



TRAINING

PACKAGE FOR EBOLA PRE-DEPLOYMENT

PARTICIPANT HANDBOOK



World Health
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GO TRAINING

PACKAGE FOR EBOLA PRE-DEPLOYMENT

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Introduction

The governments and peoples of Guinea, Liberia and Sierra Leone are working together with the international community to stop an outbreak of Ebola virus disease (EVD) of unprecedented magnitude in West Africa.

The outbreak has highlighted major existing challenges in health systems in all three countries. It has underscored the fact that in the 21st century, with highly mobile populations connected by common social, economic and trade links, a threat to the health of people in one part of the world can quickly become a threat for everyone everywhere. The unprecedented nature of the outbreak has been matched by an unprecedented response by governments and international organizations across the world.

WHO plays a central role in the Ebola response. The Organization is the UN's specialized agency for public health and the Secretariat for the International Health Regulations (2005) which is the international law that determines international cooperation in the event of a public health emergency of international concern. In late 2014, The Director-General of WHO discussed with the UN Secretary General to create a coordinated UN-wide response to Ebola following which the UN Mission for Ebola Emergency Response (UNMEER) was established.

The Ebola outbreak is highly complex. It requires the continuous effort by hundreds of different kinds of organizations and tens of thousands of frontline workers and volunteers to it quickly, effectively and efficiently respond to the outbreak. Countries large and small have stepped up to provide doctors, mobile clinics, outbreak control experts and funding. These efforts show the immense value of international cooperation. The strategy is making progress and we are starting to see a slowdown in the number of new cases.

The massive number of personnel deployed in the response are faced with many risks. For most deployees the Ebola outbreak in West Africa poses a new experience. This is why a pre-deployment training - tailored specially to the Ebola outbreak in West Africa - has been offered to WHO personnel, consultants, and key partners. The material covered in modules 1-4 is applicable and useful to frontline response workers, national and international. Only Module 5, which focuses on operational aspects - the code of conduct for international civil servants and human resources arrangements for WHO deployees, are specifically geared to all internationally recruited personnel and to WHO deployees respectively.

Acknowledgements

This is the first time a “just-in-time” training has been developed quickly during an emergency response and made available for personnel being deployed to the response. The GO Training package was developed under the leadership of Dr Sylvie Briand, Director of Pandemic and Epidemic Diseases Department (HSE/PED) at WHO. She led the technical teams involved in the response and oversaw the Ebola training team.

Dr Gaya Gamhewage, Ebola Training Coordinator for WHO, led the project; the development and review of the package; and the transformation of the GO Training into video lectures. The GO Training team comprised of experts and WHO staff who were part of the Ebola training team who made significant contributions in the design, material development, testing, review and packaging of the training course. They include:

Aphaluck Bhatiasevi, WHO; Gaya Gamhewage, WHO ; Emma Kettle, Red R; Suvi Peltoniemi, WHO; Heini Utunen, WHO; Ursula Zhao, WHO; Elizabeth Kane, WHO intern.

The following WHO staff provided invaluable inputs into and reviewed the material in Module 4:

Case management: Edward Kelley, Elizabeth Mathai, Nahoko Shindo, Sergey Eremin, Rosa Constanza Vallenias Bejar De Villar, Paola Montes.

Contact tracing and active case finding: Eric Bertherat, Mikiko Senga.

Safe and dignified burials: Pierre Formenty

Community engagement and social mobilization: Gaya Gamhewage, Yolanda Bayugo, Aphaluck Bhatiasevi, Cristiana Salvi.

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MODULE 1

Course Introduction



MODULE 1: INTRODUCTION TO THE GO PRE-DEPLOYMENT TRAINING

What is this module about?

This module introduces you to the GO training package and sets the overall learning framework to guide you through the course.

What will you learn?

By the end of this module, you will be able to:

1. List the objectives of the GO pre-deployment training,
2. Describe WHO's role in the Global Ebola Response, including the 4 pillars of the international response, and
3. Be able to access key sources of information required for personnel deployed under a public health emergency response.

The GO Training

Personnel being deployed for Ebola response are required to complete two trainings before deployment.

1. WHO's e-PROTECT training is aimed at keeping deployees safe during deployment and minimizing the risk to themselves and to others around them. This online e-learning tool takes about two and a half hours to complete and has life saving information and advice for you to use during your deployment to Ebola-affected countries. It is a basic occupational health and safety training for working in the Ebola response. It is a prerequisite for all WHO staff and consultants deployed for the Ebola response to take the online tool before their deployment to the affected countries.
2. WHO's GO Training. This training is a modular, pre-deployment training. It provides essential knowledge, information and skills for WHO staff and consultants who are deployed for the Ebola response. The objective of this training is to ensure that all personnel stay safe and understand the rationale and components of the international response so that they can contribute safely and effectively to controlling Ebola outbreak.

> The Course Outline for the GO Training includes:

Module 1: Introduction to the course

Module 2: Introduction to Ebola

- 2.1 Facts about Ebola virus disease
- 2.2 Staying safe and healthy during the mission

Module 3: Global Ebola Response

Module 4: Pillars of the Global Ebola Response

- a. Case management
- b. Case finding and contact tracing
- c. Safe and dignified burial
- d. Social mobilization and community engagement

Module 5: Working for WHO

- a. Introduction to WHO
- b. Recruitment arrangements
- c. Code of conduct
- d. Guidance for communications and media interventions
- e. Country contexts
Guinea, Liberia, Sierra Leone

The course materials in this package include the core learning materials presented as text in this pack, power point presentations, supplementary reading materials, web links to key documents and the relevant contact details at the country level. Video lectures of all five modules and most sub-modules are available on-line or as electronic files.

This module is accompanied by PowerPoint presentation 1.1.

> Information sources

The Ebola portal on WHO's web site has information, resources and tools that all deployees will find useful. <http://apps.who.int/ebola/en/our-work/training>

The training pages of this site will host the GO package, and have direct links to other trainings such as the ePROTECT training. For Ebola updates, situation reports and data by country visit: <http://apps.who.int/ebola/>

Anyone being deployed to the field for Ebola response or prevention can request access to a SharePoint site where training materials being used by WHO and partners can be found for pre-service and in-service training clinical management of Ebola patients, contact tracing and active case finding, social community engagement and safe and dignified burials. While not all of these materials have been through the usual rigorous process of clearance, partners on the ground are using them. WHO does not endorse non-WHO materials on the SharePoint. These can be used by WHO deployees for reference and information, in consultation with technical leads on the ground. Here WHO technical materials produced since the beginning of the Ebola outbreak include:



Since March 2014, WHO has produced over 45 guidance documents to support the Ebola response

Based on **evidence** and expert review

Covering all aspects of outbreak response

Responsive to **needs** from the field

Strengthening **national capacities** to prepare and respond

Activity 1

Before we conclude this segment, take some time to reflect on the following and complete the sections below. This is important and gets you in the right frame of mind for completing this course, and for preparing yourself for deployment in general.

I. List three motivations you have for taking part in the Ebola response

- 1
- 2
- 3

II: List three questions you want answered or addressed through this training

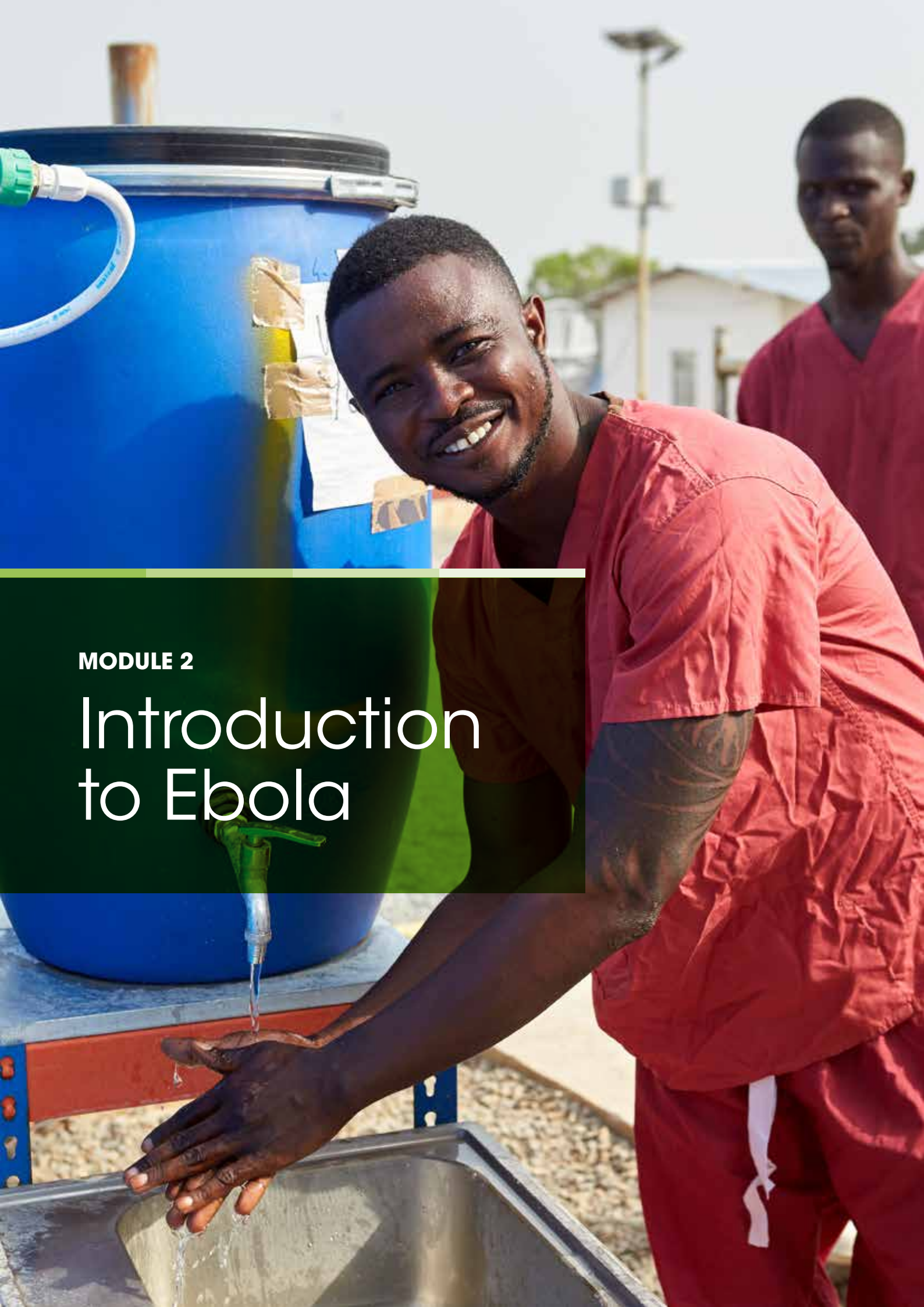
- 1
- 2
- 3

Activity 2

List three concerns you have about your readiness to deploy to the field for the Ebola response and ways in which you are going to address them

My concern	What I will do to address this concern
1.	
2.	
3.	





MODULE 2

Introduction to Ebola

MODULE 2.1: INTRODUCTION TO EBOLA VIRUS DISEASE IN WEST AFRICA

What is this module about?

This module introduces you to the Ebola virus disease (EVD) and the Ebola outbreak in West Africa.

What will you learn?

By the end of this module, you will be able to:

1. Recall basic facts on the Ebola virus disease
2. Explain how the Ebola outbreak in West Africa is different from other outbreaks in the past and,
3. Describe measures to prevent the transmission of Ebola.

Activity 1

Write down the answers to these two questions:

1. What do you already know about Ebola virus disease?

.....

.....

.....

2. What would you like to learn about Ebola from this training?

.....

.....

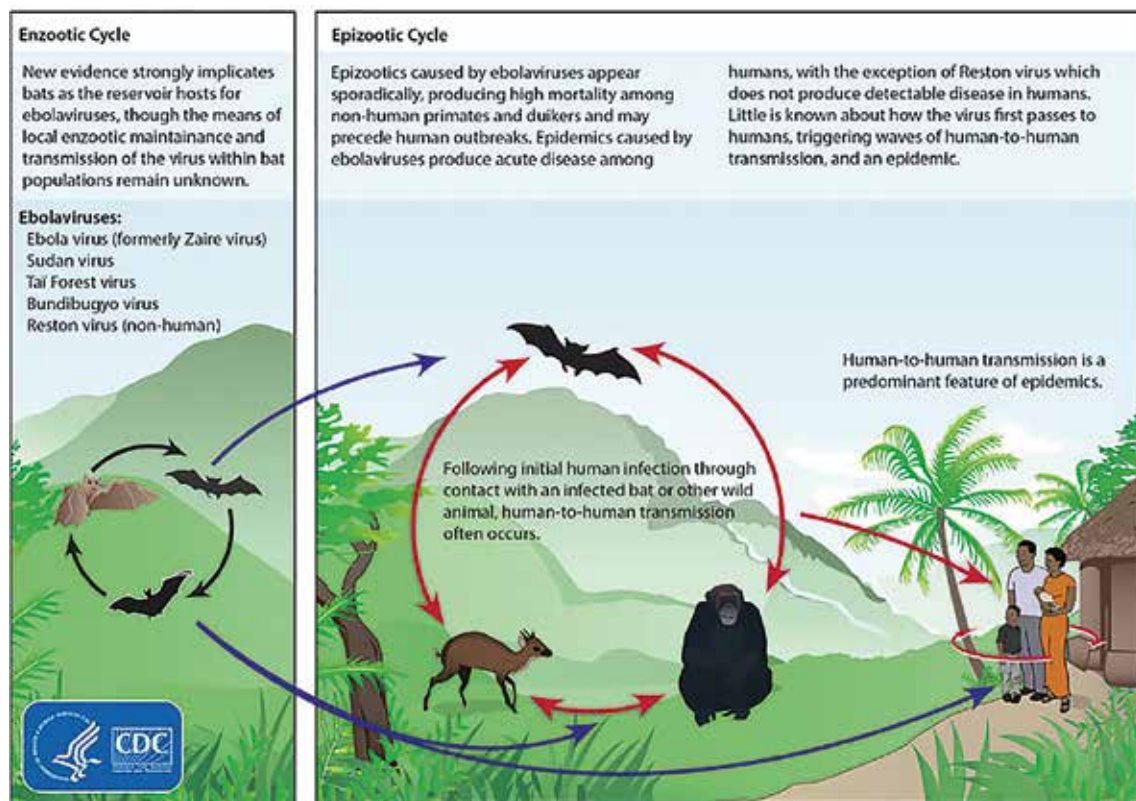
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Ebola Virus Disease in West Africa

The Ebola virus disease (EVD) originated in animals, in fruit bats. The name Ebola comes from the Ebola River, which was the region where this disease was first discovered in the 1970's.

It is believed that fruit bats are natural hosts of the Ebola virus. Ebola is introduced to humans through close contact with the blood, secretions and organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats and monkeys. Ebola then spreads from one person to another through direct person-to-person contact with broken skin or bodily fluids of an infected person, or materials contaminated with the virus.

In the beginning of this Ebola outbreak, people were more concerned about the transmission of the virus through consumption and handling of bush meat. The virus was however predominantly spreading from one person to another, or through human-to-human transmission. What we are seeing in West Africa is the transmission of the Ebola virus from one human being to another.



In the past, Ebola outbreaks occurred in remote villages. The outbreaks usually caused high deaths among those infected. These outbreaks were contained through the usual 'classic' outbreak response measures. In the West Africa outbreak, which is believed to have originated in Guinea in an area close to the borders of Liberia and Sierra Leone, the situation was very different. People frequently moved around from village to village, and from country to country. They had family across the borders and the disease took hold. With travel between the countries, and in and out of larger settlements and cities, Ebola spread fast and far in West Africa.

> How Ebola is spread

Ebola is spread through

1. Direct contact with bodily fluids of someone who is infected with and has symptoms of Ebola, or
2. Direct contact with bodily fluids of someone who is infected with and has died from Ebola, or
3. Direct contact with Ebola contaminated objects or the environment like bed, bed linen, surfaces, etc.

What are bodily fluids? Bodily fluids are stools or faeces, vomit, blood, urine, saliva, semen or breast milk. The body fluids of a person sick with Ebola or has died from Ebola contain the virus and are sources of infection.

Ebola is not airborne. If someone who is sick with Ebola vomits or coughs, it can be a source of infection.

A person can become infected with Ebola only if the person comes into contact with the bodily fluids of an infected person. These include fluids from:

- the eyes
- the nose
- the mouth
- sexual organs
- wounds in the skin
- cuts on your hands or when using instruments that have been used by an infected person.

The virus cannot pass through the skin if there is no wound.

Facts: Ebola is spread through direct contact with bodily fluids of a person who is sick or has died of Ebola. Ebola can also spread through direct contact with the environment that has been contaminated by somebody sick with Ebola. Ebola is NOT airborne.

> Ebola in concepts and numbers

Incubation period

The incubation period - the time from when the virus enters our bodies to the time when symptoms show - is between 2 and 21 days. Therefore, if someone thinks they have come into contact with Ebola, they will have to be observed for 21 days. If they show no symptoms, you can be confident they do not have Ebola.

