Republic of Sierra Leone

NATIONAL COMMUNICATION STRATEGY
FOR EBOLA RESPONSE IN SIERRA LEONE

"We Go Win De Ebola Fet"

September 2014

MAP OF SIERRA LEONE

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1.0 Background

On Monday 25 May 2014, the Government of Sierra Leone through the Ministry of Health and Sanitation declared an outbreak of Ebola Virus Disease (EVD) in Sierra Leone following the laboratory confirmation of a suspected case from Kailahun district. This outbreak appears to be a spillover from the on-going outbreak in Guinea and Liberia since March 2014. As of 28 September 2014, the cumulative number of laboratory confirmed cases are 2090, with 552 confirmed deaths and a Case Fatality Rate (CFR) of 25% in twelve districts (Kailahun, Kenema, Kambia, Port Loko, Bo, Bonthe, Bombali, Tonkolili, Kono, Phjehun, Moyamba and Western Area)[1].

On 30 July 2014, the President of Sierra Leone announced a national health emergency. A Presidential Taskforce on Ebola has been established to lead the response. On the same day, the Sierra Leone Accelerate Ebola Virus Disease Outbreak Response Plan was launched. The National operational plan was also developed with the goal to reduce morbidity and mortality due to Ebola through prompt identification, notification and effective management of cases, effective social mobilization and coordination of the epidemic response activities.

According to the Sierra Leone Accelerated Ebola Virus Disease Outbreak Response Plan, major challenges contributing to the on-going outbreak include:

1. Inadequate understanding within the communities of the EVD as this is the first major outbreak reported in the country
2. Lack of experience among health care workers and limited capacities for rapid response
3. High exposure to Ebola virus in the communities through household care and customary burial procedures. This has resulted in a high level of community deaths leading to panic and anxiety
4. Denial, mistrust and rejection of proposed public health interventions arising from misinterpretation of the cause of the new disease
5. Fear of the disease by frontline health workers leading to either suboptimal care for patients or substandard implementation of protective measures
6. Close community ties and movement within and across borders has led to difficulties in tracing and following up of contacts for the three countries

The magnitude and the geographical extent of the EVD outbreak in the country require significant and robust response capacities and structures. This outbreak poses serious challenges in terms of human capacity, financial, operational and logistics requirements and threatens national and international health.

In response to these challenges, the Ebola Operations Centre (EOC), a coordination body spearheading the Ebola response was established. The EOC serves as the Sierra Leone National Central Command and Control Center for Outbreak Response activities. The District Level Ebola Operations Centers (DEOCs) were also established at all districts to coordinate response activities at district level. The National Ebola Taskforce contains four pillars which correspond to the following thematic areas: 1) Coordination/finance/logistics; 2) Epidemiology/ surveillance and laboratory; 3) Case management, infection control and psychosocial support; and 4) Social mobilization/public information.

[1] The Government of Sierra Leone, Ministry of Health and Sanitation, EBOLA VIRUS DISEASE - SITUATION REPORT Vol. 106,

The National Communication Strategy for Ebola Response serves as a guiding document of the Social Mobilisation Pillar (SM Pillar), a coordination platform for evidence based, dialogical and participatory social mobilization and communication responses to EVD at all levels.

2.0 Situational Analysis

2.1 Epidemiology

In Sierra Leone, as of September 28th[2], the cumulative number of laboratory confirmed cases are 2090. With 552 confirmed deaths the Case Fatality Rate (CFR) based on confirmed cases is 25%. The district of Kailahun leads the case count with 529 cumulative confirmed cases while the district of Kenema leads the death count (232) and 54.5% CFR.

2.2 Knowledge, Attitude and Behavioural Practices (KABP)

In August 2014 a KABP assessment[3] was conducted in nine EVD affected districts covering over 706 households and 1416 participants. According to this study over 99% of respondents (n=1413/1416) are aware of EVD and 97% (n=1369/1416) believe that it currently exists in Sierra Leone.

