achieve our goals by understanding some of the constraints or obstacles that stand between people and desired behaviours. Travel is almost always an issue – how can we reduce travel costs or compensate for lost time and associated expenses? Can we bring services to the workplace or other local community venues to better serve working adults? Can we persuade employers to provide paid leave to become vaccinated? How can we provide services that take into consideration the full-time caregiving responsibilities of working mothers? We have seen that offering products and services in a variety of settings (in the home, pharmacy, workplace, and marketplace) increases uptake.

10.2.3 Appealing to Who People Are

Lastly, we would also suggest that as important as our work may be, we need to remind ourselves that health concerns are not the only issues that people are dealing with. When we speak to them, we must speak to who they are, not to how we imagine them to be, or would like them to be. Our communities are made up of different groups who have a diversity of needs, wants, responsibilities, identities, and aspirations. We cannot assume that everyone perceives health risks in the same way, or that arguments that work for one person or group will be equally effective with another group. People routinely risk their own health and welfare to make a living, to pursue their own dreams, or for the sake of loved ones. We cannot assume that clearly outlined arguments will inevitably resonate. However, if we listen to our communities, if we work with them to understand them more deeply, and, most of all, if we respect who they are, we will have a much better chance of engaging with them to develop interventions in which public health goals will align with community goals.

10.3 R. Umamaheshwari: 'Pandemic' Times and a Hill Village of Himachal Pradesh State, India (Case Study 2)

A providential outcome of the Covid-19 lockdown in India from mid-March 2020 resulted in my seeking shelter in a rented house in a small village named Hiwan, near Shimla, in Himachal Pradesh state, India. This became home for the following year and a half. 'Home' and 'family', two terms used considerably in 2020, have meanings that extend beyond one's place of birth or domicile and blood ties; if we can *belong* where we are *accepted* or vice versa, regardless of race, religion, or gender. Being in a village in Corona times was unintentionally in synch with the metaphor of the times: the other-worldness of rural India, its real distance from the *centre,* including the mainstream media/information discourse. The epiphany of this was seen in one of the longest held protests in the world (November 2020–November 2021) during a 'pandemic', led by peasants and agriculturists of Punjab and Haryana against three market-driven Farm laws introduced by the Indian government, which have since been withdrawn.

Fear of contagion takes second place when people's identities, lands, and livelihoods are at stake. The Covid-19 'infodemic' – too much or misleading information – was subverted successfully by the movement, forcing mainstream elite media to step outside of their 'reporting from home' syndrome to give prime-time to the protests. Few regard lockdowns as human rights violations. Extreme medicalisation of the discourse, in 'pandering' to the 'pandemic', made less visible or less relevant issues such as climate change, ecological crises, and the future of Earth itself.

The pandemic turned the purely for-profit entities – IT giants, online retailers, telemedicine and cellular service providers, global traders in medical products,

including those selling the PPE kits and sanitisers, and OTT platforms, as well as private educational app manufacturers – into 'essential services'. The worst-hit were street-based vendors, whose daily earnings came from the informal sector. An internet-based global 'pandemic-economy', involving virtual currencies, accompanied by the conscious expansion in the amount of information provided, created the space for infodemics via the media. This phenomenon insidiously altered individual psyches through the power of suggestion and by impacting natural responses, so people simply accepted a stated suggestion as truth until a newer suggestion entered the arena replacing it.

No one questions the fact of the pandemic itself as a term or event, and the flow of information on the terminology can be seen as top-down from the centres of power. However, alter-narratives among the general population in India increasingly question the politics of vaccination programmes, inequality, the business of medical treatment, and the benefits (or futility) of shutting down schools. My experience of an alter-narrative stems from personal experience in the village but is located within this larger context.