Case fatality ratio

The case fatality ratio is the number of people who have been infected by a particular disease, Ebola in this context, and the number of people who actually die from it. In the past the case fatality ratio for Ebola was between 25% - 90% - It means that the number of patients who died of Ebola ranged from one out of four people infected or nine out of 10 people infected with the virus. It is important to know that in this outbreak, because of the national and international response and the support that has been given to people who are sick, the case fatality ratio has actually been lowered. It is between 50% and 60%. The sooner people with Ebola get supportive treatment, the higher are their chances of survival, and hence lower the case fatality ratio.

Diagnosis

The only way to diagnose Ebola is through a diagnostic test. Specimens - body tissue used in the laboratory diagnosis of Ebola - that we take from someone who is sick from Ebola to confirm whether they have Ebola or not, have to be handled very carefully. Ebola is transmitted through bodily fluids so it is bodily fluids like blood that is taken to confirm the Ebola infection. The specimens need to be handled very carefully.

Swab samples can be taken from dead bodies to confirm Ebola infection.

Treatment versus cure

Currently there is no cure for Ebola. But we know that when we provide supportive treatment early in the course of the disease, we can improve the chances of patients' survival. More and more patients have recovered from Ebola. The supportive treatment usually involves restoring fluids and electrolytes (orally or through intravenous routes) and treating any complications or already existing diseases and conditions. WHO's guidelines on management of patients with viral haemorrhagic fevers (of which Ebola is one such disease) has been used extensively throughout West Africa to treat and save lives of tens of thousands of people who have had Ebola.



When someone with Ebola recovers, they are no longer contagious through most bodily fluids. However, there are studies that show that men who have recovered from Ebola can continue to spread the virus to their partners through their semen for up to 12 weeks after recovery. This is a point of caution and recovered Ebola patients, their sexual partners have to be counselled about this important fact to prevent further spread of the disease during these this period.

> Signs and symptoms of Ebola

Ebola virus disease is a viral haemorrhagic fever. Ebola usually presents with fever accompanied by weakness, muscle pain and severe headache and sometimes sore throat. This is usually followed or accompanied by vomiting, diarrhoea, and sometimes rash. In some cases, there will be internal and external bleeding.

Patients become contagious only once they show symptoms and Ebola infections can only be confirmed through laboratory diagnosis. Other diseases can have similar symptoms - malaria, typhoid, shigella, cholera, leptospirosis, relapsing fever, meningitis, and other haemorrhagic fevers. Laboratory diagnosis is the only way to confirm a diagnosis of Ebola.

> Managing Ebola patients

What happens when someone has Ebola? It is very important to be honest from the outset that there is currently no cure for Ebola just as there are no cures for many viral diseases. But we know the sooner someone with Ebola comes for treatment, the greater are their chances of survival. This is why WHO, foreign medical teams and other organisations have set up Ebola Treatment Units and Community Care Centres to provide supportive treatment, particularly rehydration, which significantly increases the chances of survival of patients.

Several treatments such as monoclonal antibody treatment are under development. But currently there is limited availability, and information on their safety and effectiveness is limited. Vaccines Currently, prevention and supportive care are the main mechanisms of our response.

Activity 2

In the space below, answer the questions

1. How does Ebola spread from person to person Give 3 examples?
2. What is the incubation period for Ebola?
3. What percentage of people survive Ebola if they receive early care?
4. Why is it important to safely handle laboratory specimens from suspected or confirmed Ebola patients?
5. What kinds of treatment are given to people who have Ebola?

> Ebola in West Africa

The Ebola outbreak in West Africa originated in Guinea, close to the borders with Liberia and Sierra Leone. Parts of the villages affected were in one country and the rest of the village was in other countries. The people living in the border villages of the three countries were related or came from the same families. We must not forget the affect fear and denial had on the people, which impacted the effectiveness of the Ebola response.

Ebola spread quickly in the three countries, claiming lives, devastating families and communities, causing socio-economic and political upheaval. It soon became a regional issue and triggered an unprecedented international response.

In a region with limited numbers of doctors, nurses and health care workers, Ebola claimed many frontline health workers. It highlighted the weakness of the health systems in the three countries and the urgent need to strengthen infection prevention and control measures.

> Ebola can be prevented.

The good news is we can prevent the transmission of Ebola with common household items that can be found at home. Soap and water kills the virus. If we practice how to wash our hands properly with soap and water, we can protect ourselves. If the environment is contaminated, we know how to disinfect the area. We know that with alcohol-based products and many commonly used disinfectants like bleach, we can kill the virus.

Ebola does not spread easily in the environment. Is not air borne. The risk of infection is very small if you don't have direct contact with a sick Ebola patient. If you are being deployed for clinical care of sick people, you will be given additional training on how to protect yourself, including the putting on and taking off full personal protection equipment. If you are being deployed for clinical management and have to take care of Ebola patients or you are assigned to work with a burial team, you will receive specialised training on the ground. Also remember that people who have Ebola can only pass the virus from one person to another when the symptoms appear.



Activity 3

Circle either True or False for each of the following statements

1. Fever, headache, body aches, vomiting and diarrhoea are symptoms of Ebola virus disease (True/False)
2. All patients with Ebola have internal or external bleeding or haemorrhage. (True/False)
3. The only way to diagnose someone as having Ebola is through a laboratory test. (True/False)
4. There is currently no treatment for Ebola. (True/False).
5. Ebola is part of a group of diseases called viral haemorrhagic fevers. (True/False)
6. Rehydration, intensive care, and treating existing illnesses are the ways in which patients are treated. (True/False)
7. The Ebola virus can be killed with soap and water, alcohol base products, and bleach. (True/False)
8. You should wear full head-to-toe personal protective equipment (PPE) whenever you have contact with people in West Africa. (True/False)

MODULE 2.2: STAYING SAFE

What is this module about?

The objective of this session is for everyone deployed for the Ebola response to stay safe while being deployed to the affected countries. Any sickness will have an impact on you, all your colleagues, your family and on the whole mission. This module provides essential information you need to stay safe and healthy during your mission.

What will you learn?

By the end of this module, you will be able to:

1. Describe ways to stay healthy while contributing to the Ebola outbreak control
2. Identify ways in managing stress during Ebola mission
3. Recall what to do when someone gets sick/ or exposed to Ebola or other diseases



> Medical clearance before departure

Before you start your mission, it is very important to ensure that you are healthy. WHO staff members based in WHO Headquarters must take an appointment with Staff Health and Wellbeing services by calling 13040 to receive medical advice, vaccinations, the medical kits to take on mission and be medically cleared.

Consultants must submit a WHO 223 form to obtain their medical clearance before departure as well as the proof of their vaccinations being up to date.

Personnel who are pregnant are not allowed to be deployed for the response.

> Vaccinations for West Africa

Personnel deployed to affected areas should be up to date with the following vaccines:

- Yellow fever (mandatory)
- Diphtheria-Tetanus (ideally within 5 years)-polio +/- pertussis
- Typhoid vaccine
- Hepatitis A and B
- Meningitis ACYW 135 (mandatory if outbreak ongoing)
- Measles vaccines for those born after 1963 who did not have the disease or 2 doses
- Rabies vaccine is recommended
- Cholera vaccine: only recommended in limited situations and based on risk assessment

> Vector-borne diseases

Vector-borne diseases are common in West Africa. Guinea, Sierra Leone and Liberia are endemic countries for malaria. Chemoprophylaxis and personal protection against mosquito bites during the day and night are important in preventing vector-borne diseases.

Therefore, it is mandatory for staff members deployed to affected areas to:

- take malaria chemoprophylaxis before during and after the exposure,
- wear clothes that cover the body including arms and legs,
- use insect repellent day and night,
- sleep under insecticide- impregnated bednet,
- know malaria symptoms (fever plus flu-like symptoms , diarrhoea),
- consult a doctor within 24h from an onset of fever,
- carry standby treatment for malaria.

> Water-borne diseases:

It is important to apply general protective measures such as:

- Only drink safe water : Water purification tablets, chloramine (“Aquatabs”) should be used to make drinking water for yourself if the access to potable water is not guaranteed. This will protect you from most water-borne diseases including cholera. Please note that if the water is turbid/dirty, you’ll need to filter it first!
- Frequent hand washing with soap and water (to prevent any kind of communicable disease) especially before food preparation and eating, before and after toilet use and after touching surfaces or items likely to be dirty (e.g. cash, door handles)

- Ensure safe food preparation techniques to prevent diarrhoea: boil it, peel it or leave it; eat cooked food while still hot, cover the food. More information on “guide on safe food for travellers” <http://www.who.int/foodsafety/publications/consumer/travellers/en/>
- For diarrhoea: only oral dehydration salts made with safe boiled and chlorinated water should be consumed.

> Stress management

When working in emergency operation responses, employees can experience strong emotions. You will be in a strange environment, under pressure having to make rapid decisions and actions. You will be surrounded by the seriousness of the Ebola outbreak which is dangerous leading to the loss of lives and severe disease. You may experience mental and physical fatigue, and may even be exposed to actual life-threatening situations.

Key measures that staff can put in place to keep healthy and prevent stress:

- observe adequate rest and breaks during the working day;
- maintain healthy habits (exercise, relaxation, nutrition, enough sleep, etc.);
- attend group debriefing and share coping skills;
- make sure there is clear communication and information flow within the team;
- put in place buddy systems to look out for signs of exhaustion in colleagues;
- follow routine health and safety practices and participate in stress reduction activities, including regulating work schedules, taking breaks, taking time off and engaging in personal stress reduction activities;
- recognise and understand one’s individual signs of stress;
- manage one’s own stress, analyse one’s coping skills and ways of improving them;
- accept, express and share emotions, fears, difficulties, satisfaction (in a secure place);
- participate in training and briefing sessions to ensure that fear, stress, etc. are not affecting the learning and concentration capacity of the teams (i.e. briefings on isolation methods, infection control measures, transmission, etc.);
- set goals to provide a sense of control that could include keeping up with paper work even if staff are not able to work in the field, writing a diary, learning a new skill, knit a scarf, keeping fit, etc; keep the mind active by reading, writing, playing games, etc;
- look for, or inject humour into their situation, which can mitigate stress or hopelessness;
- believe in something strongly meaningful to them (e.g., in family, a god, or other);
- actively and regularly apply stress management techniques;
- make friends and build support systems;
- stay sensitive towards others, as families of local staff may be affected by the outbreak.

Signs of stress may be physiological, emotional, cognitive or behavioural. This is a list of most common signs that might help you recognize that you are experiencing a stress condition:

PHYSIOLOGICAL reactions to stress: increasing heart rate, increasing blood pressure, increasing muscle tension, sweating, increased adrenaline production and secretion, and superficial breathing at higher frequencies.

EMOTIONAL reactions to stress: fear, irritation, depressive mood, anxiety, anger, and diminished motivation.

COGNITIVE reactions to stress: decreased attention, narrowing of perception, forgetfulness, less effective thinking, less problem solving, and reduced learning ability.

BEHAVIOURAL reactions to stress: decreasing productivity, increasing smoking, increasing drug use and/or alcohol consumption, making errors, and reporting sick.

Professional help by staff counsellor or psychologist is available to all staff members and consultants before, during and after being deployed to the affected zones either in Geneva or with regional medical offices.

> Medical kit and toilet items

A medical kit should be carried with sufficient medical supplies to meet foreseeable needs for the duration of the trip. This kit will include basic medicines to treat common ailments including a thermometer, first aid articles and any other specific medical items such as syringes and needles to minimize exposure to bloodborne viruses.

Toilet items should also be carried in sufficient quantity (dental care, eye care, skin care and personal hygiene). During the mission be vigilant to stay in good health.

> Staying safe from Ebola

In the absence of effective treatment and a human vaccine, raising awareness of the risk factors of Ebola infection and the protective measures individuals can take is the only way to reduce human infection and death. Therefore, close physical contact with Ebola patients should be avoided unless you are competent in the adequate implementation of infection prevention and control precautions.

All personnel are required to apply basic hygiene measures (hand hygiene and respiratory hygiene) in all circumstances and to apply Standard Precautions whenever within a health care setting. In addition, deployees who provide direct medical care to suspected, probable or confirmed cases should be well trained on how to put on and take off Personal Protective Equipment (PPE). This includes the adequate use of protective clothing, including medical masks, gloves, long-sleeves, gowns, facial protection (goggles or a face mask), hand hygiene and disinfection measures.

Refer to the document: "Interim Infection Prevention and Control Guidance for Care of Patients with Suspected or Confirmed Filovirus Haemorrhagic Fever in Health Care Settings With Focus on Ebola August 2014".

> Daily life in Ebola affected countries

- Do not touch dirty surfaces (contaminated with fluids of unknown source)
- Regularly wash hands
- Do not hand-shake or hug
- Keep your distance (>1 m) if you think someone has symptoms of Ebola
- Practice respiratory etiquette
- No kissing or sex

Hand hygiene is paramount

- Before, during and after preparing food
- Before eating
- After using the toilet
- After touching garbage
- After touching frequently touched surfaces
- After touching an animal, animal feed or animal waste
- After blowing your nose, coughing (into your hands)

1. Avoid touching your face (eyes, nose, mouth)

2. No nail biting

3. Cover small cuts and wounds

You will notice that bleach or chlorine solutions are used widely in Ebola-affected countries to prevent transmission.

- 0.5% bleach (chlorine) solution is used for disinfecting but not on the skin
- 0.05% bleach (chlorine) solution is used for decontaminating hands



How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

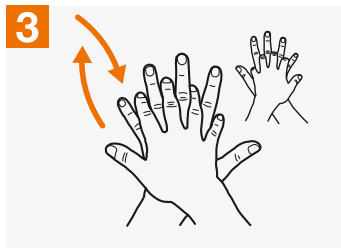
🕒 Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



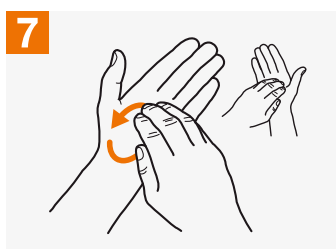
Palm to palm with fingers interlaced;



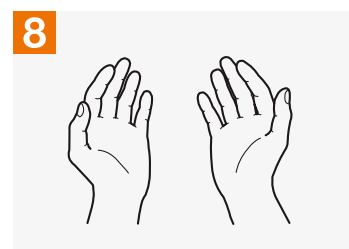
Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.



**World Health
Organization**

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES

Clean Your Hands

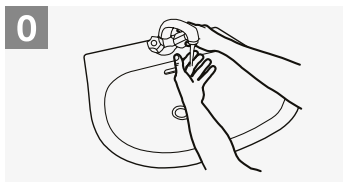
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May 2009

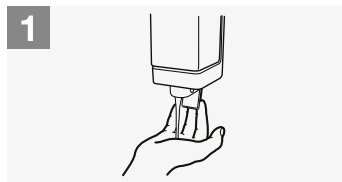
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

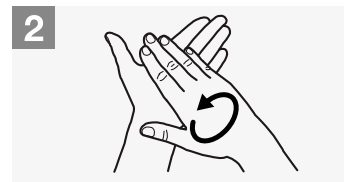
 Duration of the entire procedure: 40-60 seconds



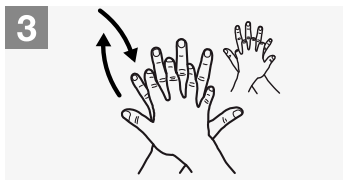
0 Wet hands with water;



1 Apply enough soap to cover all hand surfaces;



2 Rub hands palm to palm;



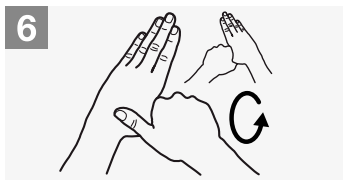
3 Right palm over left dorsum with interlaced fingers and vice versa;



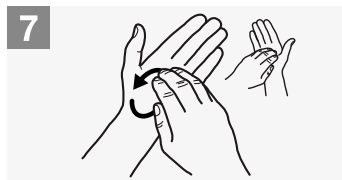
4 Palm to palm with fingers interlaced;



5 Backs of fingers to opposing palms with fingers interlocked;



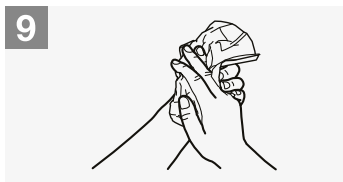
6 Rotational rubbing of left thumb clasped in right palm and vice versa;



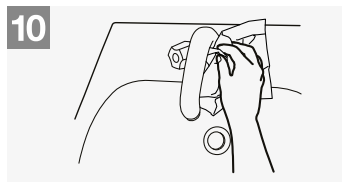
7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



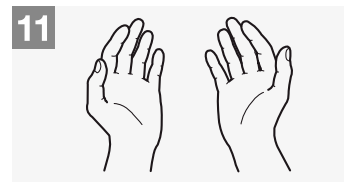
8 Rinse hands with water;