At the same time, the study highlights that misconceptions or inaccurate knowledge of EVD transmission remains high as nearly 30.4% of the population believe that EVD is transmitted through air and a similar proportion (29.6%) believe that EVD may be transmitted through mosquito bites. Similar lack of knowledge also exits regarding prevention and treatment of EVD. Nearly 41.5% believes that bathing with salt and hot water can prevent Ebola. Belief on spiritual healers in treating EVD is reported 19.4%. Based on these findings there is a felt need to shift emphasis of messaging from "Ebola is Real" to addressing misconceptions about the disease and providing people with clear/simple messages on key protective practices, especially on:

- Avoiding physical contact with bodily fluids (as well casual contact such as shaking hands)
- Avoiding burial ceremonies and rituals that involve the washing of the dead body of someone suspected to have had Ebola.

The study also advocated for increased emphasis on survivor reintegration into their communities and recommends development of special messages around community acceptance of Ebola affected persons and families so as to reduce the high level of stigma and discrimination currently reported.

2.3 Communication Channels

The KABP study reconfirmed radio as the most popular and singular most accessible medium for mass information dissemination nationwide. At the same time the study suggests increased use of television, especially to convey survivor stories so that communities may 'see and believe' and thereby reduce high levels of stigma associated with the disease.

Radio forms a central pillar in the communication and social mobilisation strategy for Sierra Leone with over 85% of respondents preferring to receive EVD educational information through radio programming. The radio network mainly consist of local commercial stations with a limited broadcast range, and a selected number of stations have regional coverage. Radio jingles, news programmes,

[2] EVD Situation Report Vol 112, the Government of Sierra Leone

[3] Study on Public Knowledge, Attitude and Practices Relating EVD Prevention and Medical Care in Sierra Leone, September 2014, Focus 1000/CRS/UNICEF

music and drama playlets and public service announcements, phone-in discussions are the most common forms of radio broadcasting. Unfortunately, creative programme design and development for radio stations is limited resulting in an equally limited scope of the approaches being used among community media in particular. In Sierra Leone the television channel network consists of only one television station, the Sierra Leone Broadcasting Corporation (SLBC). Even though TV is mainly concentrated in the capital city of Freetown, coverage is gradually extending to most districts in the country.

One medium that is consistently on the rise over the last few years is mobile telephony. There are an estimated 2.2 million mobile users in the country, twice the number of radios. There are three main mobile phone service providers in the country – Airtel, Comium and Africell. Smart has also recently launched mobile communication services in Freetown and is expanding to other parts of the country.

Other communication means most likely to reach caregivers and individuals are one-on-one communication channels such as counselling from community health volunteers and interactions with health workers at the health facility or during their outreach visits. The KABP study indicated that with regards to important information about EVD, including rumours, the health professionals and MoHS are the most trusted source. For women this is a particularly important communication channel. Women often have limited access to information so health worker/volunteer are sometimes the sole source of reliable information. Various NGOs and CBOs use health workers/volunteers in their operational areas as part of behaviour change communication campaigns and social mobilisation. Traditional birth attendants (TBAs) and market women leaders are also key communication channels to reach young girls and women.

Community meetings and religious meetings are particularly useful for community education and mobilisation. Community meetings and religious gatherings also emphasise the leadership and role of key influencers in the community such as Paramount Chiefs, town and village chiefs, Mammy Queens (women leaders), religious leaders and teachers. Presently, UNICEF Sierra Leone is supporting Women's groups such as Wi Pikin (nutrition and education mother to mother support groups) for reaching and engaging community members – boys and men, girls and women and community elders to build a supportive environment for the adoption and maintenance of positive behaviours and practices.

Sierra Leone also has a rich history of folk media, with its various forms being used for community education and for facilitating discussions and debates within the community on harmful behaviours and social norms. Interpersonal Communication (IPC) formats have not been sufficiently tested or applied, as many extension workers have veered towards modern mass media as a more cost-effective mechanism to reach larger numbers of people. However, folk media has been used successfully for post-war reconciliation in the country, as well as in improving uptake of immunisation services during the UCI campaign. There is an urgent need to invest in related low cost facilitation tools that assist frontline staff in their interaction with targeted home-based groups. Such tools include: visually focused flip charts and flash cards, visual testimonials / photographs, popularising the use of community based signs and symbols and signals communicated between members of secret societies including direct orders and messages emanating from similar groups.

3.0 Aims and Objectives

The overall programmatic goal is to contribute to the National Strategy of the Government and partners to end transmission of the Ebola outbreak in Sierra Leone through effective, evidence-based social mobilization and public education that supports desired behaviour changes.

