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Risk Communication and Community Engagement
(RCCE) Considerations: Ebola Response in the
Democratic Republic of the Congo



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Risk communication and community engagement (RCCE) considerations: Ebola response in the Democratic Republic of the Congo

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This document was developed by the World Health Organization's Health Emergencies Programme as a resource for the response to the Ebola Virus Disease (Ebola) outbreak in the Democratic Republic of the Congo in May 2018.

It is intended to be used to guide risk communication and community engagement (RCCE) work which is central to stopping the outbreak and preventing its further amplification. Unlike other areas of response, RCCE draws heavily on volunteers, frontline personnel and on people without prior training in this area. As such, the document provides basic background information, scopes the socio-economic and cultural aspects (that are known at the time of publication), and provides the latest evidence-based advice and approaches based on WHO's Guideline: Communicating Risk in Public Health Emergencies, 2018.

The document also annexes a checklist for RCCE considerations in all pillars of the response, from surveillance and contact tracing to clinical care and safe and dignified burials.

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EBOLA VIRUS DISEASE OUTBREAK - DEMOCRATIC REPUBLIC OF THE CONGO, MAY 2018

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I. WHAT YOU NEED TO KNOW ABOUT EBOLA

Ebola is a serious and often fatal disease. It has no specific treatment, but a range of interventions can bring the outbreak under control and significantly increase patients' chances of survival.

1. What is Ebola?

The Ebola virus causes an acute, serious illness which is often fatal if untreated. The virus is transmitted to people from wild animals and then spreads in the human population through human-to-human transmission.

The average Ebola case fatality rate is around 50%. Case fatality rates have varied from 25% to 90% in past outbreaks. Early supportive care with rehydration and treatment of symptoms improves survival.

Ebola virus disease (EVD) first appeared in 1976 in two simultaneous outbreaks, one in present day Nzara, South Sudan, and the other in Yambuku, Democratic Republic of the Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name.

Five species of Ebola virus have been identified. Among them, Bundibugyo ebolavirus, Zaïre ebolavirus and Sudan ebolavirus have been associated with large outbreaks in Africa. The virus causing the 2014–2016 West African outbreak belongs to the Zaïre ebolavirus species.

The origin of the virus is unknown, but current evidence suggests that fruit bats (Pteropodidae) may be a host.

2. How is it transmitted?

People become infected with Ebola either through contact with infected live or dead animals (usually following butchering, cooking or eating) or through contact with the bodily fluids of infected humans. Most cases are caused by human-to-human transmission which occurs when blood or other bodily fluids or secretions (stool, urine, semen) of infected people enter a person's body through broken skin or mucous membranes.

Infection can also occur if the broken skin or the mucous membranes of a person come into contact with items or environments contaminated with bodily fluids from an infected person. These may include soiled clothing, bed linen, gloves, protective equipment and medical waste, such as used hypodermic syringes.

During an outbreak, those at higher risk of infection are:

- health workers
- family members or others in close contact with infected people
- mourners who have direct contact with bodies during burial rituals.

Health-care workers are at greater risk of infection if they are not wearing correct personal protective equipment (PPE) or are not applying infection prevention and control (IPC) measures when caring for patients. All health-care providers working at all levels of the health system – hospitals, clinics and health posts – should be fully informed about the disease and its mode of transmission and should follow recommended precautions strictly.

Levels of Ebola virus in body fluids remain high after death. Bodies of those who have died from Ebola virus disease must be handled only by people wearing appropriate personal protective equipment and buried as soon as possible as agreed upon by the family and/or community. WHO advises that bodies of people who may have died from Ebola virus disease should be handled only by trained burial teams, who are equipped to properly bury the deceased, safely, and with dignity.

Sexual transmission of the Ebola virus, from males who recovered from Ebola to their partner has been documented in rare instances. Less probable, but theoretically possible, is female to male transmission. More surveillance data and research is needed on the risks of sexual transmission, and particularly on the prevalence of viable and transmissible virus in semen over time. WHO recommends that male survivors of Ebola virus disease are provided with counselling at ETC discharge and practice safer sex and hygiene for 12 months from onset of symptoms or until their semen tests negative twice for Ebola virus.

3. Signs and symptoms?

Ebola symptoms vary but sudden onset of fever, intense weakness, muscle pain, headache and sore throat are commonly experienced at the beginning of the disease (“the dry phase”). As the disease progresses, people commonly develop vomiting and diarrhoea (“the wet phase”), rash, impaired kidney and liver function, and in some cases, both internal and external bleeding.


The incubation period, or the time interval from infection to onset of symptoms, is from 2 to 21 days. People are not contagious until they develop symptoms.

Ebola virus disease infections can only be confirmed through laboratory testing. It can be difficult to clinically distinguish EVD from other infectious diseases such as malaria, typhoid fever and meningitis.