9 Dry hands thoroughly with a single use towel;



10 Use towel to turn off faucet;



11 Your hands are now safe.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES













Clean Your Hands

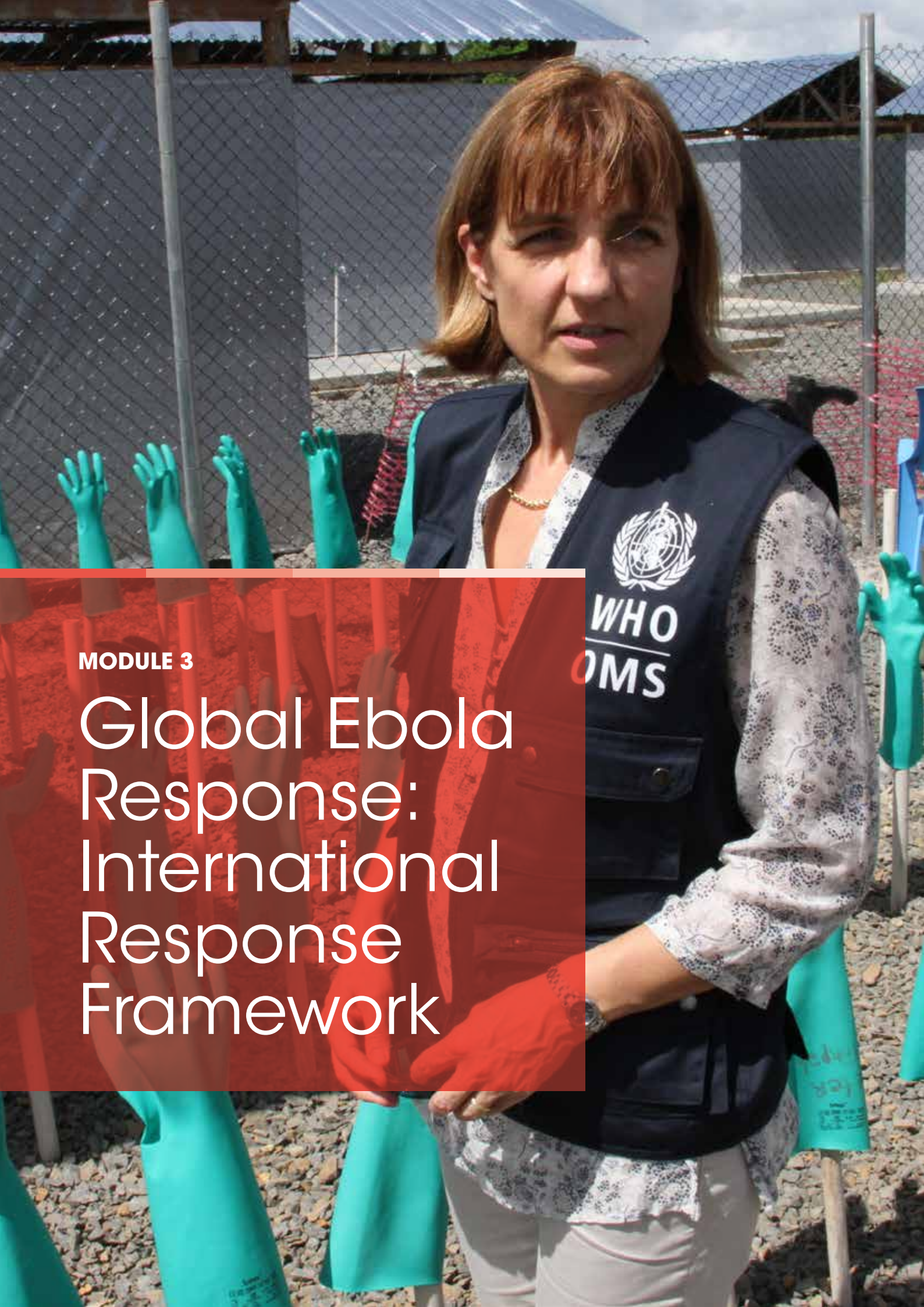
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May 2009

Activity 1

Katie has been deployed to an Ebola affected country. Look at steps 1-14 of events this morning. Indicate when and how she should practice hygiene in any of the steps that pose a risk to her or others' health.

	1	Katie enters the building, saying good morning to people in reception as she walks past
	2	She opens the door and climbs the stairs
	3	She opens the next door and walks towards her desk saying hi to her colleagues
	4	She puts her bag down and sits down to read some papers, eating her breakfast bar
	5	She is called by a colleague at the next table who says they are not feeling well
	6	Katie stands up and walks towards her colleague who looks very pale and is perspiring slightly
	7	She puts her hand on her shoulder and says that the colleague should report to the doctor
	8	Katie walks with her colleague out of the office to the corridor to wait for the doctor to arrive – they sit on the communal seating
	9	Katie's colleague then says she feels sick and stands to go to the toilet but vomits there in the corridor
	10	Katie tells her colleague to go to the toilet. She collects some towels to cover the spill, calls the cleaning team, tells the doctor to go to the toilet
	11	Katie covers the vomit with paper towels
	12	Katie returns to her desk and prints a note to tell people not to use the toilet temporarily
	13	She places the note on the toilet door
	14	She returns to her desk to work



MODULE 3

Global Ebola Response: International Response Framework

MODULE 3: THE GLOBAL EBOLA RESPONSE

What is this module about?

The outbreak of Ebola in West Africa is unprecedented and requires the international community to come together like never before. This module covers the evolution of the international response to Ebola in West Africa and looks in detail into the four pillars of the response.

What will you learn?

By the end of this module, you will be able to:

1. Describe the mandate of UNMEER in Ebola response (UN Mission for Ebola Emergency Response)
2. State the four pillars of global Ebola response



> The International response to Ebola

The Ebola outbreak is highly complex. The response requires the continuous effort by hundreds of different kinds of organizations and tens of thousands of people to implement measures quickly, effectively and efficiently. Countries large and small have stepped up to provide doctors and nurses, mobile clinics, and funding for the Ebola response in West Africa. These efforts show the immense value of international cooperation. The strategy is effective and we are seeing a decline in the number of new cases.

In the response to the Ebola virus disease in West Africa, the current roles and responsibilities are

- National governments lead the Ebola response and fully implement the relevant temporary recommendations issued under the International Health Regulations (IHR 2005)
- WHO provides technical leadership and operational support to governments and partners for Ebola control efforts
- UNMEER complements the work of governments and partners and serves as an umbrella structure for UN actors for streamlined response, effective ground-level leadership and operational direction

Milestones

2-3 July 2014: Emergency Ministerial Meeting in Accra, Ghana operations coordination centre in Conakry, Guinea

31 July 2014: Launch of Ebola Outbreak Response Plan, Main pillars of activities; initial resource estimates

8 Aug 2014: The Director-General of WHO declares Public Health Emergency of International Concern and issues a temporary recommendations under the International Health Regulations

19 Sept 2014: Establishment of UNMEER Global coordination and strategic guidance

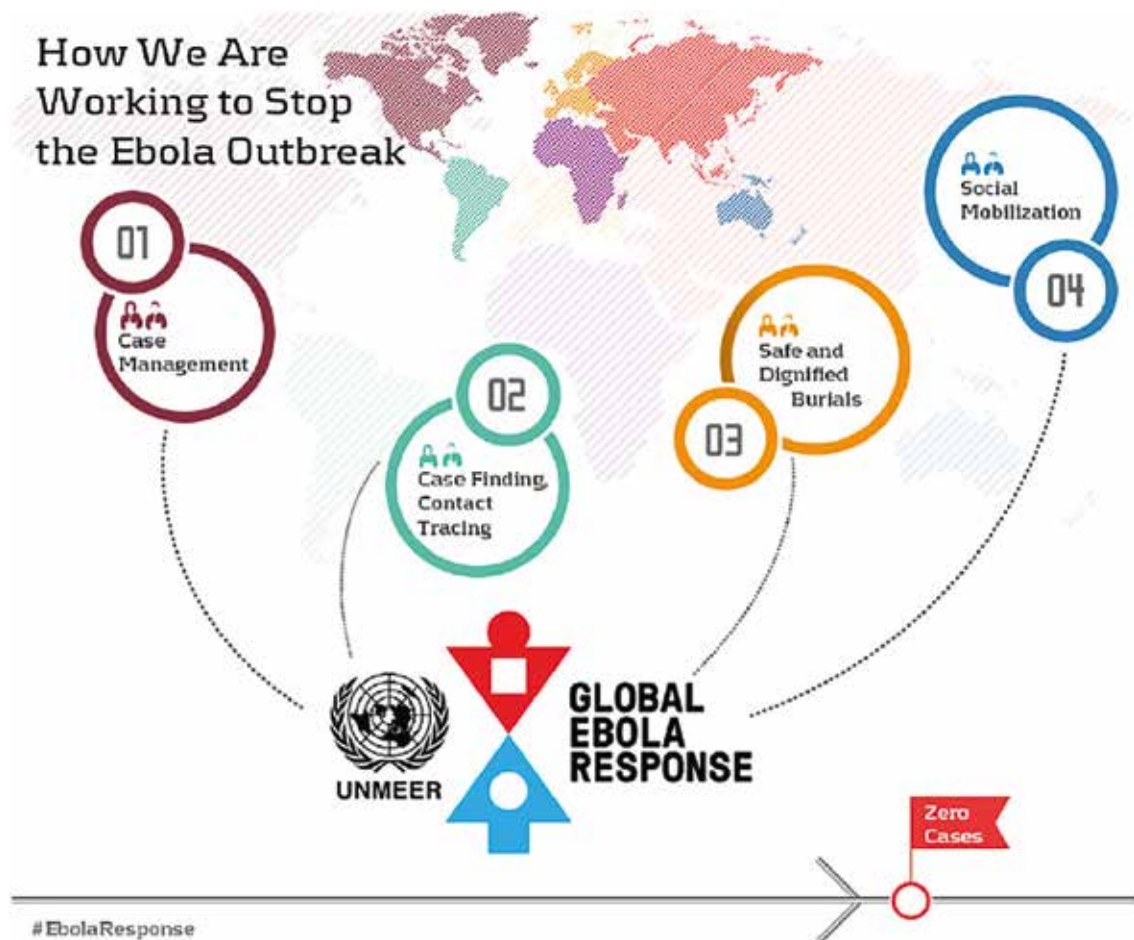
The goal of the Ebola Response Roadmap is “Stop Ebola transmission globally, while addressing the broader socioeconomic impact in intense transmission areas & rapidly managing consequences of international spread.”

	Objectives	Key milestones
1	Full geographic coverage with complementary Ebola response activities in countries with widespread & intense transmission	Reverse trend in new cases & areas within 2 months; stop all Ebola within 6-9 months
2	Emergency application of comprehensive Ebola response in countries with initial case(s) or localized transmission	Stop all transmission within 6-8 weeks of index case
3	Preparedness of all countries, esp. those sharing land borders with intense transmission areas and with international transportation hubs	Surveillance, preparedness, in all bordering areas & int’/ transport hubs in 1 months

UNMEER is the UN Mission for Ebola Emergency Response . It is the first-ever UN mission for a public health emergency established to address the unprecedented Ebola outbreak. The Ebola response has a five point strategy:

1. Stop the outbreak
2. Treat the infected
3. Ensure essential services
4. Preserve stability
5. Prevent further outbreaks

It has four response pillars:



Within the Global Ebola Response Framework, 4 pillars have been highlighted as priority to get to 'zero' cases. These include:

RESPONSE PILLAR 1

Case Management

RESPONSE PILLAR 2

Case Finding and Contact Tracing

RESPONSE PILLAR 3

Safe and Dignified Burial

RESPONSE PILLAR 4

Social Mobilization and Community Engagement

Five key enablers were also identified

- Logistics
- Staffing and human resources
- Training
- Information management
- Cash payments and coordination

WHO was identified as the lead agency in the joint international response coordinated by UNMEER for response pillars 1 and 2 (Case management and Case finding and contact tracing) and for the enabling function of Training.

Communities at the heart of the response

The outbreak in West Africa will end when we get to zero cases. To achieve this goal, communities must be at the heart of the response. If people with Ebola are to come forward and transmission is to be interrupted, communities must be fully involved in, the outbreak response.

Special Envoy and the global coalition

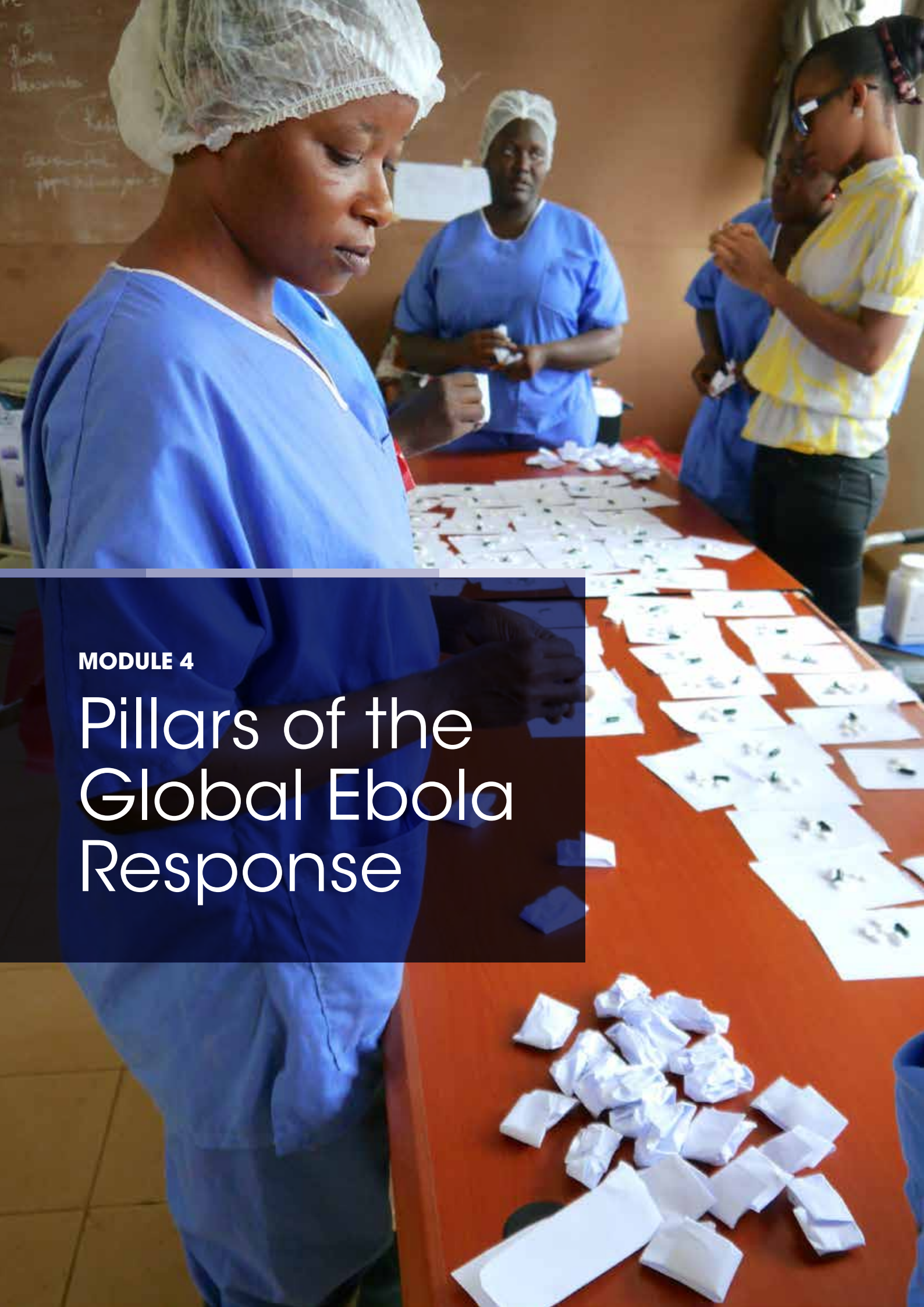
The UN Secretary-General appointed a Special Envoy on Ebola and established the Global Ebola Response Coalition - a committed group of organizations to collectively provide strategic coordination and play a concerted role in the Ebola response.

UN Mission

As part of the response the international community established the first ever emergency health mission the UN Mission for Ebola Emergency Response.

WHO's contribution to the Ebola Response

WHO has been working in Ebola-affected countries to help UNMEER achieve the goals set out in the Ebola response.



MODULE 4

Pillars of the Global Ebola Response

MODULE 4.1: CASE MANAGEMENT

What is this module about?

This module introduces you to “case management” which is a core response pillar of the Ebola response. It deals with caring for patients with Ebola virus disease safely and effectively so that patients receive the best care possible, while minimizing the risk of transmission of the disease to health care workers, caregivers and others around them.

What will you learn?

By the end of this module, you will be able to:

1. Describe in simple terms what case management is,
2. State how case management contributes to stopping Ebola, and
3. Identify how your work relates with the case management work.



> What is case management and why is it a priority?

Case management is one of the 4 critical areas of work – response pillars - which aim to stop this outbreak by progressing towards “zero cases.”

The work in case management includes having the capacity to care for patients with Ebola, having the capacity to isolate them and to have sufficient infection prevention and control mechanisms in place so as to protect health workers and others who are responsible for taking care of them.