3.1 Aims

The aims of the National Communication Strategy for Ebola Response are to:

- Ensure that communication and social mobilization interventions implemented by the Government, International Partners, NGOs, CSOs, media and private sector operate in a coordinated manner.
- Establish a programme management framework, including monitoring and evaluation, for social mobilization/communication activities at all levels.
- Guide and ensure development of evidence-based messages, communication materials and approaches for various participant groups to achieve the behavioural outcomes that facilitate interruption of EVD transmission and a reacceptance of survivors into communities and homes as healthy members of society.

3.2 Communication Objectives:

The strategic communication objectives that the national communication strategy will strive to achieve:

- By end December 2014 80% of population has comprehensive knowledge (accurately rejects at least three misconceptions and identifies three means of prevention) about Ebola.
- By end December 2014 more than 90% of the population believe that it is possible to recover from and survive EVD by seeking prompt medical care and services within 24 hours.
- By end December 2014 90% of suspected EVD deaths have been accorded safe and dignified burial practice.
- By end December 2014 less than 60% of population will hold any form of discriminatory attitude towards EVD survivors.

4.0 Participant Groups

Recognizing the heterogeneity, diversity, and varying levels of EVD risks in the general population, targeting specific participant groups is very critical. The Communication Strategy will focus on these groups at micro, meso and macro levels with relevant behaviour change communication strategies and messages.

A significant focus of the communication interventions will be at the micro or the individual, family and community level.

4.1 Primary Audiences

The primary audiences for the EVD behaviour change communication strategy are:

General population

Ebola is not airborne, food-borne, or waterborne – therefore the risk is not generalized. Protective measures at the community level to disrupt the transmission of the infection include frequent hand-

washing with soap, being vigilant in identifying and reporting suspected cases, and avoiding burial ceremonies in which the deceased may have been an Ebola victim.

Heads of households / families with individuals suspected to have contracted EVD

Transmission patterns and epidemiological data show that individuals in the same household as a suspected EVD patient are at increased risk of contracting the infection and spreading it through unprotected contact with bodily fluids and blood. Once a family member exhibits signs and symptoms, s/he may become unable to take care of him/herself depending on the severity of the illness. Household members could play a key role in containing the spread of the infection within the household by taking appropriate and timely actions. As a result, they need to be empowered with accurate information and provided with the necessary skills/support to decrease the risk of further spread through unprotected contact within the household or neighborhood.

Individuals who are suspected / at risk to have contracted EVD

This audience is defined as someone who:

- exhibited signs and symptoms of EVD; or
- been in contact (directly/indirectly or protected/unprotected) with a suspected/confirmed EVD patient; or
- participated in the burial ceremony of a suspected/probable/confirmed EVD victim

Similar to heads of households, these individuals should be provided with accurate information, materials, and skills that enable them to take personal actions that prevent the spread of the disease to other uninfected household members, relatives, friends, or neighbors.

Special groups

This audience includes: children/students, adolescents/youth, health workers, survivors of EVD, affected family members, religious leaders especially who deal with funeral and burial, people in hotspots and quarantine, people in hard-to-reach areas and physically challenged people. For these groups, context-specific needs/gap assessment/analysis is conducted and linkage with appropriate services such as psychosocial support system strengthening.

4.2 Secondary Audiences

As mentioned, secondary audiences play an important role as *direct influencers* of the primary actors. This audience includes influential and respected community members who shape normative behaviours such as cultural and religious practices. While this segment of the population is small in number, their collective influence helps reinforce preventive measures. Individuals in this category include:

- local and traditional authorities such as Paramount Chiefs, Section Chiefs and Village Elders
- heads of secret traditional societies such as Sowes, Agbahs, etc.
- religious leaders such as imams and pastors, community evangelists and koranic teachers.
- Cultural and traditional practices are not static, and as such, these 'influencers' are uniquely positioned to advocate and promote positive shifts in norms that contribute to curbing the EVD epidemic in Sierra Leone.

4.3 Tertiary Audiences

Tertiary audiences are those who influence the secondary actors in the decision making process in promoting protective norms at the community level. In Sierra Leone, these include District Health Management Teams (DHMTs), District Social Mobilization Teams, District Councils and civil society.

This category may also consist of authorities in central government (e.g. Ministry of Local Government) and development partners with longstanding relationships Sierra Leone (such as respected development agencies and bi- and multi-lateral partners). While this audience is far removed from taking the immediate actions necessary to curtail the transmission, it has the ability to influence important decisions affecting the promotion of preventive measures against EVD in the country and sub-region in West Africa.