10.3.1 Nature and Habitat

Comprising of around 100 farming-based people, with small farm lands growing self-consumption-oriented food crops such as corn and wheat, potatoes, pumpkins, and gourds, Hiwan (with two sections, the original, in the valley, and the relatively newer, modernised one further uphill by the road-head) is a virtual ecological niche amidst dense cedar, pine, silver oak, and other local species of trees. A few underground natural springs provide drinking water and amazing wildlife, including leopards, barking deer, occasional wild boars, langurs, reptiles, and amphibians, and a plethora of bird, butterfly, and moth species. There are also various medicinal ferns and fungi. Traditional homesteads in the valley are built at a distance from each other. Cows, a few livestock, and domesticated dogs are part of every home. This way of living is in stark contrast to the dense cluster settlements found in large cities that are without 'lung space' and are exposed to shrinking water bodies and decreasing tree cover. The question arises if we should explore such settlements as future alternatives to the urban living environments that so often engender diseases?

10.3.2 Community Cohesion and Human Bonds

I was welcomed into the village in the midst of the COVID-19 scare, and at a time when numerous news reports of prejudice and hatred for outsiders were circulating. Despite this, I was gradually invited to take part in family meals or offered cups of tea more and more often. When schools were closed, the degree of trust I was held in was reflected in the fact that neighbours sent their children over to be taught by

me and through them supporting my idea of opening a library for the children in the community centre. Children attended regularly for a while, albeit reluctantly adhering to protocols of wearing masks and using sanitisers. In the months of May and June 2021, a few members of a family in the valley, two of which had been vaccinated, as well as two migrant workers staying in a rented room near the road-head, contracted the virus. The family self-quarantined, while the workers were looked after by men of the village who took turns in providing them with food and essentials. They also coordinated with the visiting medical team to monitor those infected. Everyone recovered completely. No further cases were detected thereafter. People became more careful, while not breaking community bonds, and did not exhibit the same level of prejudice or paranoia that was evident at that time in Indian cities.

10.3.3 The e-Learning 'Infodemic' and Consumerism

Initially, with the closure of schools and colleges, children and young adults (irrespective of gender) returned to the agricultural and household work cycle, helping parents in their farms and homes. Childhoods more reminiscent of the past were restored. WhatsApp-based schooling impacted not only the nature of learning and reading habits but also pushed youngsters towards greater consumerism and an increased presence on Facebook, Twitter, and Instagram, alongside news-gathering, and viral videos of pandemic-related information. Unfortunately, they did not have an adequate level of skill or knowledge to sift genuine facts from false news. Many became addicted to gaming apps, often downloaded on the single phone of the family. Gradually, each family was forced to buy more than one device in order to deal with pressures of erratic online classrooms. With constant power outages, online sessions were constantly disrupted.

Most families do not own computers, and computer literacy has not made inroads here. The brief re-opening of schools and colleges in mid-2021 reduced the usage of phones for learning. Yet, with the ongoing winter break (until February 2022), schools have forced children to stay connected to a centralised e-learning platform. This will indirectly increase the profits of private vendors and cellular service providers. There is as yet no critique of this state-sponsored 'infodemic', a centralised curriculum or the impact of telecommunications.

10.3.4 Autonomy and Dignity of the Body

I observed that funerals in villages in Himachal retained a level of human dignity, ritualistic orthodoxy notwithstanding, which those in cities did not experience. For example social boycotting of families of COVID-19 patients who had died was reported in cities but was not heard of in the villages. There is a significant difference between the autonomy of a family over the treatment of a dead body as opposed

to letting it slip into the hands of a distant, unfeeling system where, once gone, it is stripped of the dignity of a name and family history. Bombardment in mainstream media of visual (and visceral) images of human bodies piled up and cremated en-masse may have led to underground funeral ceremonies in some villages, with the cause of death undisclosed.