Case management is a priority because every person infected with Ebola has the right to safe and comfortable care, in order to improve their chances of survival. It is worth emphasising that early treatment increases chances of survival amongst Ebola patients. The earlier they are provided with safe care, the better are their chances for survival and comfort.

By separating or isolating patients with Ebola we can also reduce the spread of the disease, both in the communities and in health care settings. Admitting patients in designated Ebola treatment facilities like Ebola Treatment Units (ETU) or other designated facilities such as Community Care Centres (CCCs), helps to prevent the spread of Ebola to the family and community members. In other words, it helps break the chain of transmission.

Principles of Case Management

A key principal of case management is to provide safe and effective care.

Safe and effective care

Different categories of staff require different levels of personal protection, when caring for someone sick with Ebola. WHO provides guidance on what types of protective equipment should be worn and other infection prevention control measures in what instances. Health care workers working in areas where treatment is provided to Ebola patients need to strictly follow infection prevention and control (IPC) procedures.

Health care workers need to provide patients with effective care, based on the treatment guidelines for patients with Ebola. They need to take into consideration the fact that specific populations have specific needs and adapt to those needs accordingly.

All patients have to be treated with respect and dignity, even if they are terminally ill and cannot help themselves.

Health care workers need to ensure that family members of patients and close friends are provided with the necessary information and support they may require while the patient is in the treatment facility.

When the patient recovers, health care workers need to ensure that the patients are properly discharged and provided with the necessary equipment or advice, and are followed-up as and when needed.

If the patient dies, the health care workers need to ensure that the steps indicated for safe and dignified burial is properly followed.

Protect caregiver from getting infected while caring for patients

Health care workers need to undergo special training on use of personal protective equipment (PPE) and other procedures required for IPC. They need to also closely follow up on the hygiene guidance and understand the cleaning and disinfection practices in health care facilities. It is also important for health care workers to be aware of is the segregation of waste for proper disposal.

Provide effective care for patients: initial steps

In the treatment facility, there are designated entry and exit points and patient care areas. It is critical for all – health care workers and patients or visitors – to respect the ‘red’ and ‘green’ zone policies. More on this can be found in the clinical guidelines.

Patients usually reach a facility through either efforts of epidemiological investigation, or self-reporting. Triage is the first step done by specially trained personnel when a patient arrives at a treatment facility. Based on the findings, the patient is either admitted or discharged.

If the patient is admitted, the patient will be assigned to a designated area where they will receive treatment with care to prevent transmission to the care providers or other patients. There will be laboratory investigations conducted to confirm the diagnosis of the patient. Other tests could also be conducted to better understand the patient’s treatment needs. The patient’s basic needs such as food, water, cleanliness, emotional support will also have to be taken care of at this stage.

Laboratory diagnosis

Once a suspected or probable patient is admitted to a treatment facility, laboratory specimen needs to be collected and transported to the nearest laboratory for tests. Results of the laboratory test needs to be provided to the health worker responsible for proper management of the patient. The patient and their family need to be informed about the laboratory outcome. The laboratory outcome of the patient needs to also be reported to other relevant authorities so that they can take the necessary action in areas relevant to other pillars of the response and for managing the data and information management on the Ebola outbreak.

Follow treatment guidelines

Supportive treatment is the most important form of treatment for Ebola patients at the moment. We still have no approved specific treatment for Ebola, so the most effective treatment for Ebola patients is mainly provision of fluid and the maintenance of electrolyte balance. This is life saving and a must for all Ebola patients. It should be provided early and in adequate amounts. Oral rehydration salts (ORS) is provide to patients with mild symptoms and other intravenous fluids for other patients with more severe symptoms.

Other medicines should be provided as needed, for relieving pain, for vomiting, agitation and other symptoms.

Patients should also be provided with treatment for other infections, like malaria, sepsis, etc.

Special populations have special needs

Patients with special needs like children and pregnant women should be given special attention. Children need closer supervision and psychological support from adults.

Pregnant women need special attention because tragically, a high percentage of pregnant women with Ebola die. Most babies of mothers with Ebola die either in the womb or after delivery. The fluids discharged from an infected pregnant woman and their baby can be infectious and therefore, health care workers are required to follow strict infection prevention and control precautions as needed. Miscarriage can be a sign of Ebola virus infection.

Provide patient care with respect and dignity

Patients being treated for Ebola virus disease have a right to decent living conditions. They have a right to be treated with respect and dignity in all aspects – while talking to them, caring for them or helping them. They have the right to be provided with adequate food, water and other basic needs. They have the right to be informed about their condition and provided with other necessary information. They have the right to meet and be connected to their family, relatives and friends.

Family, relatives and communities of Ebola patients need to be provided information on how to protect themselves, how to reduce fear, anxiety and how to accept Ebola survivors back into the community. This work can be done jointly with those involved in community engagement and social mobilization. More on social mobilization and community engagement will be provided in Module 4.4.

In the event a patient dies, safe and dignified burials need to be strictly followed. More about this will be provided in module 4.3.

Transmission of Ebola virus disease

The incubation period for transmission of Ebola, which is the time from when a person is exposed to the virus from an Ebola patient (alive or dead) to the time during which the person develops symptoms is between 2-21 days.

The groups most at risk of Ebola infection are front-line health workers, family members of the Ebola patients, care givers, traditional healers and those involved in unsafe burials.

Challenges and solutions

Provision of medical care to critically ill patients can be challenging in any setting, particularly in resource limited areas. Health workers have an obligation to provide the best medical care to improve the patient’s chances of survival, or to relieve them of the symptoms they are suffering from. The application of appropriate skills and case management protocols makes the care for Ebola patients easier.

Appropriate case management supports all other Ebola control measures

Appropriate management of patients with Ebola supports all other Ebola control measures, mainly because it saves lives, improves comfort of the patient, their family and their community. Managing Ebola patients appropriately can also reduce the transmission of the virus in health facilities and the community. It also strongly contributes to the confidence the community has on the Ebola response and hence their support in bringing the outbreak to its end.

Activity 1

Answer the following questions.

1. What treatment is available for Ebola?

.....

2. Why is so much emphasis placed on “safe and effective care”?

.....

3. Why are laboratory tests needed?

.....

Activity 2

What new things have you learnt about “case management” – caring for people with Ebola?

.....

.....

Activity 3

How does your work relate to or can contribute to the work in case management? List 3 ways in which your work relates to the work on case management.

- 1
- 2
- 3

MODULE 4.2: CASE FINDING AND CONTACT TRACING

What is this module about?

Case finding and contact tracing is an essential part of controlling the Ebola outbreak by identifying people who may be infected with the Ebola virus, and following up on all the people who have come into close contact with that person (case).

What will you learn?

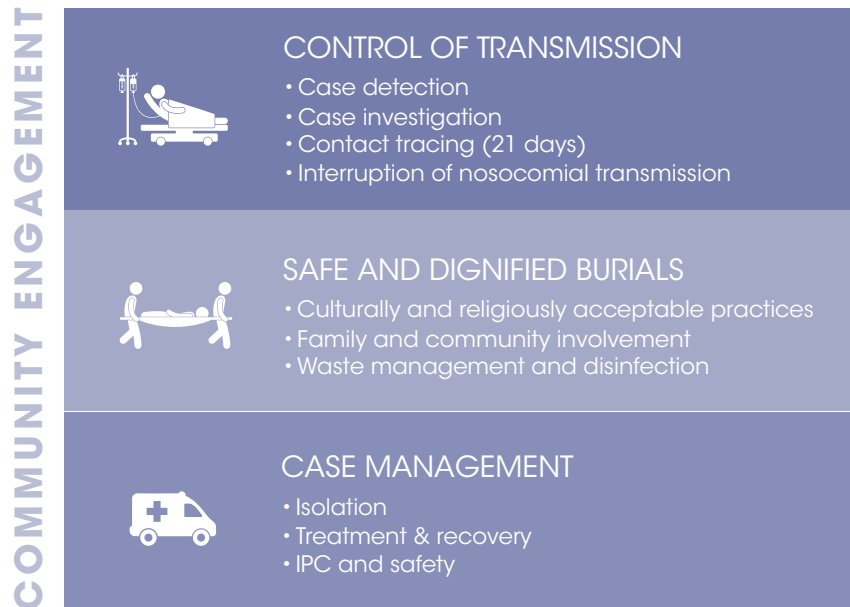
By the end of this module, you will be able to:

1. Explain the basic features of contact tracing within the operating surveillance systems
2. Describe how contact tracing can stop the Ebola transmission, and
3. Give examples of how your work can contribute to contact tracing.

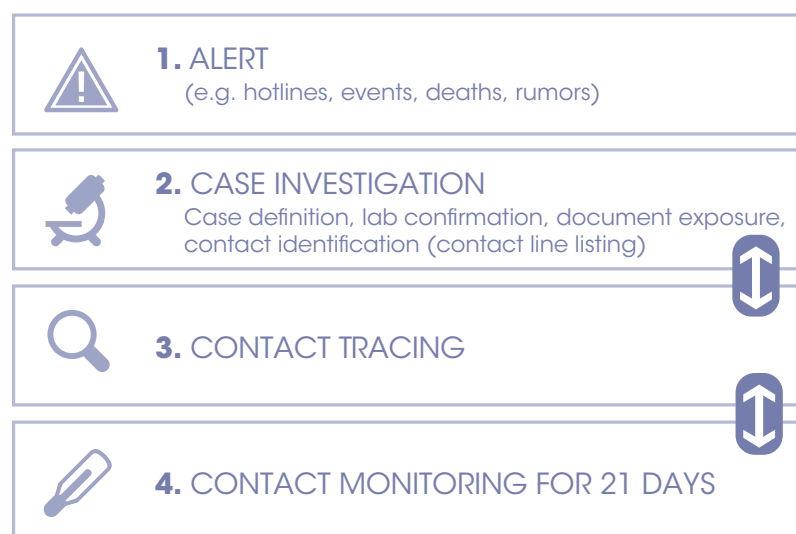


> Principles of control

There are many important components to enable control and prevention of Ebola. This diagram illustrates the four pillars or main strategies with which the Ebola outbreak can be brought under control. Three of the four strategies – case management, community engagement and safe and dignified burials - will be covered in other modules in this course. This module focuses on the “control of transmission” of the virus from one person to another.



> Key components of Ebola outbreak surveillance



This is a flow chart that summarizes the most important functions of surveillance in an Ebola outbreak.

1. Alert

Case investigation begins with an alert that signals that there may be a potential Ebola case. Alert comes in many forms. Whenever an alert comes in, the surveillance team is notified and immediately prepares for case investigation.

Information from the community is directly picked up or is indirectly routed to the surveillance team through telephone hotlines, events and rumours, reports on a death in the community, monitoring of contacts, self-reporting or through laboratory results.

The information is then communicated to the surveillance team to assign epidemiologists or trained surveillance officers to conduct case investigation.

2. Case Investigation

Once a case, or a person who may have Ebola is detected, the surveillance team will have to investigate the case. This is usually done by interviewing the case directly, on-site. If the case is deceased, a proxy- family members or neighbours - must be interviewed.

The interview is conducted to ascertain whether the case meets the case definition and to obtain epidemiological information which includes information such as personal hygiene, and demographics, symptoms experienced by the case, the exposure of risk factors, information on previous contacts and information to further identify other contacts. A 'line listing' of new contacts would have to be developed.

The key findings from the investigation will have to be collected in the case investigation forms.

Following the investigation, this person would have to be isolated and provided access to medical care. Specimens have to be collected for laboratory testing. Before collecting a biological specimen, informed consent must be obtained from the patient or their family. All contacts of the case have to be identified and followed up on for a period of 21 days (the incubation period or the period from exposure to development of first symptoms is from 2-21 days). This is important because once the suspected case goes into an isolation facility, surveillance officers cannot always collect information regarding the contacts because they are often not allowed to enter the 'red zone' of the treatment facility and also because contact tracing should begin immediately.

The patient and their family must be informed that the patient needs to seek care in a hospital and that transportation will be arranged for them.

If a case has died, the family must be informed of the procedures for safe and dignified burials.

3. Main rationale for contact tracing and monitoring

The ultimate purpose of the surveillance system in the Ebola outbreak is to promote early detection of new cases. Early detection of new cases is important mainly for two reasons:

1. It facilitates isolation of cases from communities, thereby minimizing exposure to others; and
2. It maximizes the patient's survival by initiating early treatment. Repeating this cycle will eventually lead to decreased transmission.

Contact tracing is crucial in achieving those objectives.

Contact tracing is the process of identifying contacts of a person with Ebola to ensure that they are aware of their status and to communicate expectations on what to do in the event they start to feel ill. Once contacts have been traced, contact monitoring is pursued to observe development of any symptoms for 21 days (the maximum incubation period of Ebola virus) from the last day of contact with an Ebola case.

While the main purpose of contact tracing is to identify relevant contacts of an Ebola case in order to create the opportunity for monitoring; the objective of contact monitoring is to detect any new case that may arise among the contacts that are being followed so that they are isolated as early as possible.

Early isolation of new cases is crucial not only because it prevents further transmission,

but it also increases their chances of survival by initiating treatment to minimize the likelihood of developing complications.

Contact tracing: 3 basic elements

Contact tracing is identification and follow-up of persons who may have come into contact with a suspected, probable or confirmed case, with the ultimate goal of detecting and isolating new cases as soon as possible.

The 3 basic elements of contact tracing include:

Contact tracing begins with case investigation. Once the contacts are identified and listing of contacts have been done, the contacts are identified on the basis of the following information:

a. Contact Identification

Who lived with the case?

Who visited the case?

Who and where did the case visit?

All the health facilities visited by the case

All persons who have had contact with the body of a deceased person from the time of his/her death

All places, including markets, schools, offices, health centres work places, leisure places the case has visited.

Contact identification is however, more than just asking questions to obtain answers. The prerequisites for contact identification are to understand the strategy and the tactics in approaching the contacts so as to lead to better compliance of individuals and the community. Contact tracers should have excellent inter-personal and communications skills with knowledge and interest on cultural awareness and able to adapt quickly to the new working environment.

To begin contact tracing, the basic requirements include a comprehensive line listing of relevant contacts, personnel to conduct the investigation, transport to reach the contacts and the commitment and perseverance to carry out the work.

b. Contact listing

Empathy plays an important part when the surveillance officers inform the contacts about their status as contact of a case. Priority should be given to contacts who are considered to be at high risk.

Once contacts are listed on the form, surveillance officers and/or contact tracing team physically look for contacts by visiting the contacts. Having to do this for many, contacts require persistence and a lot of resources. Also, community acceptance is needed from the very beginning, from the very moment the team goes into communities to explain why they are there and what they will be doing.

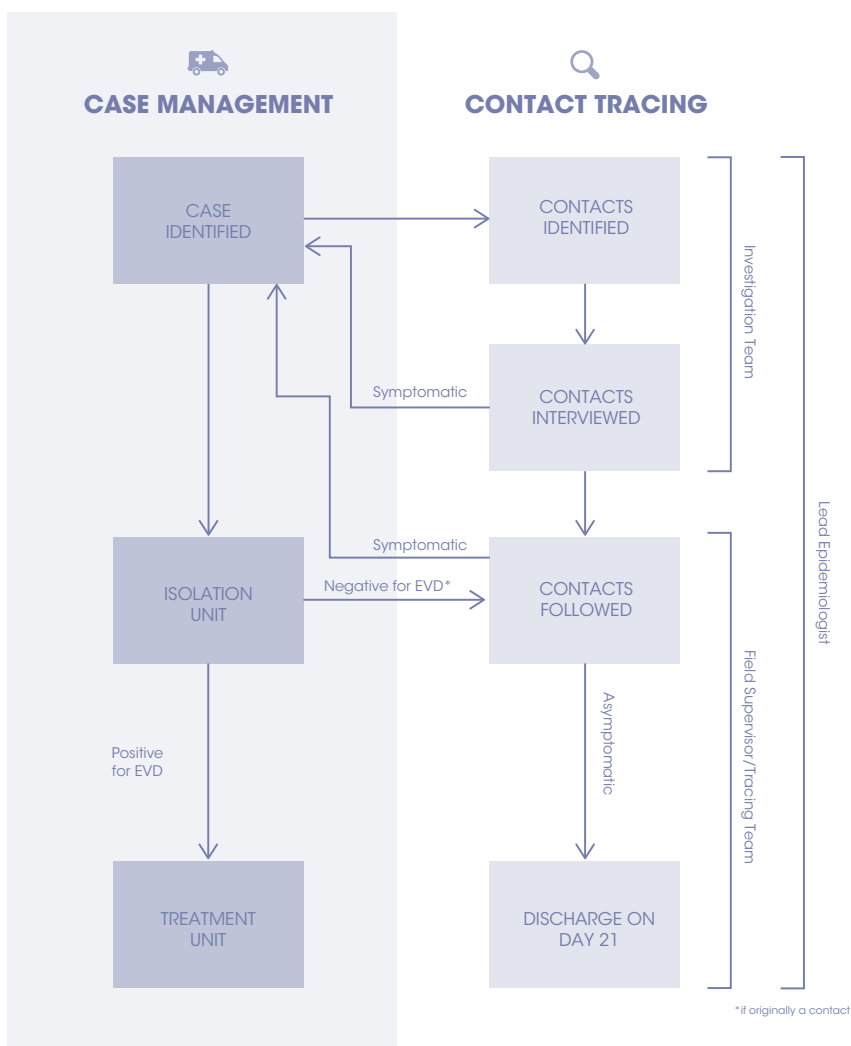
c. Contact follow up

Contacts have to be followed up and monitored for 21 days after the last exposure to the case. The follow up of contacts is done by the epidemiological surveillance officers, under the supervision of the supervisors, who manage the teams that are assigned to follow up on the contacts. The supervisors have to follow-up on the daily work of the epidemiological surveillance officers.