Participant group specific messaging and key behavioural outcomes are outlined in Annex.

5.0 Messaging & Materials

Proper messaging is a vital component of the communication efforts to contain the spread of EVD in Sierra Leone. The National Communication Strategy on Ebola proposes evidence based messaging to resonate with the respective participant groups to attain the desired behavioural outcomes.

5.1 Quality Principles of Communication in Emergency[4]

- Announcing early and prevents rumours, myths, misconceptions and misinformation
- Transparency – communicating facts as they are available
- Dialogical / two-way communication – creating mechanisms which allow population to express their concerns and recommendations for the response activities
- Using general messages for the wide population and relevant messages to specific groups
- Practicing positive communication – research reveals that negative messages that invoke extreme fear and hopelessness may not trigger positive behaviour change.
- Proactively preventing and fighting rumours: mechanism of "rumour bank" is served as detecting early diffusion of rumours and misconceptions
- Quality control of messages and communication materials – the messaging and dissemination subcommittee is served as a standardised national mechanism in order to avoid rumours, misconception, myths, discriminatory messages and the design of new and relevant messages as applicable.

5.2 Message Framing

Based on the knowledge gaps identified by the KABP study and application of the Health Belief Model (HBM)[5] to the current Ebola epidemic in Sierra Leone, the following should be incorporated into core messaging:

- Perceived EVD susceptibility (risk of contracting the disease)
- Perceived benefits of adopting preventive behaviours
- Perceived barriers or costs associated with the promoted actions
- Self-efficacy (confidence to engage in the promoted behaviours)
- Cues to action (reminders that reinforce the promoted behaviours)

Key messages

[4] Adapted from « *World Health Organization Outbreak Communication Planning Guide* »

[5] Janz, N. K., and Becker, M. H. (1984). "The Health Belief Model: A Decade Later." *Health Education Quarterly* 11:1–47 - U.S. Public Health Service (1950)

Messages should be accurate and consistent among partners, and should be developed in guidance with the Social Mobilization Messaging and Dissemination Subcommittee. The Knowledge, Attitude and Behavior Practices (KAP) survey informed the overall key message areas. Throughout the Ebola response, core messages should continue to be emphasized, and new messages should evolve from awareness and knowledge to actions people can take to protect themselves, their families, and their communities from Ebola.

Ongoing core messages:

- Prevent infection
- Recognize the signs and symptoms of Ebola
- Promote 117 call center
- Get to a health facility if sick with symptoms of Ebola
- Care and treatment increases the chance for survival for the individual, and can reduce the chance of transmission to others.

Building upon the core messages, additional message areas include:

- Take action to protect individuals and families in the home while waiting for help
- Promote safe funeral and burial practices
- Support and provide accepting environment for survivors
- Address misperceptions and stigmas
- Promote unity, cooperation, and hope to against Ebola

Participant group specific channels and materials are outlined in Annex.

6.0 Channels and Materials

The Communication Strategy will employ a multimedia approach using a mix of channels and materials to reach the key audiences.

Radio

Radio programming will be prioritized in behaviour change communication efforts. Radio programming – when done in Krio or other local languages – can overcome the barrier of low literacy / education level. The possibility of simulcasts presents a unique opportunity to deliver harmonized messages to a sizeable nationwide audience. Memorandum of Understanding will be signed with key radio stations whose capacity will be developed to promote accurate, balanced, clear and well-targeted messages. A system will also be developed to monitor the media to ensure they are maintaining agreed standards and best practices, especially in the application of specific programme formats, locally developed songs and news reports that may undermine efforts to instil positive responses from the public at large.

Interpersonal Communication

Interpersonal communication approaches, in particular house visit, is the second preferred channel by respondents in the KAP study. Through key informant interviews with community members during the KAP, participants shared that they need a platform where they are able to interact, ask questions, and get clear answers – especially around preventive actions they could take to reduce their risk of transmission as well as understanding the medical care and treatment options available for infection persons. Interpersonal communication skills capacity of Medical / health care providers and ministry

of public health staff, the most trusted sources of information, will be built. An immediate investment in practical low-cost visual tools for frontline community personnel will be investigated and popularised as applicable.
The use of community signs, symbols, songs and approaches will be popularised at village and community levels. Town Criers should be used as an important link in the delivery of correct information to village households.