10.3.5 The Last Mile Walker/Worker

Accredited Social Health Activists (ASHAs) are the 'last mile' walkers/workers in the area. The worker in Himachal asked to maintain her anonymity and be referred to simply as 'Asha'. Largely invisible to the media, she has intimate connections with families, recording births, deaths, sickness, and promoting health awareness. During the lockdowns, she had the additional duty of reporting new entrants into a village, their health status, and contact details. She was also expected to encourage people to become vaccinated through phone calls and, later, personal visits. Asha is paid a minimal Rs. 2700/- per month, without any additional perks or job protection. PPE kits rarely reached any of the ASHAs and sometimes Asha had to walk up to 7 kilometres from her village to the health centre for vaccinations. Though her working hours were 10 am to 4 pm, often she started from home at 7 am to reach the centre. She had to cover villages spread over a large Panchayat (local governance unit), yet received no free passes or concessions on state buses. Her duty phone calls were not reimbursed either. Initially, she also faced prejudice in villages due to her contact with COVID-19 patients in the course of her work. Neither snow nor rains halt her efforts. Should Asha fall sick in the line of duty, she would receive no monetary compensation from the government: 'It is a thankless job', she said. With fears of a new strain of the virus, Asha may have extra work brought about by another vaccination programme, without any prospect of increased wages or job security.

The pandemic has now become more about the digital/cyber economy and control than about a disease per se. Had it been simply an 'epidemic', it may not have resulted in the constant and often frightening visual images that have been disseminated for purposes other than the control and prevention of disease. The apparent lack of a moderating structure is of concern, as the rationale behind the publication of certain information is at best questionable. There are, however, communities and environments where the impact of the virus has been neutralised through local solutions and resources rather than through a universally applied, blanket ban on all activity other than cyber activity. Perhaps it is time to remember that cautionary tale about not burning the house down to kill a mouse.

10.4 P.D. Akana: Strengthening Community Engagement Towards COVID-19 Vaccine Acceptance in Cameroon (Case Study 3)

Socio-anthropological studies analysed rumours and fake news disseminated during the COVID-19 pandemic in Cameroon by traditional media and social networks (World Health Organization 2020a, b). Strong reluctance and hesitation regarding vaccine acceptance and compliance with preventive measures was highlighted. Additionally, evidence further revealed that communities were strongly influenced by the infodemic through a real lack of accurate information on vaccination. This not only allowed multiple conspiracy and false theories to flourish, it also led to the feeling that beyond mass awareness campaigns, the essential message of the pandemic response teams remained inaccessible to people where communities were not engaged in the interventions. Therefore, COVID-19 vaccination in Cameroon was launched within a context of doubt, suspicion, and inequity in access to quality information. This situation prevented communities from committing themselves or being able to make genuinely informed decisions.

National health authorities and WHO carried out a survey during the mass gathering event of the African Nations Championship in January 2020 that revealed negative trends in community attitudes. For example 73% of the people interviewed in the city of Yaoundé were opposed to the COVID-19 vaccine, while 27% were in favour (Fig. 10.1).

This data correlated with that of a KAP survey in September 2020 (Ministry of Health/World Health Organization 2020), which confirmed a significant point already observed; low levels of community engagement are strongly correlated with negative attitudes and perceptions towards the disease and vaccination (Fig. 10.2).

Indeed, a geographical analysis of attitudes shows an overall saturation of negative attitudes in the five main regions where the KAP survey was conducted. Only three health districts among the 20 enrolled had neutral or positive attitudes (Fig. 10.3).

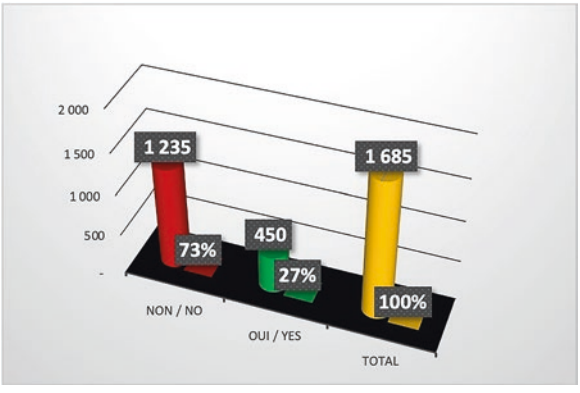

Fig. 10.1 Survey results for the city of Yaoundé. (Source: Ministry of Health/World Health Organization 2021)

In order to reverse the trends and enhance community engagement for vaccine acceptance, health authorities and WHO designed and implemented the strategy of community dialogues, coupled with public and publicised[1] vaccinations of community leaders and political and administrative authority figures. The strategy was built in an inclusive and concerted manner by state actors (Ministries of Health, Ministry of Youth and Civic Education and the National Program of Immunization), WHO, and civil society. It quickly became an example of collaborative teamwork, with a strong commitment to discussion and deliberation manifested in a workshop to validate the tools (community dialogue training module, community dialogue methodological guide).