Monitoring contacts for any symptoms they develop is intensified for early detection of new cases. The contact tracers or monitoring personnel are often on their own when monitoring the contacts. It is therefore, important for them to gather information and data on the overall progress, in the form of a daily or weekly update, which can be presented to the supervisors so that they are aware of the latest progress and can take further action and decision accordingly.

Self-initiated reports are very useful. But first, the team needs the community members to understand the importance of reporting in a timely manner. They also have to feel comfortable about reporting so they are not subjected to negative consequences such as retaliation. The initial relationship between the team and the community is very important in building rapport and trust. It is also important that the correct knowledge and information is provided right from the beginning, in order to avoid any confusion that may be caused due to misinformation.

There is no "one size fits all" approach. The integrity of technical (epidemiological) standards must remain, but how contact tracing and monitoring activities are implemented may differ significantly from community to community.



The above diagram shows how cases are identified and handled. Similarly, it illustrates what happens to contacts once they are identified.

The figure also shows responsibilities of surveillance officers. Once case investigation has been completed with all relevant contacts identified by the investigation team, the information on contacts (personal identifiers, including name, age, address and relationship to other case), is passed on to the contact tracing coordinator or supervisor at the district level. Members of the community who are familiar with the geography, the people and the language do the monitoring.

A public health worker, such as a surveillance officer, directly reaches out to a contact and monitors the contact every day for 21 days. This approach works well in areas with low transmission, or for a very specific group of individuals who need to be traced and monitored, e.g. health care workers in a hospital, or for close contacts at higher risk like close family members.

With more contacts over larger areas, effort needs to increase, and it becomes time consuming and labour-intensive. This process will not be discussed in this module.

Surveillance activities and community engagement

Cultural, social or political acceptability could impact or accelerate outbreak response. Initially, we want people to accept response teams and help us perform important work in their communities. Over time, we want them to be engaged as much as possible in both active and passive surveillance (more of which is explained later in this section). There is no "one size fits all" – flexibility is needed.

It is important to get community support to initiate the surveillance work. The willingness of the community to accept health workers in their communities is critical. If the community is resistant and perceives health workers as being an obstacle, or are fearful or are in denial, it makes the surveillance work more complicated.

Community engagement is needed to facilitate and enhance continued surveillance activities. This leads to a proactive approach in active case finding, voluntary reporting in a timely manner and enables the health workers to anticipate and resolve any conflict that may arise effectively. Community engagement also contributes to early identification of problems and solutions that can often be found within the community.

However, there are many challenges in surveillance and contact tracing.

Insufficient resources.

- The workload is often heavy. Each case investigation form is on average 3 pages long, and information for each case has to be documented in these forms.
- The contacts are often located in a wide geographical area.
- Often, there are difficulties with diagnosis because most cases have no specific symptoms or because there is limited laboratory capacity.
- It is very difficult to trace contacts in urban areas because the population is mobile and is exposed to many contacts.
- Logistics to obtain vehicles and fuels for reaching out to contacts often proves to be challenging and has to be arranged and prepared in advance in order to avoid wasting time.
- Adaptation of surveillance and contact tracing standards to the context of transmission, for instance whether it is localised or intense transmission or whether it is in urban or rural areas.
- Data management is often a huge challenge. It is important to obtain complete and quality information. There is insufficient use of innovative technologies like mobile phone devices where appropriate. The use of mobile device can help generate information through timely reporting. Data flow can be unclear.

- Different beliefs and practices based on religious, cultural, political, societal, individual, etc.
- Emotions such as fear, reluctance, anger, sadness, hopelessness, denial can all impede this work.
- Building trust with communities takes time but is essential. E.g. several episodes of violence against surveillance teams have been witnessed due to lack of trust.

Activity 1

Answer the following.

1. Why is contact tracing and active case finding so important in the Ebola response?

.....

.....

2. Can you name the four main steps in Ebola outbreak surveillance?

.....

.....

3. Why is it so important to engage communities for contact tracing and active case finding?

.....

.....

4. Can you list a few challenges in this area of work?

.....

.....

Activity 2

Can you describe how your own work relates to contact tracing and active case finding?

.....

.....

MODULE 4.3: SAFE AND DIGNIFIED BURIALS

What is this module about?

Ensuring that the burials of people who have died from Ebola are conducted safely with dignity and respect is essential to help the bereaved family cope with their loss and to ensure that the Ebola virus disease is not spread to other people. Safe and dignified burials is one of the four main pillars of the Ebola response.

What will you learn?

By the end of this module, you will be able to:

1. Describe basic features of safe, supervised and dignified burials,
2. State how safe burials are critical to stopping the Ebola outbreak, and
3. Identify how each area of work in the response relates to safe and dignified burials.



Activity 1

Take couple of minutes to write down answers in the space below:

1. What do you understand by safe and dignified burials ?

.....

2. Describe why safe and dignified burial is so critical to stopping the spread of Ebola?

.....

A big challenge

This is a very challenging area of response conducted when Ebola has claimed a life, when a family member has passed away. It is both tragic and dangerous as the Ebola virus still continues to have the ability to infect people who come into contact with the deceased. It is very important that all of us, regardless of whether we work in this area or not, understand what this area of the response is about.

During an Ebola epidemic, any unprotected handling of the bodies of Ebola patients who have died constitutes a biosafety hazard. Bodies of dead Ebola patients contain high levels of Ebola virus. At least 20% of new Ebola infections occur during burials of deceased Ebola patients. Ebola infections occur during burials when family and community members perform traditional and/or religious rites, which requires directly touching and washing of the body of the deceased person. Ebola infection can also occur when family members distribute personal property of the loved one who has died of Ebola, which may be infected with the virus.

The burial process is very important for the family and the community and can cause community resistance or even conflict towards the overall Ebola response if the importance of supervised safe and dignified burial is not properly addressed. Before starting any procedure the family must be fully informed about the safe and dignified burial process. Their traditional, religious and personal wishes should be accommodated as much as possible during this process. Families need to show respect for the deceased but this may involve dangerous practices from the perspective of preventing the further spread of Ebola.

A time of mourning, a time of danger

It is extremely important to understand the social and cultural context of where and how people live in the three countries most affected by this Ebola outbreak. Death is a very important certain duties and rites must be performed, and we cannot disregard the importance of these rituals. We need to understand these rituals and find a safe and dignified way to enable the family and community to perform them in the safest possible way. The process can be performed while protecting all those involved.

While focusing on stopping the spread of Ebola, it is also important to show respect and dignity for the deceased. We have to remember that this was a father, a mother, a brother, a sister, a child, of a family, of a community, of a village or a town.

Before starting any procedure for a safe burial, the family must be fully informed about the safe and dignified burial process. The process must include respect for traditional and religious rites and the family's wishes to show respect for the deceased. No burial should begin until the family has agreed.

Traditional burial practices in West Africa include the preparation of bodies for funerals, and includes practices such as wiping, massaging, kissing and embracing the body of the deceased. Respect for the dead is demonstrated by attending funerals, and sometimes the mourners also kiss and touch the body. Funerals rites may go on for several days.

Protocol on safe and dignified burials

WHO worked with key partners to develop a protocol for safe and dignified burials of people who have died from Ebola. The protocol was jointly developed by an interdisciplinary team at WHO, in partnership with the International Federation of Red Cross and Red Crescent Societies (IFRC) and faith-based organizations including World Council of Churches, Islamic Relief, Caritas Internationalis and World Vision.

This protocol outlines step-by-step processes for safe and dignified burials. The protocol encourages inclusion of family and local clergy in the planning and preparation of the burial. The protocol takes into consideration religious practices for Muslim and Christian burials. The protocol includes measures Ebola burial teams need to take to carry out their work safely while respecting the wishes of the family of the deceased. This means that burial teams must not wear personal protective equipment (PPE) when they enter the community for their first meeting with the family, in order to avoid frightening and further distressing them. It means asking the family if there are specific requests for managing the burial and personal effects of the deceased. In some instances, taking photographs of the deceased in the body bag provides reassurance and comfort to family and friends.

12 Steps of the safe and dignified burials protocol

There are 12 steps outlined in the safe and dignified burials protocol. These include:

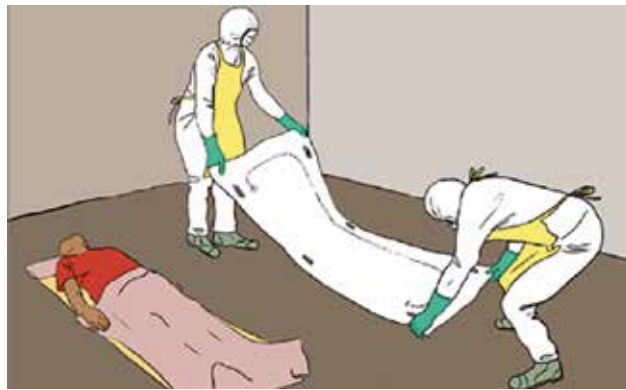
1. Prior to departure: assemble the burial team and prepare disinfectants.
2. Assemble all necessary equipment.
3. Arrive at the deceased patient's home. Team prepares burial with family and evaluates the risks.



4. Team puts on PPE as required.



5. Place the body in the body bag.



6. Place the body bag in a coffin where culturally appropriate.



7. Sanitize the family's environment.



8. Remove the PPE, manage waste and perform hand hygiene.

9. Transport the coffin or the body bag to the cemetery.



10. Burial in the cemetery. Place the coffin or body bag into the grave.

11. Burial at the cemetery: engaging community for prayers as this dissipates tension

and provides a peaceful time.



12. Return to the hospital or team headquarters to continue with follow-up activities.

Caution

This module aims at providing you with basic information on how safe and dignified burial is carried out in the Ebola response. If you are required to be part of a burial team, you will need special training, which is provided on the ground.

Activity 2

Please write down how your area of work relates to the work on safe and dignified burials.

1.

.....

2.

.....

3.

.....

Activity 3

Complete these sentences:

1. Safe and dignified burials are important to the bereaved family because...

.....
.....

2. The burial of a person who died from Ebola is dangerous because...

.....
.....

3. Affected families and the community need to be involved in the decisions about how their loved one will be buried because...

.....
.....

4. It is important not to wear full PPE when the burial team first approaches the village or the bereaved family because...

.....
.....

MODULE 4.4: SOCIAL MOBILIZATION AND COMMUNITY ENGAGEMENT

What is this module about?

The other three pillars of the Ebola response - case management, active case finding and contact tracing, and safe and dignified burials - all rely on social mobilization and community engagement. While social mobilization and community engagement is at the heart of the Ebola response, this has been one of the most challenging pillars of the response.

What will you learn?

By the end of this module, you will be able to:

1. Describe basic principles of social mobilization and community engagement,
2. Describe how community engagement contributes to stopping the spread of Ebola, and
3. Identify the linkages between the different thematic areas of work with social mobilization and community engagement.



Communities must be at the heart of the Ebola response.

As the UN Mission on Ebola Emergency Response (UNMEER) underscores,

“The outbreak in West Africa will end when we get to zero cases. To achieve this goal, communities must be at the heart of the response. If people with Ebola are to come forward and transmission is to be interrupted, communities must be fully involved responding to the outbreak.”

Activity 1

Apart from social mobilization and community engagement teams, list all other responders (by speciality or role) who engage or need to engage directly with communities.

.....

.....

Social Mobilization, as defined by UNICEF – the lead agency for social mobilization in the Ebola response - is a “broad scale movement to engage people’s participation in achieving a specific goal through self-reliant efforts. It involves all relevant segments of society: decision and policy makers, opinion leaders, bureaucrats and technocrats, professional groups, religious associations, commerce and industry, communities and individuals. It is a planned decentralized process that seeks to facilitate change (stopping the Ebola outbreak in this case) through a range of stakeholders engaged in interrelated and complementary efforts. It takes into account the felt needs of the people, embraces the critical principle of community involvement, and seeks to empower individuals and groups for action.” People who are affected, and all those who are linked in any way with the challenge at hand (Ebola outbreak) have to be “mobilized” to solve the problem.

Community engagement involves informing the community of the dangers and solutions to Ebola, consulting the community as part of a process to find the solution, and build community awareness and understanding. It requires involving the community through a range of mechanisms to ensure that issues and concerns are understood and considered as part of the decision-making process. There has to be collaboration with the community by developing partnerships to formulate options and provide recommendations and strong efforts undertaken to empower the community to make decisions and to implement and manage change.

> Why engage with communities?

Everyone has a right to know about risks to their health and well-being, and engaging with communities allows for sharing of information and discussion. Culturally, traditionally, socially, ethnically, politically-appropriate information can help people at risk of getting Ebola, make informed decisions and empower them to take necessary actions. The scientific information that we have needs to be shares in an appropriate context (culturally, traditionally, socially, politically, economically) with communities through their engagement, so that they can make informed decisions to reduce the risk of infection of Ebola. The actions taken by individuals, families and communities affected are key to controlling the spread of Ebola.

Community engagement is much more than producing messages, leaflets, posters, T-shirts, radio spots, TV advertisements, etc. These are channels and tactics and tools to reach communities, but engagement is much more.

Perception

What the public hear and what they perceive can be two different things. This is a very important concept in communicating risks and we need to understand this before we explore ways in which we can engage communities. Perception not only of individuals, families and communities affected by Ebola, but for all of us as individuals, is influenced by beliefs, traditions, and practices. There can be reasons for why people believe in something. Cultural, religious, political, emotional, traditional factors influence our perception.

The public have access to information from many sources their perception is based on these and not just on what officials or experts or emergency response personnel say. They have their own source of trusted information. So when we go to communities and we hand out a leaflet with key messages, people can be very accommodating and polite and nod and listen to what we say. Unless we understand that there is a gap between facts and what people perceive, understand, internalise, and act on it, we will not be able to stop the transmission of Ebola.

There are a lot of studies that provide evidence that there are some factors that actually affect how people perceive things. People who are affected by a risk, tend to be more concerned about the health risk if it is involuntary, a risk that is unfamiliar, a risk that is uncontrollable or controlled by others, a risk that is seen as unfair, acute, happening very quickly, or fatal. These findings also have to be contextualised in the lens of what communities perceive in terms of cultural, religious, traditional, economic, social, political context. This is why anthropologists and risk communications experts are important for the response operations. It is important to understand the factors that affect perception and behaviours.

Activity 2

Let us take a moment to answer the following questions in the context of the Ebola outbreak.

1. Who are the influencers in the communities?

.....

.....

2. With whom will you/your agency engage with in the communities?

.....

.....

3. Identify groups or individuals :

- Who are the connectors in the community?

.....

.....

- What are their power relations with the community?

.....

.....

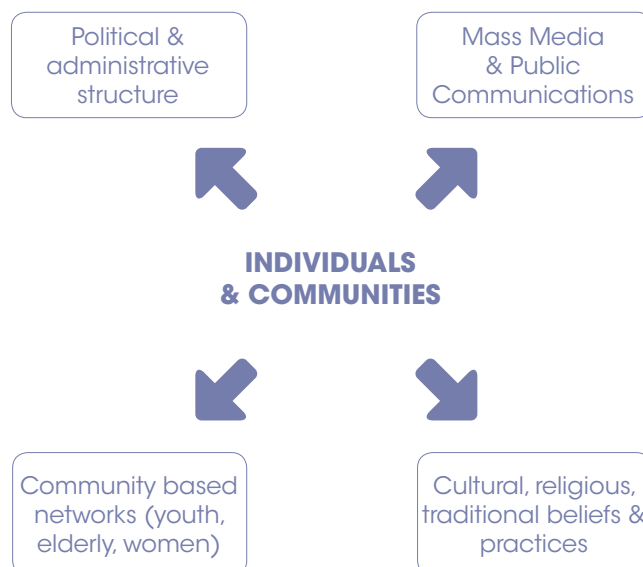
- Who are their information sources and preferences?

.....

.....

This is something you should do before you start any work on community engagement, regardless of your primary area of work in the Ebola response.

Elements that influence perception



The above graph maps out the key elements that influence perception. These include the environment in which we grew up and live in, the culture which we are part of, the religion we follow, our life experiences, the society we live in, the political conditions around us, and so on. In an emergency, when people are under stress, their perception of risk is influenced by their familiarity to the risk, whether the risk is fatal or if it affects children, their personal experiences, their cultural values, etc.

Understanding community practices

It is essential to understand what the community behaviour and practices were before the Ebola outbreak. So how were people greeting each other? Did they shake hands? Did they hug? Did they touch? How did they care for the sick? Who fed the sick person food? Who cleaned the sick person? Did they hug and touch a sick person?