Outdoor promotion

Outdoor promotion is focused on providing information to people when they are "on the go" in public places, in transit (such as an OKADA, taxi or bus), waiting (such as in a health facility), and/or in specific commercial locations (such as shops or hair dressers). Outdoor promotion formats can be billboards, banners, posters, wall painting, and transport promotion.

Television

Being a visual medium, television will be strategically used to share the stories of healthy Ebola survivors. These survivors will be given a visual platform to tell their stories in an honest and open manner that ordinary citizens can relate to. By so doing the stigma and discrimination associated with EVD could be reduced while also persuading the public that 'it is possible to survive and recover from Ebola'. An investment in a variety of short EVD spots will be designed, developed and promoted not only for SLBC but for future use in hundreds of local community-based cinema viewing centres, to be played between football programme viewing and African Movie shows, popular throughout the country. The same can be popularised in short EVD periods to be instituted in many urban churches with huge following where announcements/sermons are visually projected.

Religious venues

Religious venues such as mosques and churches will be leveraged as critical channels for the dissemination of Ebola messages. As an important secondary audience (influencers), Imams and pastors, koranic teachers, Sunday school teachers and evangelists will be engaged in using Kutubas and sermons, Home Cell Worship Groups with relevant citations from the Quaran and the Bible, to persuade congregations in adopting EVD preventive actions and prompt medical seeking practices. Pastors and Imams are uniquely positioned to reshape religious burial norms, thereby discouraging practices that involve the touching and washing of deceased EVD victims.

Mobile Phones

The use of mobile phone technology will be used in reaching mass audiences – especially the younger demographics and urban settings such as Freetown and district headquarter towns. Using SMS platform is already planned to reach wider audience as well as with specific target groups.

7.0 Management and Coordination

At the national level, the Social Mobilisation (SM) Pillar chaired by Programme Manager, Health Education Division at Ministry of Health and Sanitation and co-chaired by UNICEF Sierra Leone will lead and coordinate programme communications activities, the use of mass media, interpersonal communication approaches and social media to enhance understanding of the disease, risks and risk mitigation measures, putting people at the centre of the response. The pillar is supported by four technical subcommittees focusing on various components of communication programme

management. Similarly, each district has a SM committee and SM coordinator who will be tasked to coordinate, manage and monitor communication interventions at district level.

Sub-committee 1: Coordination, Monitoring and Evaluation

Ensure that all interventions related communication and social mobilization implemented by the Government, International Partners, NGOs, CSOs, media and private sector operate in a coordinated manner and are monitored by the SM pillar

Expected Outcomes:

1. A single coordination mechanism for social mobilization/communication interventions in response to EVD are in place and the meeting is convened regularly at the national and district level including of mapping of partners.
2. A national action plan is developed and all 13 districts adopted the National Communication Strategy and develop a district-level action plan for social mobilization and social and behavior change communication.
3. A simple monitoring & evaluation system is developed and used to track the implementation of activities shown in the Action Plan.
4. Appropriate studies/survey are conducted **for evidence-based programming and decision making.**

Sub-committee 2: Capacity Building

Strengthen capacity of government and partners to plan, implement and monitor evidence based social mobilization/communication programmes at all level

Expected Outcomes:

1. Map of partners including media is created through identification of 'who is doing what and where'.
2. Capacity of government and partners are assessed and necessary inputs are provided. This includes: material development for training, training of appropriate personnel, and provision of relevant communication and social mobilization related supply and equipment.

Sub-committee 3: Messaging and Dissemination

Ensure that evidence-based messages and communication materials are developed for the general public as well as for target populations and disseminated through multi channels of communication at all levels in order to raise awareness of Ebola and contribute to social and behaviour changes to end transmission of Ebola

Expected Outcomes:

1. A quality assurance mechanism is put in place for messages and communication materials developed by various partners for harmonisation and quality control.
2. Messages and communication materials are developed, printed, and widely disseminated at all levels.
3. A database of various messages and communication materials are created and managed to generate knowledge on Ebola communication.
4. A rumours management mechanism (rumours collected, analysed and addressed through 117, rumour bank and social mobilisation activities) is established and function with efficient feedback mechanism.