The strategy was extended to other actors such as the Red Cross, UNICEF, and Breakthrough Action. Using evidence from KAP surveys and socio-anthropological rapid studies, behaviours resulting directly from community resistance to the COVID-19 vaccine were identified and challenges and solutions were prioritised (WHO n.d.).

The consultations led to a social organisation to co-construct the community dialogue, in particular by identifying and discussing strategies to

- Build consensus with community leaders for the acceptance of vaccination.
- Lead the development of a community-led action plan that could promote a positive approach to immunisation and behavioural change.

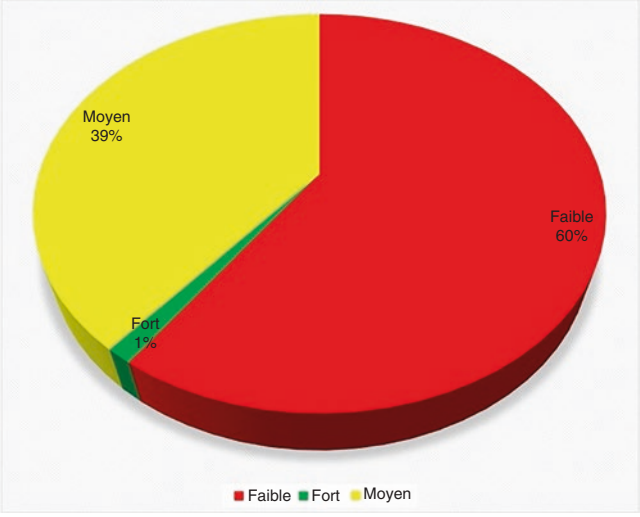

Fig. 10.2 Attitudes towards vaccine acceptance in 4 main districts. (Source: Ministry of Health/World Health Organization 2020)

[1] Media coverage of vaccination is a powerful advocacy tool that sends clear messages of the commitment of community leaders and political and administrative authority figures to communities. Publicising vaccination also makes it transparent and can help dispel doubts and hesitation, making other beneficial public health practices more visible.