The traditional and cultural practices in the area you are being deployed to could be very different from the practices you are familiar with. So please make time to take these factors into consideration.

It is a big challenge to ask the communities to do something that they are not used to, without properly understanding their context, and without providing them with a rationale for why they should do what we are asking them to do.

For example, we are asking them not to shake hands, not to touch one another because of Ebola. This is very different from what they are used to doing before the spread of Ebola. In many African cultures, people not only shake hands but they keep holding hands while they talk. This is a big change in their daily practice. We are asking communities to frequently wash their hands, which also requires additional resources like a water container for running water to wash hands, clean water and soap.

On top of cultural and traditional influences, there are also practical influences. We are asking people not to do something very fundamental when they see off a person in their family who has died. We are asking them not to touch not only people with Ebola-like symptoms, but not to touch people who have died. We are asking them to take the sick immediately to a treatment facility where no family member is allowed inside the patients' area.

Myths and misconception

There are myths and misconceptions about Ebola. There have been several knowledge, attitude and practice (KAP) surveys conducted to look into the factors that influence perception, fear, behaviour, etc. These studies have provided us with information on why people fear Ebola.

Based on information from previous outbreaks which generally happened in remote villages, the case fatality rate for Ebola was as high as 90%. This belief that most Ebola patients die led to the belief in some communities that Ebola, like other illnesses, is a curse. For this reason, some communities felt that since patients die anyway and there was no need to take them to health care facilities where they would die alone and that it would be better for the deceased to die in the surrounding of their family members.

Because Ebola was seen as a curse, it also led to dismissal and denial in some communities. Some communities did not want to acknowledge it, they did not want to believe that Ebola existed in their community and they did not want to accept it. In some communities, there was a distrust in the concerned authorities. At one point the demand for the response was so high that it overwhelmed the authorities and the resources that were in place. This effected the level of trust communities had on the concerned authorities.

In anthropology, there are ways of decoding some of the challenges like rumours to understand, the underlying meaning for those rumours, their proximity concepts from where the rumours originated and how we could reconceptualise and deal with the rumour effectively.

> What did we do ? Phase 1 (From March - July 2014)

Let us look back at the Ebola response. UNICEF is the lead agency for social mobilization. In this first phase, during the early days of the Ebola outbreak in April-July 2014, volunteers were trained, and the key risk messages focused on preventative methods. Tremendous work was done to reach out to the people, but as the outbreak continued, we realised that we had to do more. We had to engage communities.

So in phase 1, it was really social mobilization and crisis communications, and the rationale for this was because past experiences of Ebola outbreaks were associated with 90% deaths. The key messages used during this phase were: "Ebola kills. There is no cure." and that people should avoid consumption of bush meat.

In this phase, most of the social mobilization outreach for Ebola was done through the mass media, posters, radio and house-to-house visits (sharing key messages and teaching protective behaviours such as hand washing) where possible. The messages were scaring people because we said 'Ebola kills'. And the outcome of this was mixed including that of denial. The general perception people in the city areas had was that Ebola was not a problem for them because it only spread in remote villages and that it was caused by bush meat. Also because it was mentioned that there is no cure for Ebola, most people preferred for the patients to die at home, surrounded by their family.

> What did we do ? Phase 2 (From August - September 2014)

During the second phase, the strategy we used was a new wave of awareness-raising. The rationale for this was because Ebola was spreading in major cities. There were increased survival rates being observed, especially among people who were brought to Ebola Treatment Units (ETUs). The key messages were mainly around 'Ebola is real' and the focus was on providing information on the signs and symptoms of Ebola and on encouraging people to call the telephone hotlines set up for the Ebola response.

The interventions were more in a campaign mode with the use of hotlines, mass media – print, broadcast, posters, radios, town criers, loud speakers on trucks and motorbikes.

The outcome was an increased demand for services. The demands exceeded the response capacity the authorities could provide in the beginning and this led to lack of confidence and trust in the Ebola response.

> What did we do ? Phase 3 (From October 2014 onwards)

In the third phase, the strategy being used is community engagement. The rationale for this was that we will not be able to stop this outbreak without engaging the community. Community members were engaged more strongly as participants and not just recipients of our advice and services. The key messages were focused around avoiding contact with dead bodies, that early treatment increases chances of survival, and to prevent the stigmatization of Ebola survivors. The approaches used during this phase is focused on applying risk communications principles to interpersonal communications with the use of mass media and other channels.

The outcome we are seeing so far is engagement and involvement of community influencers, including traditional leaders, religious leaders, traditional healers, and various community group, including women's groups and the youth groups. But we still have a long way to go. In some areas, is resistance to routine vaccines because people believe that new Ebola vaccines are being tested on them. There are sporadic attacks on response teams visiting communities and even instances of response workers being threatened or killed.

Here are examples of attacks on social mobilization teams in Guinea and some successful examples of community engagement from Sierra Leone.

The example from Guinea highlights the security threats faced by a team of social mobilizers. Despite much effort in raising awareness and engaging communities, a team in Guinea faced security threats as recently as early this year.

On 14 Feb 2015, Reuters news agency reported *"crowds attacked Ebola facility, health workers in Guinea. They destroyed an Ebola facility and attacked health workers in central Guinea on rumours that the Red Cross was planning to disinfect a school, a government spokesman said on Saturday."*

Last year, on 19 Sept 2014, Aljazeera reported that *"eight bodies, including of three journalists, found in remote village following attack on team trying to educate locals."*

In another example from Sierra Leone, communities were part of the Ebola response right from the beginning.

Daru was one of the most-affected areas in the Ebola outbreak. Community health centre served as a temporary center before patients were transported to MSF treatment unit in Kailahun and Kenema. Villagers were very engaged from the beginning. There was strong political support from the chief who lost his wife and daughter due to Ebola. WHO clinician visited once a day to provide assistance. Community health officers maintained excellent communication so laboratory samples and patients could be transported to Kenema for diagnosis and treatment. Community health officers initiated an admissions and maintained a log book even during the peak of the outbreak. Daru no longer receives cases. Community health officers actively participate in surveillance. They respond to alerts from nearby villages and arrange transport as needed. They conduct contact tracing and organized monitoring teams. They also take care of Ebola orphans in the village.

Monitoring at Community and National Levels

The work we do in different areas, including social mobilization and community engagement is monitored and reported back from the local to the national level. At the local level, there is a saytem of daily reporting. Some reporting is done through self-reporting, u-report or rapid pro (different reporting systems by use of mobile sms devices is used in different countries). This form of reporting includes answering questions like:

- Did you see any community meetings about Ebola today?
- Have you seen any house to house visits being conducted today?
- Did any contact tracers or burial team report experiencing resistance today?
- Have you heard of any secret burials this week?

- Have you heard of any exhuming of bodies this week?
- At the provincial or county or national level, reporting is done on a weekly basis. The weekly reporting generally involves the following questions:
 - Have you heard a rumor today relating to Ebola
 - Did you hear any Ebola messaging delivered by religious leader at the Mosque on Friday?
 - Did you hear any Ebola messaging delivered by religious leader at the Church on Sunday?
 - Was the paramount chief contacted by any social mobilization partners this week?

This information is used at local, provincial, national and global levels to inform and shape the response.

Reminder

Here is a reminder for you on the work in the area of social mobilization and community engagement.

1. Communities must be at the heart of the Ebola response
2. Work with the influencers
3. Understand community perception, practices and needs
4. Empower local leaders, officials, networks
5. Monitor progress and adapt strategies, tactics and approaches accordingly.

Activity 3

From the perspective of your specific area of work in the Ebola responses:

1. What are the 3 key steps you would take to engage community influencers

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.....

2. What top 3 challenges do you anticipate in engaging community influencers?

.....
.....

3. What resources would you need to engage community influence?

.....
.....

4. Write down how your area of work relates to or can contribute to the work on social mobilization and community engagement.

.....
.....



MODULE 5

Working with WHO

MODULE 5.1: INTRODUCTION TO WHO

What is this module about?

How much do you know about the World Health Organization? Complete this module to find out more about WHO's mandate, functions and priorities, as well as about how it works in health emergencies. For existing staff this module is a quick refresher. For consultants and partners, it is important to digest the information in this module to help you integrate into the Organization's response to Ebola.

What will you learn?

By the end of this module, you will be able to:

1. Describe WHO's core mandate and functions,
2. Describe how WHO is working in countries, and
3. Describe how WHO works in a health emergency.



A timeless vision

When diplomats met in San Francisco to form the United Nations in the aftermath of World War II in 1945, one of the things they discussed was setting up a global health organization. The UN's specialized agency for health was established when WHO's constitution came into force on 7 April 1948. Every year on the anniversary of its birth, the Organization celebrates World Health Day.

Even nearly seven decades ago, WHO's vision was to create world where everyone has the right to the highest levels of possible health, with values of human rights and equity embedded into its constitution. The Constitution also embraced a broad definition of health, looking to wellbeing in every aspect of human life and not just at illness and death.

"The mission of WHO is the attainment by all peoples of the highest possible level of health."

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Source: WHO's Constitution, 1948

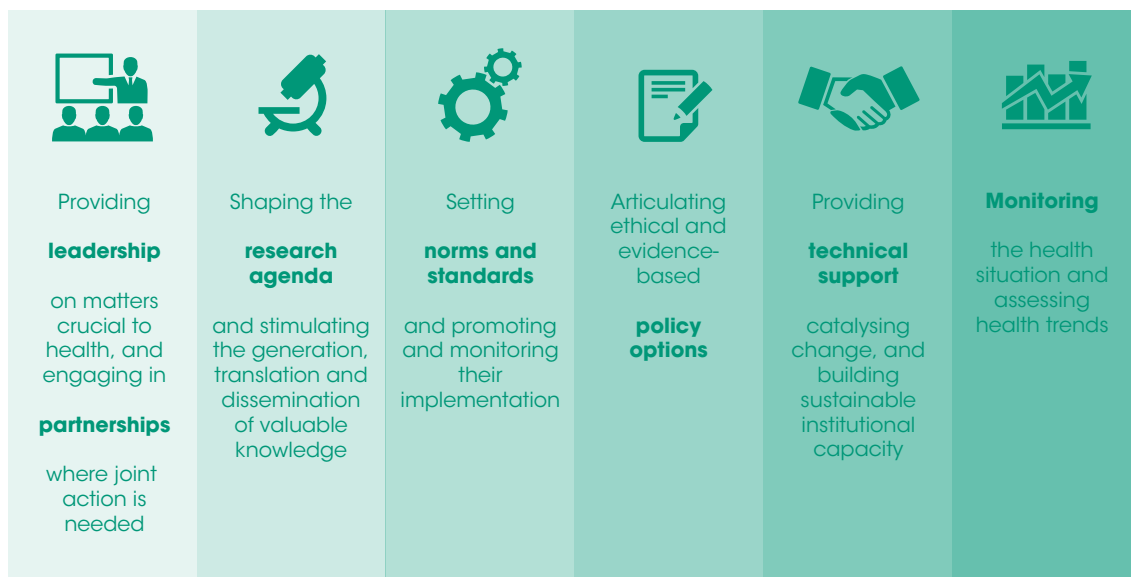
Delegates from 53 of WHO's 55 original Member States came to the first World Health Assembly (WHA) in June 1948. The WHA that year decided that WHO's top priorities would be malaria, women's and children's health, tuberculosis, venereal disease, nutrition and environmental sanitation – many of which we are still working on today. But year after year, new global health priorities are added to the list, including smallpox, expanded programme of immunization and neglected tropical diseases have now been joined by more complex and difficult to address challenges like HIV/AIDS, non communicable diseases such as cardio-vascular disease, diabetes and cancer; and ever-increasing inequities in people's ability to receive the good quality health services that they need, want and can afford. The Organization's role in detecting and responding to disease outbreaks has been unique for decades, and its work in addressing health response in humanitarian crises and natural disasters has been growing.

> Who runs WHO?

Today, 194 Member States through their delegates at the World Health Assembly and through the Executive Board Members decide on the main strategic directions of the Organization, set its priorities and programmes and oversee its implementation and management. The Secretariat is comprised of around 7,000 staff working across more than 155 locations around the world. The Headquarters is based in Geneva, Switzerland; and work at country level is managed by its six regional offices - African Regional Office (AFRO), Eastern Mediterranean Regional Office (EMRO), European Regional Office (EURO), South East Asian Regional Office (SEARO), the Western Pacific Regional Office (WPRO), and the WHO Regional office in the Americas, along with the Pan American Health Organization - AMRO/PAHO.

A Director-General is elected by all Member States, and by six Regional Directors heads the Organization, each elected by the Member States in their respective regions. The staff of the Organization is selected mostly by competitive selection and includes medical doctors, public health experts, epidemiologists, economists, policy advisors, information managers, project officers, communications and risk communications experts, administrative staff, logisticians, information technology (IT) professionals, and emergency preparedness and response personnel.

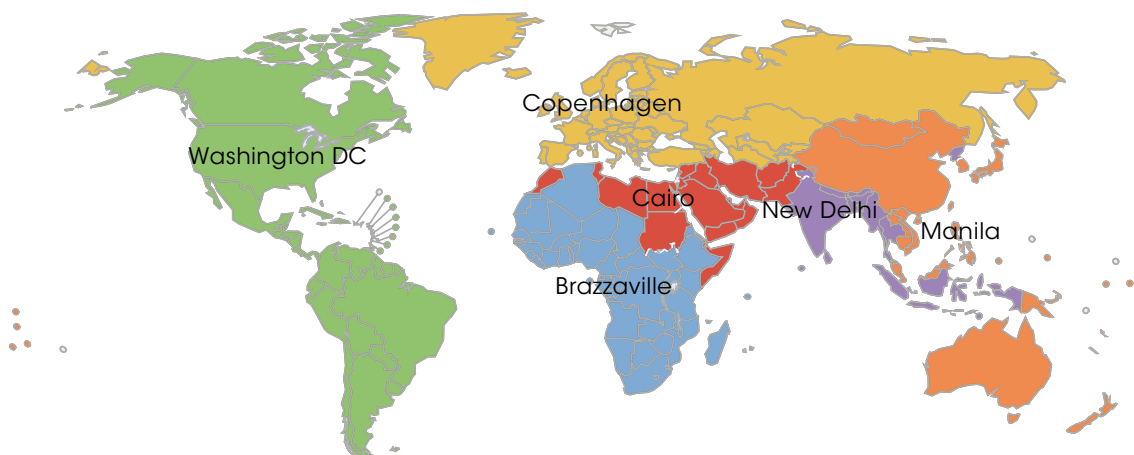
Core functions



WHO fulfills its objectives through its core functions:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change, and building sustainable institutional capacity; and
- Monitoring the health situation and assessing health trends.

These core functions are set out in the 12th General Programme of Work, which provides the framework for the organization’s programme of work, budget, resources and results. Entitled “Not merely the absence of disease.” It covers the 6-year period from 2014 to 2019.



To see information about the location of WHO country offices and sub-country offices, hover over a cc

- Africa
- Americas
- Eastern Mediterranean
- Europe
- South-East Asia
- Western Pacific

The comparative advantages of WHO

Here is a summary.



Neutral broker



Nearly universal membership



Impartiality



Strong convening power



Normative and technical roles

How WHO works in emergencies

WHO has permanent presence in more than 150 countries and has established programmes, working relationships with government ministries, UN partners, NGOs and others. It has programmes and a good analysis of capacities and gaps. This stands the organization in good stead to work in emergencies. Its work in public health emergencies and humanitarian crises are linked, and fall under two international frameworks.

Public health emergencies

WHO's work in disease outbreaks and other public health emergencies (including radiological, chemical, food safety emergencies), is framed by international law – the International Health Regulations(IHR), revised most recently in 2005. All WHO Member States have ratified this law and WHO's Secretariat is the Secretariat for the IHR(2005). The IHR and its revision highlights that in today's interconnected and globalized world, nations agree to give up some of their sovereignty to address shared threats through joint action. Below, you will find some important points about the IHR.



- It is one of the only two **international legally binding public health instruments** agreed upon by 194 countries (State Parties), including all WHO Member States.
 - It significantly contributes to global public health security by providing a new framework for coordination of the management of events that may constitute a public health emergency of international concern.
 - It supports improvement of the capacity of all countries to detect, assess, notify and respond to public health threats.
 - It has been implemented since 15 June 2007.
 - The IHR(2005) obligates all Member States to build up their capacity to detect, share information about risks, and take action to contain a public health event of international concern.
- The Ebola outbreak in West Africa was declared a Public Health Emergency of International Concern in August 2014, and triggered a series of actions by affected countries as well as for international response.

You can read more about the IHR(2005) in all six official Un languages at the following link: <http://www.who.int/ihr>

WHO’s Emergency Response Framework (ERF)

WHO is the global Health Cluster Leader that responds to the health aspects of any humanitarian crisis or natural disaster. The Organization has an Emergency Response Framework that outlines WHO’s response in emergencies. The current version is under revision but it is nevertheless important to be familiar with the framework.

- Purpose of the ERF
 - To clarify WHO’s roles and responsibilities in public health emergency response.
 - To provide a common approach for WHO’s work in emergencies across the organization.
- Requires WHO to act with urgency and predictability to best serve and be accountable to populations affected by emergencies.
- The Ebola outbreak in West Africa was shifted from Grade 2 to a Grade 3 event in WHO since July 2014.