Sub-committee 4: Special Needs

Ensure that context-specific supports is provided to special groups including survivors from EVD, affected families, disabled persons, homeless persons, and commercial sex workers

Expected Outcomes:

1. Special needs groups are identified and assessments of needs are identified.
2. Context-specific support is provided to the groups including strengthening their capacity for response to EVD

8.0 Monitoring and Evaluation

The RE-AIM Framework provides a flexible and comprehensive approach to assessing the results of the Communication Strategy triangulating both quantitative and qualitative data to better gauge process and outcome measures in terms of reach, effectiveness, adoptability, implementation, and maintenance. Data collection efforts may consist: (i) national household surveys, (ii) smaller purposive surveys with key audiences (iii) in-depth interviews with key informants, and (v) focus group discussions. Secondary sources of data including monitoring reports of the Communication Activity Plan could also provide data process level indicators.

There is a need to continuously collect empirical data (qualitative and quantitative), conduct rigorous analysis, and make concrete recommendations on how to address bottlenecks in the BCC efforts and improve the quality of the interventions. Annex to be developed will serve as an M&E Plan for the Communication Strategy and Action Plan.

9.0 Annex

Annex 1: Behaviour Analysis

Who?		Behaviour Risk	Behaviour Result
Primary	Everybody	• Ignorance of symptoms and mode of transmission • Ignorance of the fact that early treatment can save the life • Ignorance of free medical treatment • Lack of physical hygiene to prevent Ebola (hand washing with soap, use of latrines, use of potable water, sharing needles and razor blades) • Hunting and handling wild animals • Handling or consumption of sick or dead monkeys or other wild animals • Panic-led behaviours (non-collaborating to case tracking, fleeing the area) • Eating wild animals especially monkeys, chimpanzees and bats • Eating fruits that bats or wild animals have partly eaten (bat mot) • Touching persons who are suspected of the EVD, Ebola patients or a deceased victim of Ebola • Washing dead bodies • Misconceptions of "traditional" healing and medicine • Beliefs in divine healing (Prayers) • High discriminatory attitude toward survivors and persons/families affected by Ebola • Delaying of seeking medical treatment/health care •	• **Knowledge of symptoms and mode of transmission** • **Knowledge of the fact that early treatment can save the life** • Knowledge of free treatment for Ebola in all government health facilities • Improvement of physical hygiene (hand washing, use of latrines, use of sterilised water, not sharing needles and razor blades) • No hunting and handling of wild animals • No handling or consumption of sick or dead monkeys or other wild animals • Collaborating with case tracking, non-fleeing from the area • Avoidance of eating wild animals • Avoidance of bat mot • No eating any animals found dead • Do not touch person who suspected of Ebola, Ebola patients or died by Ebola • No washing of dead bodies • Rumours on treatment that: 1) washing the body with hot water and salt; eating btter kolanut and 2) drinking herb tea with honey do not cure Ebola • Positive/supportive attitudes toward survivors and persons/families affected by Ebola • Encourage sick persons to seek health care instead of seeking treatment by religious leaders or community based "druggists/nurses" • Seeking medical treatment/health care early
	Family of suspect case/victims	• Non recognition of symptoms • No referral of suspect case • No hygiene around suspect case	• **Recognition of symptoms** • **Referral of suspected cases to health facilities or # 117**