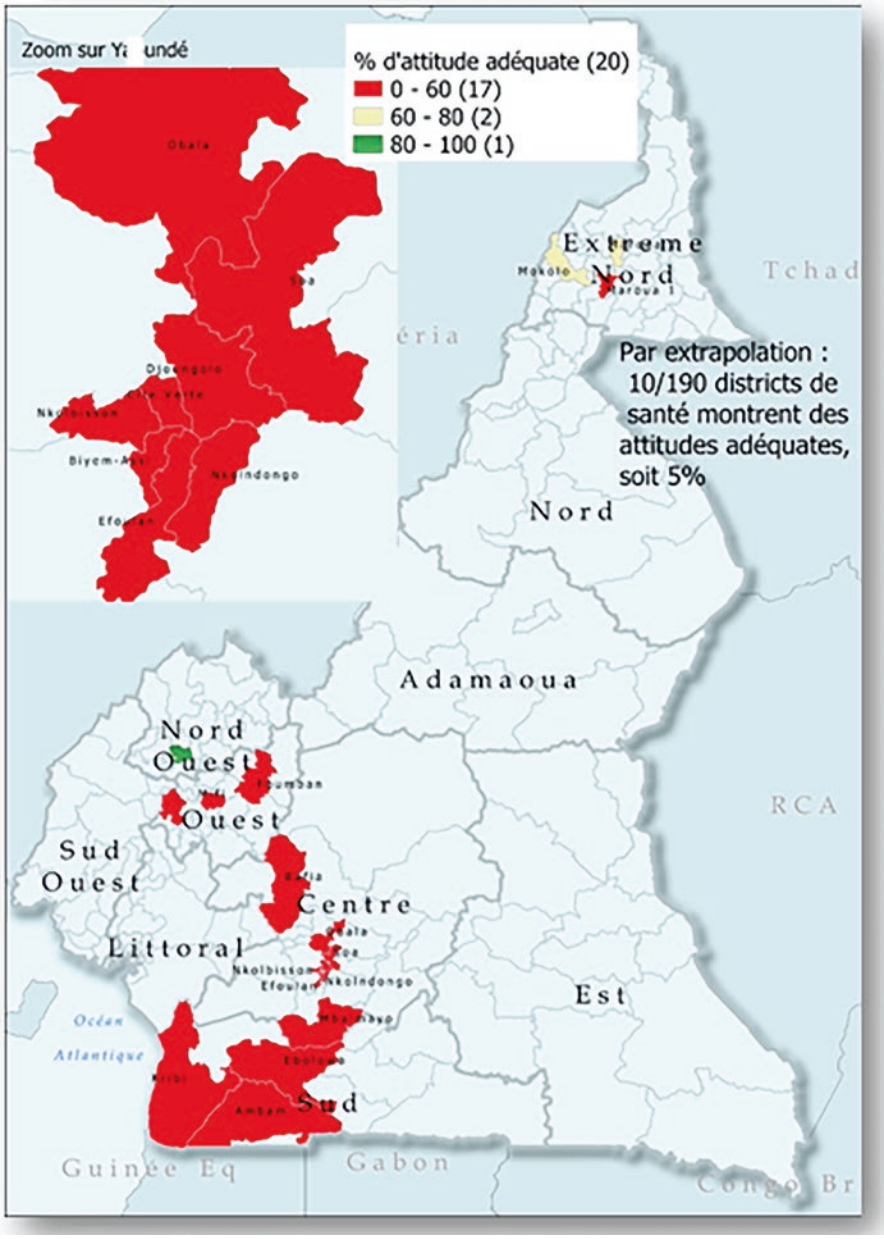

Fig. 10.3 Attitudes towards COVID-19 in the health districts. (Source: Ministry of Health/World Health Organization 2020)

The main results of this approach include

- The development of one community dialogue module.
- The enrolment of 26 health districts of four mains districts.
- 210 community mediators and facilitators put in place to enable community dialogue
- The conduct of 1107 community dialogues, coupled with vaccination.
- Vaccination points decentralised from health facilities to community spaces such as markets, mosques, churches, bars and other drinking places, streets, esplanades of places of worship, courts, and other public buildings.
- 1565 people mobilised by community mediators and facilitators publicly vaccinated and their vaccinations made public through the media
- At least 10 articles published by private and public media and a large number of testimonies of vaccinated people recorded and disseminated in real time.

One of the key successes of this approach was the priority mobilisation of community prescribers and the trust in leaders such as traditional chiefs, political and administrative authority leaders, leaders of associations, and religious leaders. They supported response teams to carry out advocacy in their communities. Journalists from public and private media, as well as technical partners, relayed the operations in real time. The main challenge was in convincing influencers and trusted leaders to take part in public vaccination as their participation could then snowball and reassure communities. Despite the constraints, this innovative pilot project achieved its objective: co-construction of solutions with communities. During community dialogues, response teams were able to observe people flocking to be vaccinated.

10.5 J. N. Anoko: Effective Partnership with Communities to Rebuild an Ebola Treatment Centre (Case Study 4)

On 27 February 2019, arsonists destroyed the Ebola Treatment Centre (ETC) in the health district of Katwa, North Kivu Province, Democratic Republic of Congo (DRC). Ebola broke out in the province where people were already suffering due to more than two decades of active armed conflict. This has resulted in widespread lack of trust in government authorities and in health response teams. Insufficient listening and engagement of communities in terms of the response to the health situation has also led to strong resistance, rumours, misinformation, conspiracy theories, and even the murder of health responders. The burning of the ETC can be viewed as the culmination of this deep crisis of trust with communities throughout an epidemic that lasted 22 months (August 2018–June 2020). A total of 3470 people were infected, 2287 died, and 1171 survived. The partnership to rebuild the ETC is an example of the commitment of communities to establish co-construction of solutions in equal partnership with response teams.