Type of support	Grade 1	Grade 2	Grade 3
Technical	Remote technical assistance from international level	Time-limited missions; remote input to strategic plans; technical advice	In-country on-going technical assistance through surge; issuance of hazard-specific and country specific guidance
Financial	Minimal to none (handled with financial resources available at country level)	Access to regional WHO financial resources; international resource mobilization on request	Access to global and regional WHO financial resources; international resource mobilization and donor outreach
Human Resources	Minimal to none (handled with human resources available at country level)	Surge of emergency experts, as required	Surge team deployed on a no-regrets basis

The Global Outbreak Alert and Response Network



GOARN is a technical collaboration of existing institutions and networks that pools human and technical resources for rapid identification, confirmation and response to public health events and infectious disease outbreaks of international concern.

The network provides an operational framework to link expertise and skills to keep the international community constantly alert to the threat of outbreaks and ready to respond.

Thousands of experts have been deployed through GOARN since the Ebola outbreak in West Africa was first confirmed in March 2014.

Activity 1

List five new things you have learnt about WHO

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MODULE 5.1.1: RECRUITMENT ARRANGEMENTS FOR THE EBOLA RESPONSE TO WEST AFRICA

What is this module about?

WHO deploys many personnel to work in a wide range of roles as part of the Ebola response. This module provides an overview of the recruitment arrangements for such deployments.

What will you learn?

By the end of this module, you will be able to:

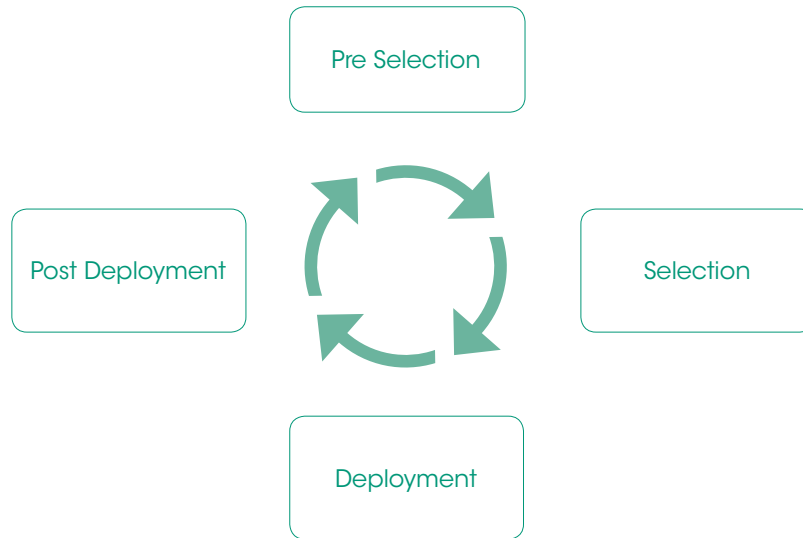
1. Describe basic recruitment arrangements

Who and how?

WHO deploys its own staff from offices from around the world, and personnel recruited as consultants and from partner agencies. Each group has its own deployment mechanism.

The WHO deployment process has four steps that are linked. The pre-selection which is to identify suitable candidates, the selection which is based on the job to be performed, and the deployment and the post-deployment steps.





Activity 1

Take couple of minutes and write down in the space below

- Have you had a briefing on your deployment? YES/NO
- Whom have you met with?

.....

.....

.....

.....

.....

The process



Identify candidates



Obtain medical and other clearances



Complete documentation, visas and contract



Complete medical briefing and receive medical kit



Collect equipment (laptop, etc)



Complete pre-deployment training



Deploy



Debrief once mission is over



Re-deployment

For consultants

It is important to complete all documentation as soon as possible. All medical requirements must be met and WHO will reimburse costs of the medical examination. For any consultant to be able to travel at the request of WHO, a medical examination and proof of medical clearance have to be available.

Like staff and partners, consultants will have to undergo pre-deployment training. This includes the health and safety module – PROTECT or ePROTECT; and the GO pre-deployment training.

Visas have to be obtained from the location of recruitment and security clearance must also be obtained. UN Certificates may be issued.

Consultants who are performing work for WHO in locations other than the place of their residence will be paid Daily Subsistence Allowance (DSA). While under contract, consultants have insurance covered and are eligible for medical evacuation and rest and recuperation (R&R) according to WHO standards.

On completion of the deployment or mission, consultants should be de-briefed and they should submit a travel claim. All equipment issued by WHO including access badges must be returned at the end of the mission.

Activity 2

Make a list of things you need to remember to do before and after you deploy.

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MODULE 5.1.2: WORKING FOR WHO AS AN INTERNATIONAL CIVIL SERVANT

What is this module about?

Regardless of your contract type – staff, consultant or partners, there are values, ethical considerations and behaviours that you will have to know about, internalize and to demonstrate in your actions when you are deployed by WHO. This module is a good refresher for existing staff and a very important source of information if you are new to working with WHO.

What will you learn?

By the end of this module, you will be able to:

1. Describe existing codes of conduct that are applicable to all personnel working for WHO, including during an emergency response, as the basis of accepted conduct for personnel working in an international organization.



The basis

This module is based on a compilation of existing documents, "Ethical Principles and Conduct of Staff" (2009). Its applicability is defined follows:

"The contents of this Compilation apply to all staff members of the Organization. All staff members are expected to observe these standards at all times, in their work and where appropriate, private lives, irrespective of whether or not they are in active service, working on a full-time or part-time basis or seconded to WHO. Persons employed by WHO as consultants, on special service agreements or APWs will be made aware of this Compilation and are expected to conduct themselves in accordance with the requirements stated in this document as appropriate."

What is an International Civil Servant?

According to its Constitution (Article 69), WHO is a specialized agency of the UN ruled by Article 57 of the **United Nations Charter** (signed in 1945, in San Francisco).

"All staff members of the Organization are international civil servants." (WHO **Staff Regulations** Article I.1.1 Duties, obligations and privileges).

The following principles govern international civil servants:

- WHO Staff Regulations and Rules (Article 1, and E-manual Section III.1 on Duties, Obligations and privileges) and WHO Ethical principles and conduct of staff establish civil servants' **international character & independence**:
- The responsibilities of WHO staff members are not national but **exclusively international**. By accepting appointment, they pledge themselves to discharge their functions and to regulate their conduct with the interests of the WHO only in view (WHO Staff regulations Article I.1.1)
- In the performance of their duties staff members shall **neither seek nor accept instructions from any government or from any other authority** external to the Organization (Staff rules Art. 1.3).
- Staff members shall conduct themselves at all times in a manner compatible with their status as international civil servants. They shall avoid any action and in particular any kind of **public pronouncement** which may adversely reflect on their status (Staff rules Art 1.5).

The oath of office and loyalty

- The **role of WHO International Civil Servants** is to assist the Organization in its commitment to the attainment by all peoples of the highest possible level of health (WHO constitution, Art 1).
- **Impartiality** – by being loyal to the interests of the WHO only in view (Oath of office to be taken): "I solemnly swear (undertake, affirm, promise) to exercise in all loyalty, discretion, and conscience the functions entrusted to me as an international civil servant of the WHO, to discharge those functions and regulate my conduct with the **interests of the WHO only** in view, and not to seek or accept instructions in regard to the performance of my duties from any government or other authority external to the Organization" (Staff Reg. 1.10).

The following personal values and behaviours must guide our action

- Loyalty to WHO's goals, missions, priorities and policies
- Independence and impartiality from external sources and authorities
- Technical excellence
- Integrity and honesty in actions and decisions that may affect WHO
- Discretion

- Respect for:
 - Dignity
 - Worth
 - Equality of all persons
 - Diversity
- Accountability

As international civil servants, we must embody the highest aspirations, goals and values of WHO and the UN; and bear responsibility for translating those ideals into reality. Values are the embodiment of what we stand for and to behave ethically is to behave in a manner consistent with our values.

The following are important to know, believe and do when working as part of WHO:

- Promote and protect a harassment free workplace
- Prevent sexual exploitation and abuse
- Respect national laws
- Ensure there is no interference of personal relationships in the workplace
- Do your part to ensure a safe work environment (no violence, drugs, alcohol, smoking)
- Maintain an appropriate dress code
- Respect the Organization's policy and procedures for media relations and public statements
- Use WHO's property, resources and information with respect, care and good judgment
- Declare and mitigate any conflict of interest

National Laws and Regulations

You may have heard of diplomatic immunity that provides protection to enable international civil servants to discharge their duties. However, this is not an excuse to disregard national laws and regulations. Staff members and anyone deployed by WHO have a duty to observe the laws and regulations of the host country, including traffic regulations. It is important to know that immunity is normally waived for traffic offenses. Failure to observe the laws and regulations, or abuse the privileges and immunities may lead to disciplinary proceedings.

Conflicts of interest

A conflict of interest occurs when you have a private interest that may benefit from your actions, or when a private interest could interfere with official duties. Remember, an interest need not be financial to create a conflict of interest. Most conflicts result from the exercise of discretionary authority. **No two situations are alike: what may seem acceptable in one instance may be wrong in another.** The attached compilation of "Ethical Principles and Conduct of Staff" (2009) goes into more detail on this very important topic and provides everyday examples of what constitutes a conflict of interest. If you are in doubt, the most practical thing is to speak to your supervisor and discuss the situation.

Risks independence and impartiality

Activities that might compromise our independence or impartiality and therefore restrictions are:

- Outside employment, occupation and activities
- Outside activities including political activities;
- Gifts, honours, awards and remuneration from outside sources;

- Personal and family relationships;
- Financial interests and affiliations;
- Use of information;
- Collaboration with external experts and/or institutions; or
- Publishing, press statements, blogging, etc.

Disciplinary measures

Disregarding or violating the code of conduct and ethical behaviour as stated in the compilation could lead to any of the following disciplinary measures:

- Oral reprimand;
- Written reprimand;
- Reassignment with or without reduction in grade;
- Dismissal for misconduct; and
- Summary dismissal for serious misconduct.

Where to get help

WHO has a central team at its headquarters -The Office for Compliance, Risk Management and Ethics (CRE). CRE staff

- Ensures staff members understand their ethical obligations to WHO as embodied in the various regulations, rules, policies and procedures under which we operate.
- Promotes and sustain an ethical organizational culture by:
 - Providing confidential ethics advice
 - Protecting staff against retaliation (policy on whistleblowing and protection against retaliation)
 - Administering the declarations of interest programmes for staff and external experts
 - Promoting ethics awareness and education

For more information, visit <http://intranet.who.int/homes/cre/>; or reach out to any of the following experts.

- Andreas Mlitzke, Director, mlitzkea@who.int
- Marie Bombin, Ethics Officer, bombinm@who.int (ext: 12010)
- Alma Alic, Technical Officer, alica@who.int (ext: 14653)
- Generic Email: ethicsoffice@who.int

Activity 1

Mark as TRUE or FALSE the following statements:

1. The Code of Conduct for International Civil Servants (The Code) applies to all WHO staff. (TRUE/FALSE)
2. All consultants and partners who are as part of WHO teams should also respect the Code. (TRUE/FALSE)
3. International civil servants have diplomatic immunity and therefore should not worry too much about traffic offenses when they are deployed to the field. (TRUE/FALSE)

4. The Code is just a code; nothing very serious can happen if we violate it. The most important thing is that we are good at our technical work! (TRUE/FALSE)
5. The Loyalty to WHO's goals, missions, priorities and policies, independence and impartiality from external sources and authorities, technical excellence, integrity and honesty in actions and decisions that may affect WHO, discretion, respect for dignity, worth, equality of all persons, and diversity; and accountability are all core values that must guide our work, regardless of our contract type. (TRUE/FALSE)
6. If you think that a real or perceived conflict of interest exists, you should immediately seek advice from your supervisor or the Office for Compliance, Risk Management and Ethics (CRE). (TRUE/FALSE)

Code of conduct for international humanitarian assistance

Compiled by the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief, this code of conduct gives very similar values as the Code of Conduct for International Civil Servants above. As you will see many humanitarian and disaster relief experts and teams on the ground in the Ebola response, it is very important that you know and respect this code.

Purpose

"This Code of Conduct seeks to guard our standards of behaviour. It is not about operational details, such as how one should calculate food rations or set up a refugee camp. Rather, it seeks to maintain the high standards of independence, effectiveness and impact to which disaster response NGOs and the International Red Cross and Red Crescent Movement aspires. It is a voluntary code, enforced by the will of the organisation accepting it to maintain the standards laid down in the Code. In the event of armed conflict, the present Code of Conduct will be interpreted and applied in conformity with international humanitarian law. The Code of Conduct is presented first. Attached to it are three annexes, describing the working environment that we would like to see created by Host Governments, Donor Governments and Inter-Governmental Organisations in order to facilitate the effective delivery of humanitarian assistance."

Note: Sponsored by: Caritas Internationalis, Catholic Relief Services, The International Federation of Red Cross and Red Crescent Societies, International Save the Children Alliance, Lutheran World Federation, Oxfam, The World Council of Churches, The International Committee of the Red Cross (*members of the Steering Committee for Humanitarian Response)

Definitions

NGOs: NGOs (Non-Governmental Organisations) refers here to organisations, both national and international, which are constituted separately from the government of the country in which they are founded.

NGHAs: For the purposes of this text, the term Non-Governmental Humanitarian Agencies (NGHAs) has been coined to encompass the components of the International Red Cross and Red Crescent Movement – The International Committee of the Red Cross, The International Federation of Red Cross and Red Crescent Societies and its member National Societies – and the NGOs as defined above. This code refers specifically to those NGHAs who are involved in disaster response.

IGOs: IGOs (Inter-Governmental Organisations) refers to organisations constituted by two or more governments. It thus includes all United Nations Agencies and regional organisations.

Disasters: A disaster is a calamitous event resulting in loss of life, great human suffering and distress, and large-scale material damage.

The Code of Conduct

Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes.

1 The humanitarian imperative comes first

The right to receive humanitarian assistance, and to offer it, is a fundamental humanitarian principle which should be enjoyed by all citizens of all countries. As members of the international community, we recognise our obligation to provide humanitarian assistance wherever it is needed. Hence the need for unimpeded access to affected populations is of fundamental importance in exercising that responsibility. The prime motivation of our response to disaster is to alleviate human suffering amongst those least able to withstand the stress caused by disaster. When we give humanitarian aid it is not a partisan or political act and should not be viewed as such.

2 Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind.

Aid priorities are calculated on the basis of need alone. Wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of the disaster victims and the local capacities already in place to meet those needs. Within the entirety of our programmes, we will reflect considerations of proportionality. Human suffering must be alleviated whenever it is found; life is as precious in one part of a country as another. Thus, our provision of aid will reflect the degree of suffering it seeks to alleviate. In implementing this approach, we recognise the crucial role played by women in disaster-prone communities and will ensure that this role is supported, not diminished, by our aid programmes. The implementation of such a universal, impartial and independent policy, can only be effective if we and our partners have access to the necessary resources to provide for such equitable relief, and have equal access to all disaster victims.

3 Aid will not be used to further a particular political or religious standpoint

Humanitarian aid will be given according to the need of individuals, families and communities. Notwithstanding the right of NGHAs to espouse particular political or religious opinions, we affirm that assistance will not be dependent on the adherence of the recipients to those opinions. We will not tie the promise, delivery or distribution of assistance to the embracing or acceptance of a particular political or religious creed.

4 We shall endeavour not to act as instruments of government foreign policy

NGHAs are agencies which act independently from governments. We therefore formulate our own policies and implementation strategies and do not seek to implement the policy of any government, except insofar as it coincides with our own independent policy. We will never knowingly – or through negligence – allow ourselves or our employees, to be used to gather information of a political, military or economically sensitive nature for governments or other bodies that we serve.

5 We shall respect culture and custom

We will endeavour to respect the culture, structures and customs of the communities and countries we are working in.

6 We shall attempt to build disaster response on local capacities

All people and communities – even in disaster – possess capacities as well as vulnerabilities. Where possible, we will strengthen these capacities by employing local staff, purchasing local materials and trading with local companies. Where possible, we will work through local NGHAs as partners in planning and implementation, and cooperate with local government structures where appropriate. We will place a high priority on the proper co-ordination of our emergency responses. This is best done within the countries concerned by those most directly involved in the relief operations, and should include representatives of the relevant UN bodies.

7 Ways shall be found to involve programme beneficiaries in the management of relief aid

Disaster response assistance should never be imposed upon the beneficiaries. Effective relief and lasting rehabilitation can best be achieved where the intended beneficiaries are involved in the design, management and implementation of the assistance programme. We will strive to achieve full community participation in our relief and rehabilitation programmes.

8 Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs

All relief actions affect the prospects for long-term development, either in a positive or a negative fashion. Recognising this, we will strive to implement relief programmes which actively reduce the beneficiaries' vulnerability to future disasters and help create sustainable lifestyles. We will pay particular attention to environmental concerns in the design and management of relief programmes. We will also endeavour to minimise the negative impact of humanitarian assistance, seeking to avoid long-term beneficiary dependence upon external aid.