		• Handling of corpse without an assistant of burial teams • Late burial of victims • Organisation of dignified funeral • Panic-led behaviours (hiding the sick person, hiding the dead body, secret burials non-collaboration to the monitoring of persons in contact with the victim, non-collaborating to case tracking, fleeing the area) • Treatment of sick persons at homes • Consulting traditional healers and religious leaders for treatment/cures	• **Adoption of hygienic measures around suspect cases (e.g. disinfect clothing and beddings of suspected Ebola patients with bleach)** • **Handling of corpse with an assistant of burial teams** • **Desiring to handle or be involved in final rites to a corpse** • **No washing of dead bodies** • **Quick referral of burial teams for rapid burial of corpse** • No funeral organised • Avoid crowded places • **Early referral of sick persons and dead bodies**, collaborating the monitoring of the persons in contact with suspicious patients, collaborating with surveillance and case management teams, no fleeing from the area • **Encourage sick persons to seek health care instead of seeking treatment to religious leaders and traditional healers. Quick reporting of sick persons to ascertain illness**
	Health personnel	• Ignorance of how to identify suspect cases • Ignorance of how to handle case • Lack of hygiene practices in handling the case • Fear of handling the case • Abandonment of professional duties • No sanitation of victim's household • Late burial of suspicious/patient's corpse • No case tracking • High discriminatory attitude toward survivors and persons/families affected by Ebola • Poor practice of universal precautions in medical practice • Short-cuts in the application of established protocols	• Capacity to identify suspect cases • Knowledge of means of referrals to surveillance and case management teams (contact numbers) • Adoption of hygiene practices and universal precautions in handling the case and PPE provision if necessary • Adherance to strict application of safety protocols • **Confidence in handling the case** • **Halting of secret private practice activity among nurses and community based "druggists"** • **Conducting proper sanitation of case's household** • **Quick burial of suspicious/patient's corpse with an assistant of burial teams** • Corporation with case management teams • **Positive/supportive attitudes toward survivors and persons/families affected by Ebola**
	Funeral personnel including religious leaders	• Ignorance of unsafe funeral/burial ritual of the dead body • Washing dead body	• **Knowledge of safe funeral/burial ritual of the dead body** • **No washing of an infected dead body** • Basic knowledge of self-protection

		• Unhygienic handling of corpse • Late burial of suspicious corpse • Poor self-protection • Improper environmental consideration-Disposal of protective equipment and washing of ambulances • Unaccepting safe funeral/burial ritual of the dead body • Ignorance and traditional belief systems	• **Knowledge of means of referral to burial teams** • **Quick referral to the burial teams for handling of corpse and Ebola suspicious corpse** • Safe disposal of used protective materials • **Accepting safe funeral/burial ritual** • **Reduction in dissemination of traditional belief systems that undermine positive health practices**
Tertiary	Chiefs Religious leaders Ward committee Traders/Market women Motor and bike riders Teachers Hunting society Traditional healers society	• They are not involved in Ebola-related activities • Chiefs maintain traditional beliefs and practices such as burial rites and hand shaking • Low Knowledge of Ebola • The level of hygiene practice/knowledge is low • Religious leaders maintain traditional beliefs and practices such as burial rites and hand shaking or others that undermine positive health practices • The knowledge about how to handle suspicious cases is low • Late referral of suspected patients and dead bodies • Stigma and discriminatory attitudes toward survivors and persons/families affected by Ebola are high	Chiefs, ward committees and religious/traditional leaders are capacitated to mobilise community initiatives for fight against Ebola to:1) increase comprehensive knowledge; 2) seek EARLY medical/health treatment/care; 3) practice safe funeral/burial; and 4) create supportive environment of survivors and persons/families affected by Ebola Chief and traditional leaders encouraged and ensure the conduct of all burial rites and practices only with authorised personnel Traders/Market women have comprehensive knowledge about Ebola prevention and control and take a hygiene measurement Teachers have comprehensive knowledge about Ebola and capacity on creating supportive environment of pupils who are survivors or persons affected by Ebola Traditional healers have comprehensive knowledge about Ebola, know how to handle suspected cases and refer to medical/health care as soon as possible All of the above mentioned group create an enabling environment through positive attitudes and supports toward survivors and persons/families affected by Ebola

Annex 2: The list of recommended channels and materials for each of the major primary audiences

Audience	Channels	Materials
Primary Audience • Household heads • Suspected Ebola victims • General population • Targeted population	• Radio • One-on-one engagement/ Inter-personal communication by health workers and trained community workers/volunteers • Community-based signs, symbols, songs and messages through designated spokespersons/town criers, society leaders • Television • Mosques/churches • Chiefs/traditional leaders • Public Megaphone Announcement points • Mobile phones • Social media	• Information with prioritized messages • Public announcement • Jingles • Panel discussions • Theme songs • Animations • Print materials (using images, illustrations) • Fact Sheets / Q&As • Flipcharts/Picture cards • Survivors' testimonials • Text Messages (SMS) • Website
Secondary Audience • Local authorities (chiefs, district councils) • Religious leaders (imams and pastors) • Heads of secret societies	• Paramount Chiefs, Section Chiefs and Village Elders • Interreligious Council (IRCSL) and other Faith Based Organisations • Religious Media Houses • Community based organisations	• Briefing kit with key messages and key recommended practices to be incorporated into kutubas and sermons • Print materials (Illustrative posters/leaflets) • Fact Sheets / Q&As • Panel discussions • Audio-Visual information • Survivors' testimonials
Tertiary Audience • Line ministries – MoHS, MIC, Local Govt, Youth Affairs, Internal Affairs, MSWGCA, MOET • NGOs	• District Emergency Operation Center/District Social Mobilisation Committee/Task Force • Constituency networks • Special consultation • Mass Media • NGOs	• Advocacy briefs • Opinion pieces on newspapers • Constituency League Table • TV/radio clips/ads • Website