10.5.1 Method

The response partners put in place a team composed of socio-anthropologists, members of the risk communication and community engagement commission, logistics personnel, and medical teams from the Katwa district. Three preliminary meetings were held with the chiefs of Katwa, Rughenda, and Vighole[2] to discuss the reconstruction of the ETC. In turn, each district organised a community dialogue to gather the views of their populations in the absence of the response teams. Three other community dialogues were organised with the response teams to feedback the results of the internal dialogues. The main points of discussion during the meetings were (i) the urgent need to rebuild the ETC; (ii) the socio-cultural representations of the ETC; and (iii) the construction period and operational modalities. The parties defined the action plan with the main requirement that the ETC be rebuilt exclusively and entirely by the local population. Response teams were to provide technical and financial support and oversight of the construction works. In terms of modalities, the community leaders designated 180 people on an equitable representative basis (men, women, and youths) to carry out the work under the supervision of the logistics teams.

10.5.2 Results

This section provides a summary of the main outcomes of the project:

- Exorcising the misfortune before rebuilding the ETC

For the people, the new ETC fulfils the conditions of a '*Vuhima*', that is *a* '*Nande*[3] *house of care*' or '*house of deliverance*' in spiritual terms. To this end, it had to be built entirely and exclusively by the Nande people in the style of the local houses. If the Nande build the ETC, they can appropriate it as a 'Nande property', a space where the Nande come to entrust their sick so that experts can give them appropriate care in times of illness, misfortune, and death.

Therefore, the first essential step was to exorcise the misfortune. A ritual to appease anger and fear was performed to obtain the blessing and protection of the ancestors. This purification aimed to appease the spirits and ask forgiveness for the destruction of the previous ETC. The participants in this ceremony collectively and unanimously agree to protect the ETC for the good of their community. The costs of the ritual were shared between the community leaders and partners. The ritual was performed on the first day of the event by the dean of the Bwami (singular Mwami) and local leaders in the presence of the response teams (health authorities and partners) and selected workers. Local 'Kasixsi' wine was poured on the ground over

[2] The ETC was built at the crossroads of these three districts with the agreement of the local chiefs.

[3] The Nande are the majority ethnic group in North Kivu.

the ashes of the devastated premises. Each community leader then drank from the communal cup in turn, repeating the words of the Mwami, 'Woe and death'. The Nande are strongly attached to their land and to the house as a symbol of stability and rootedness. Someone noted, 'If we build our ETC, if we build our care home, we will never destroy it' (personal communication – 22 March, 2019), carrying out the work.

Following the ritual, the work was launched under the slogan '*STOP EBOLA, STOP EBOLA*'. Logistics experts provided supervision to ensure that the protocols and biosafety standards for the construction of the ETCs were respected. Those involved worked as day labourers for about 10 days, using tools brought from home as recommended by community leaders to demonstrate ownership of the ETC.

- Securing the ETC

Young women and men were mobilised to ensure the security of the site. Some of them acted as guides to orient patients and visitors by speaking to them in local languages. Most of them came from pressure groups as, according to a community leader, 'some of the members of these pressure groups are also in the local self-defence groups and they will know how to prevent delinquency around the new ETC because they have a very good knowledge of the terrain and local realities' (personal communication – 22 March, 2019).

During humanitarian and public health emergencies, community engagement cuts across all areas, not just risk communication. Following this intervention, a woman leader working on the site said, 'It is now that we feel involved in the activities of this response. It really gives hope that together we can defeat this epidemic' (personal communication – 22 March, 2019).

The new ETC has not been attacked. Even after the end of the epidemic in June 2020, it remained secure and was ready to be used again during the 2021 Ebola outbreak.

10.5.3 Conclusion

Communities are partners and need to be empowered and supported to play their role. Such engagement through cooperation with communities calls for an urgent change in the approach to health emergency responses. This can be achieved by a moving away from the dominant biomedical design of public health emergency response towards a public health design that balances biomedical paradigms with those of social and behavioural sciences.

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