9 We hold ourselves accountable to both those we seek to assist and those from whom we accept resources

We often act as an institutional link in the partnership between those who wish to assist and those who need assistance during disasters. We therefore hold ourselves accountable to both constituencies. All our dealings with donors and beneficiaries shall reflect an attitude of openness and transparency. We recognise the need to report on our activities, both from a financial perspective and the perspective of effectiveness. We recognise the obligation to ensure appropriate monitoring of aid distributions and to carry out regular assessments of the impact of disaster assistance.

We will also seek to report, in an open fashion, upon the impact of our work, and the factors limiting or enhancing that impact. Our programmes will be based upon high standards of professionalism and expertise in order to minimise the wasting of valuable resources.

10 In our information, publicity and advertising activities, we shall recognise disaster victims as dignified humans, not hopeless objects

Respect for the disaster victim as an equal partner in action should never be lost. In our public information we shall portray an objective image of the disaster situation where the capacities and aspirations of disaster victims are highlighted, and not just their vulnerabilities and fears. While we will cooperate with the media in order to enhance public response, we will not allow external or internal demands for publicity to take precedence over the principle of maximising overall relief assistance. We will avoid competing with other disaster response agencies for media coverage in situations where such coverage may be to the detriment of the service provided to the beneficiaries or to the security of our staff or the beneficiaries.

MODULE 5.1.3: GUIDANCE FOR COMMUNICATIONS AND MEDIA INTERVENTIONS

What is this module about?

How much do you know about the World Health Organization? Complete this module to find out more about WHO's mandate, functions and priorities, as well as about how it works in health emergencies. For existing staff this module is a quick refresher. For consultants and partners, it is important to digest the information in this module to help you integrate into the Organization's response to Ebola.

What will you learn?

By the end of this module, you will be able to:

1. Describe why effective communications is essential in an emergency response,
2. List key policies and practices for communicating for WHO, and
3. Describe how additional support for communications can be accessed.



Why communicate in an emergency

Communications is central to all emergency response action. It is a public health intervention and supports the achievement of emergency response objectives – from risk perception, behaviour change in affected populations, managing rumours and misinformation. It provides support for emergency response and raising resources needed.

In a disease outbreak such as Ebola, communications:

1. Fulfils a basic right people have to be informed about the risks they face so as to take informed decisions to protect themselves and their loved ones.
2. Helps influence behaviour change. e.g. Hand washing or not touching people who show symptoms of Ebola or have died from Ebola.
3. Identifies early and immediately correct misinformation and helps address rumours.
4. Allows donors and international community know about respond needs and funds.
5. Is a means to be accountable to the general public by discussing frankly the successes and the challenges in an emergency response.

WHO's policy on communications

This can be found in WHO's eManual for staff. Consultants and partners need to be aware of these policies. In particular:

The purpose of communications at WHO is to support health outcomes needed for improving people's health. This is done in two inter-connected ways:

- direct health communications with stakeholders via a variety of platforms and channels for health policy, practice and behavioural change; and
- communications to maintain and strengthen WHO's reputation and trust so that stakeholders support the Organization's work.

WHO's communications should support transparency for health action, be evidence based whenever possible and support programmatic and political efforts to improve public health. At all times, communications should maintain and strengthen the trust stakeholders and the public have in the Organization. This is essential for public health work and for mobilizing resources for health work.

All WHO communications should:

- Contribute to clearly defined public health goals, have a specific target audience and focus on concrete outcomes;
- Be evidence-based (or consensus-based when evidence does not exist);
- When possible, motivate audiences to take action rather than just providing information and increasing awareness;
- Raise awareness of health problems, propose solutions to these problems, and indicate how WHO is contributing to solutions;
- Use WHO's priorities as a framework for key messages and be in line with the Organization's position on related issues;
- Use a consistent corporate voice throughout the Organization to build trust and maintain credibility;
- Use the medium best suited to reach the target audience;

- Be contextualized, and where possible, be presented in the language of the audience;
- Use the WHO logo in accordance with the WHO Visual Identity Guidelines; and
- Include measures to assess outputs and outcomes of communications work.

Spokespersons

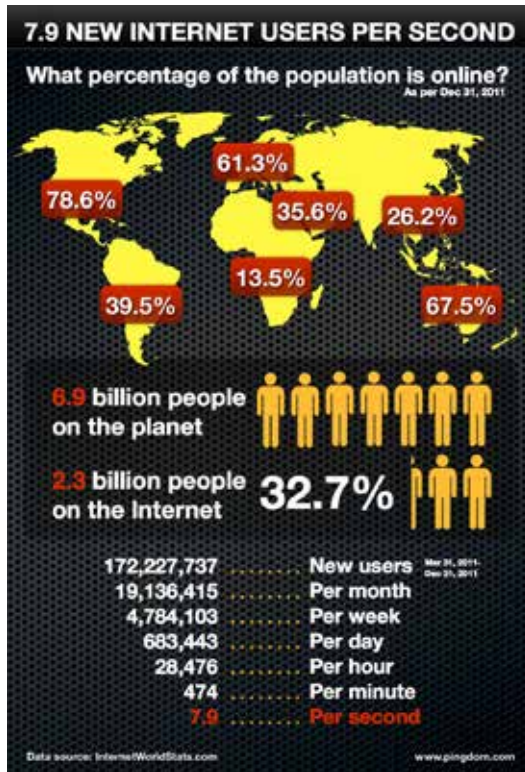
WHO staff can, and are encouraged to, communicate to stakeholders on their areas of technical expertise. With respect of issues which have political implications for the Secretariat or for Member States, staff are required to seek advice from their supervisors and to seek support from colleagues working in the area of communications. In the Ebola response, WHO has deployed communications staff and consultants to the field without interruption since the onset of the outbreak. They are part of a pre-trained and pre-assessed group of professionals who can help you in your communications work, especially related to media communications and risk communications. Please ask the country office to arrange a meeting with the communications officer when you arrive so that you know how to contact them for help.

Channels of communication

The following are important channels of communication:

- The media - newspaper, radios, TV and other forms of media,
- Text messaging and social media,
- Information Education Communication (IEC) materials (posters, banners, flyers, leaflets, campaign spots, etc.),
- Others – town criers, rallies, roadshows, house-to house campaigns,
- Direct intervention with influencers in the community,
- Direct community engagement.

As you will see from the following graph, the nature of media production and consumption is changing. While people living in Africa still account for a relatively small portion of the world's social media users (103 million people or 9%), it is important to know that this number is growing. Many Africans living abroad use social media and influence perception internationally and within Africa.



While on deployment, you will communicate with a wide variety of people – team members, partners, government officials, health care workers, donors, politicians, volunteers, community and families. Principles of communications are the same regardless of the audience.

Step 1: Always know why you are communicating. What is the change you want to see as a result of your communications? What is the problem you are addressing from the perspective of your audience? What do you want to change in your audience?

- Step 2:** Who exactly is your audience? Does your audience agree with you or disagree? Will they support you or block you?
- Step 3:** What does your audience already know and what do they feel towards this? The emotional reaction to what you want to communicate should be anticipated ahead.
- Step 4:** What is your message. Resist the temptation to think of messages until you have completed steps 1-4.
- Step 5:** Choose the channel or channels.
- Step 6:** Deliver the messages in a compelling way that is interesting and understandable to the audience. Use multiple channels and use redundancy if needed (i.e. repeat the message in different ways on different channels, all with the same outcome in mind).
- Step 7:** Monitor your message. Was it distorted. Did the audience understand and act on it? Does it solve the problem that you were initially trying to address?
- Step 8:** Go back to the beginning to either improve the cycle or use the cycle again for the next problem.

Media communications

Media communications is extremely useful for health communications, and indispensable in emergencies. But communicating effectively with the media is challenging and nerve-wracking for many people. Here is what you should remember about media communications. Media communications:

- Is the fastest way to get information out during emergencies,
- Enables for effective, two-way and transparent communication – an effective public health tool,
- Allows us to reach wider stakeholders in a cost effective and engaging way – thus building trust.

In knowledge, attitude and practice (KAP) surveys carried out during the Ebola emergency in West Africa, radio, TV, text messages and “neighbours” have emerged consistently as the most used and most reliable sources of information for the public in Ebola.



Reporters today

- Write for **more than one media**
 - Print
 - Radio
 - TV
 - Web
- Are on **24/7** production cycle
- Are bombarded with releases, advisories, statements, and most contain little “news.”

Over the past three decades three big transformations have happened in journalism. These have all impacted how journalists deal with experts and how experts are increasingly weary of reporters.

1. Horizontal journalism: from news gathered and reported by journalists to exchange of views by journalists, sources, readers and viewers.
2. 24-hour journalism and the fleeting headline and interest.
3. Lack of funds: few specialized reporters, shallow investigation, chasing the sensational, political stories or have industry influence.

When we know what reporters are looking for, it becomes easier to work with them effectively. Reporters want numbers that are up-to-date and reliable. Give the numbers, explain what they mean without jargon, and explain the background and implications. Reporters report news. This means providing information that is new, that is unexpected or surprising, that goes against the trend or against conventional or expert thinking. They like examples, first person accounts and most of all, stories that involve real people.

Journalists and reporters, at the best are:

- Champions of public interest,
- Can be a means of accountability to the public,
- Care about what people want to read, see and consume,
- Want experts to be available to speak in simple language, and be honest.

We need to nurture relations with the media as a part of our work before an emergency, as well as during one. Being available, answering your phone and returning calls are important. Be respectful of reporters. Remember that they don't understand Ebola or the challenges faced by you or your team the way you do.

Guidelines for dealing with media in the field

- In general, WHO technical staff may speak to the media on subjects within their area of responsibility and expertise. Staff should bear in mind that they speak for WHO, not as an individual, an academic or an independent expert in their field.
- Clearance must be sought from the WHO representative (WR), the national coordinator or the Ebola response, of the appointed communications officer/spokesperson.
- Staff should only speak based on their technical expertise. They should seek advice from their supervisor and the communications officer.
- Remarks made to journalists might be important to colleagues elsewhere in the Organization. Therefore, staff must keep relevant colleagues informed about work they do with the media, including the scientific media and journals.

Social media

WHO is very active on social media and we have increasing followers. The public and other stakeholders engage with WHO's Twitter, Facebook, YouTube and other social media platforms. Information you send in and photographs from the field are often used on the corporate social media accounts.

Please remember these 5 tips for WHO staff having their own social media accounts

If you are a WHO staff member at headquarters and use social media such as Facebook, Twitter, LinkedIn and blogs, you may find the following tips useful. HQ social media policies (one for the Organization, one for staff) and good practice documents here: <http://intranet.who.int/homes/new/>. The benefits of telling the WHO story on social media outweigh risks. Yet, a few tactics may be useful to protect yourself and the Organization.

- 1.** When setting up your personal accounts, use non-official design and names. Choose a Twitter handle and Facebook address that could not be mistaken as WHO and that honours your status as an international civil servant. For the design (profile, banner, background) of your social media accounts, don't use the WHO logo or photos where you stand in front of the WHO logo or building. And do not include WHO in your Twitter handle or address. All these things might give the social media account or blog an official appearance.
- 2.** Views and opinions on social media are yours. Use a disclaimer. Whatever your position in WHO, views and opinions on social media are yours. Only the corporate accounts (Twitter, Facebook, Google+, YouTube, Instagram, LinkedIn, Storify and Foursquare), the WHO spokesperson (@haertlg) and the Director-General can represent the Organization on social media (you representing WHO on social media is the same as you issuing a press release on behalf of the Organization). You can indicate your job title, but use a disclaimer. For example, on Twitter, use a disclaimer such as "Tweets here are not official WHO statements. For these, follow @who." On blogs about your work, add a disclaimer to each page.
- 3.** You are an international civil servant. Be a good ambassador. For you as a WHO staff and international civil servant, the WHO Staff Regulations and Rules apply at all times. You are expected to live up to the highest standards of conduct such as respecting diversity, being impartial and demonstrating technical excellence. For example, when you talk about WHO and your work, feel free to speak on subjects within your area of responsibility and expertise. Speak as if you are going to be quoted as a WHO spokesperson (even though you are not). Always represent the Organization positively.
- 4.** Use your best judgment. Whether you talk about WHO, your work or about personal matters, assume that personal is never private on social media. Social media are media. For you as a WHO staff in particular, even if you're not an official WHO spokesperson, the public may perceive you as such, and journalists may quote what you say on social media. Would you be comfortable seeing your tweet quoted on CNN, being asked about it by your mother or having to justify to your boss? Never divulge confidential or embargoed information, or information known to you by reason of your official function which has not been made public, except in the course of your duties or by authorization of the Director-General. Respect the privacy and integrity of colleagues and people outside the Organization.

5. How to draft tweets? Use existing hashtags if you want to see a tweet spread as far as possible, but first check in what context a hashtag has been used already. If possible, don't use all 140 characters in a tweet, better use 120 max. Otherwise, if someone replies, there may not be enough space. Whenever possible, include a short link pointing to a WHO web product. This helps avoid misunderstandings and adds legitimacy to your posts. Most URL shortening platforms (for example goo.gl) allow you to monitor the number of clicks achieved. 50 more tips for better tweets: <http://burson-marsteller.eu/2013/03/50-tips-for-bettertweets/>

Social media etiquette at a glance

- Be the first to admit a mistake
- Be open to criticism
- Be assertive, not defensive
- Feel free to correct others,
- Stick to the facts

Photos

Photos are powerful communications tools. Please obtain consent from the people whose image you are capturing on photo or video. Use the consent form that is attached as a pdf in this module. Ensure that in using their images, we are not depicting them in a way that can potentially put them at risk, stigmatizes them or diminishes their dignity in any way. Any photos or videos taken during your deployment or employment with WHO belong to the Organization. Please caption your photos clearly, write your name and submit to WHO's AV team (studio@who.int). Or contact the WHO Audio Visual manager Chris Black (blackc@who.int). He and his team will catalogue the images or film and make it accessible to the Organization through our photo and video database. The copyright for photos or video will be expressed as follows:

Copyright: WHO/ your name





**World Health
Organization**

Consent to use: name / personal story / image

Background:

The World Health Organization (WHO) is the United Nations specialized agency for health. 194 countries are members of WHO, and together they work to improve the health of people around the world. The Organization develops the health standards and guidelines that help governments, hospitals and doctors everywhere. When there are new diseases or health problems, WHO can rally resources and experts to help address them. The overall goal of WHO is for every person in the world to be as healthy as they can be. WHO produces communications and information materials that are used to explain and promote public health.

Consent:

I agree to have my name, personal story and image (photo and/or video) published by WHO for the reasons mentioned above and as explained to me. I understand that WHO might use my name, story and image in electronic or print form such as on the Internet and in videos, or in printed materials like books, reports, posters and leaflets. These materials may be seen or read by people in my community or anywhere else in the world. WHO will own the image but will not use it to make money. I also understand that WHO will not pay me for my story, my image or their use.

STRIKE OUT THE WORD(S) "NAME" OR "IMAGE" IN THE TEXT ABOVE IF CONSENT IS NOT GIVEN FOR THEIR USE.

FOR PERSONS 18 YEARS OLD OR OLDER

I am the subject and I have read and understood this document.

SIGNATURE:

NAME OF PERSON:

DATE: LOCATION: CONTACT INFO:.....

FOR PERSONS UNDER 18 YEARS OLD

I am the parent or guardian of this child. I have read and understood this document.

SIGNATURE:

NAME OF PERSON SIGNING ON BEHALF OF SUBJECT:

NAME OF SUBJECT:

DATE: LOCATION: CONTACT INFO:.....

FOR PERSONS WHO CANNOT READ OR WRITE

I have read this document to the person whose image is being taken. The person says they understand this document.

SIGNATURE:

NAME OF PERSON SIGNING ON BEHALF OF SUBJECT:

NAME OF SUBJECT:

DATE: LOCATION: CONTACT INFO:.....

Activity 1

Do you want to improve your communications skills or receive a short communications refresher before or during your deployment? Access the following eLearning course. It will take you less than 3 hours to refresh your communications skills: <http://apps.who.int/ebola/en/our-work/training>

Write to ebolatraining@who.int or contact Carey Kyer (kyerc@who.int) with Communications Basics in the subject line to access the course.

CONCLUSION

You have reached the end of the GO pre-deployment training. Remember that you will receive additional pre-service training for your specific line of work on the ground, wherever you are deployed – be it to Guinea, Liberia, Sierra Leone, or elsewhere.

Together, we have covered a wide range of topics in these five training modules. It is important to know and understand why each of them is relevant to the response as a whole. Some of them are directly related to your work in the Global Ebola Response, while others are more secondarily connected; although as you remember, all work within the response contributes to the four response pillars. Each and every person deployed to the response, with their invaluable knowledge and expertise, is needed to stop the spread of Ebola virus and help West Africa get to zero cases.

This particular international response is one of unprecedented scale. Never before have we operationalized such an immense number of people, resources or facilities.

As you prepare for your deployment, please refer back to this training package for any questions that may arise.

Thank you.

Ebola Training Team

World Health Organization.

ebolatraining@who.int

<http://apps.who.int/ebola/en/our-work/training>



For further information:

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<http://apps.who.int/ebola/en/our-work/training>