Annex 3: NATIONAL EBOLA COMMUNICATION STRATEGY OBJECTIVES AND INDICATORS

IMPACT	Impact Indicator 1		Baseline	Dec-14	Assumptions
By December 2014, there is reduced mortality from EVD in Sierra Leone	Average number of people dying from EVD per month	Planned	76	20	>Data on EVD mortality is available and accepted as reflective of the actual situation. >Government and political commitment to the containment of EVD is maintained nationwide. > Continued support from government and partners (Financial and technical) to the country is maintained. > Community involvement and commitment to the containment of EVD is maintained nationwide.
		Achieved			
			Source		
			Emergency Operations Centre (EOC) - Bulletin		
	Impact Indicator 2		Baseline	Dec-14	
	Average monthly number of new cases of EVD	Planned	280	70	
		Achieved			
			Source		
			EOC - Bulletin		
	Impact Indicator 3		Baseline	Dec-14	
	Case fatality rate of EVD	Planned	28%	15%	
		Achieved			
			Source		
			EOC - bulletin		

OBJECITIVES	INDICATOR	SEPTEMBER 2014	DECEMBER 2014
Objective 1	**Indicator 1.1**	Baseline	Target
By end December 2014 80% of population has comprehensive knowledge (accurately rejects at least three misconceptions and identifies three means of prevention) about Ebola.	Percentage of people who know three key means of prevention	79%	90%
	Indicator 1.2	Baseline	Target
	Percentage of people who reject three incorrect means of prevention/treatment of Ebola	50%	90%
Objective 2	**Indicator 2.1**	Baseline	Target
By end December 2014 more than 90% of the	Number of survivors who sought prompt medical care and services within 24 hours of experiencing the signs and symptoms of EVD	N/A	95%

population believe that people who seek prompt medical care and services within 24 hours have greater chances of recovering/surviving from EVD.	**Indicator 2.2**	Baseline	Target
	Percentage of people who agree to seek prompt medical care and services if they/their relatives are suspect to have Ebola	**91%**	**100%**
	Indicator 2.3	Baseline	Target
	Percentage of people who have seen or heard about EVD survivors	**76%**	**100%**
	Indicator 2.4	Baseline	Target
	Percentage of people who believe that people can recover from and survive EVD	**N/A**	**95%**
	Indicator 2.5	Baseline	Target
	Percentage of people who know the importance of the treatment and holding centres of EVD patients	**89%**	**95%**
	Indicator 2.6	Baseline	Target
	Percentage of people who know the contact number for reporting on suspected EVD patients	**53%**	**95%**
Objective 3	**Indicator 3.1**	Baseline	Target
By end December 2014 90% of suspected Ebola deaths are performed according to safe burial practices	Percentage of people who had suspected Ebola deaths in their households who called appropriate authorities for safe burial	N/A	**95%**
	Indicator 3.2	Baseline	Target
	Percentage of people who know safe burial practices of Ebola victims	**N/A**	**95%**
	Indicator 3.3	Baseline	Target
	Percentage of people who accept an alternative safe way of burial practice including not touching or washing of the dead body	N/A	**95%**
Objective 4	**Indicator 4.1**	Baseline	Target
By end of December 2014 less than 60% of population will exhibit any form of discriminatory attitude towards Ebola survivors.	Percentage of people who would buy from a shopkeeper who had contacted Ebola even after treatment and recovery	**33%**	**80%**
	Indicator 4.2	Baseline	Target
	Percentage of people who believe that a school pupil who has recovered from Ebola does not put other pupils in their class at risk of Ebola infection	**68%**	**80%**
	Indicator 4.3	Baseline	Target
	Percentage of people who would welcome someone back into their community/neighborhood after they had recovered from Ebola	**24%**	**60%**