A person with Ebola-like symptoms who has been in contact with living or dead people suspected to have had Ebola or has travelled to an area known to have cases of Ebola virus disease should seek medical care immediately.

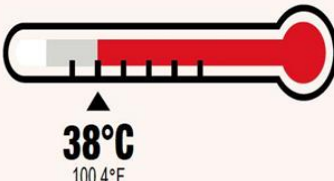
4. How is it treated?


Supportive care – rehydration with oral or intravenous fluids – and treatment of specific symptoms improves survival. There is as yet no proven treatment available for EVD. However, a range of potential treatments including blood products, immune therapies and drug therapies are currently being evaluated.

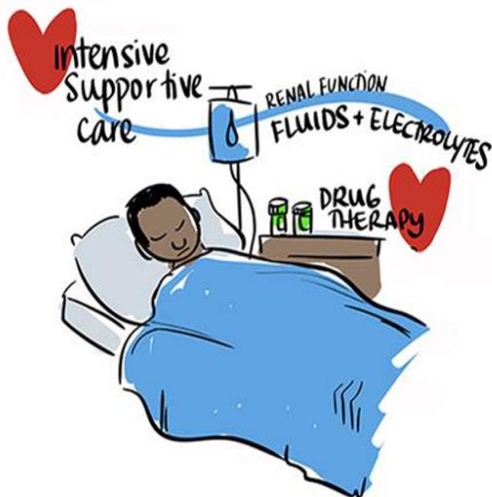
FACTS TO KNOW ABOUT EBOLA 

SYMPTOMS

 Fever, weakness, muscle pain, headache and sore throat, followed by vomiting, diarrhoea, and bleeding

 **38°C**
100.4°F





WHO does not advise families or communities to care for individuals with symptoms of Ebola virus disease at home. People with such symptoms should seek treatment in a hospital or treatment centre staffed by doctors and nurses equipped to treat Ebola virus disease.

5. The package of interventions needed to control Ebola

Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, functional laboratory services, safe and dignified burials, and

social mobilization. Community engagement is key to successfully controlling outbreaks. Raising awareness of risk factors for Ebola infection and protective measures (including vaccination) that individuals can take is an effective way to reduce human transmission. Risk reduction messaging should focus on several factors and should be adapted to the needs of the outbreak response:

- **Reducing the risk of wildlife-to-human transmission** from contact with infected fruit bats or monkeys/apes and the consumption of their raw meat. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.
- **Reducing the risk of human-to-human transmission** from direct or close contact with people with Ebola symptoms, particularly with their bodily fluids. Gloves and appropriate personal protective equipment should be worn when taking care of ill patients at home. Regular handwashing is required after visiting patients in a hospital, as well as after taking care of patients at home.
- **Reducing the risk of possible sexual transmission.** WHO recommends that male survivors of Ebola virus disease practice safer sex and hygiene for 12 months from onset of symptoms or until their semen tests negative twice for Ebola virus. Contact with bodily fluids should be avoided and washing with soap and water is recommended. WHO does not recommend isolation of male or female convalescent patients whose blood has been tested negative for Ebola virus.
- **Outbreak containment measures**, including prompt and safe burial of the dead, identifying people who may have been in contact with someone infected with Ebola and monitoring their health for 21 days, separating the healthy from the sick to prevent further spread, good hygiene and maintaining a clean environment.

6. Prevention

People can protect themselves from infection with Ebola virus following specific infection prevention and control measures. These include handwashing, avoiding contact with the bodily fluids of individuals who are suspected of or confirmed to have Ebola, and refraining from handling or preparing bodies of persons who are suspected of or confirmed to have died from Ebola.

An investigational Ebola vaccine has shown to be highly protective against Ebola. The rVSV-ZEBOV vaccine was studied in several trials that involved more than 16 000 volunteers in Europe, Africa and the United States, and it was found to be safe and protective against the Ebola virus.

II. WHAT YOU NEED TO KNOW ABOUT THIS EBOLA VIRUS DISEASE OUTBREAK IN THE DEMOCRATIC REPUBLIC OF THE CONGO

This is the ninth Ebola virus disease outbreak in DRC.

1. The situation update

On 8 May 2018, the Government of the Democratic Republic of the Congo declared a new outbreak of Ebola virus disease in Bikoro health zone in Equateur Province. The declaration occurred after two out of five samples collected from five patients tested positive for EVD at the Institut National de Recherche Biomédicale (INRB) in Kinshasa.

From 4 April through 27 May 2018, a total of 54 suspected Ebola virus disease cases have been reported, including 25 deaths (case fatality rate = 46.3%). Cases have been reported from three health zones – 60% (21) of the confirmed cases came from Iboko, followed by Bikoro (10 cases, 29%) and Wangata (4). As of 26 May, 906 contacts have been identified and are being closely monitored by field teams for early signs of EVD.¹ Response teams on the ground are verifying information on reported cases.

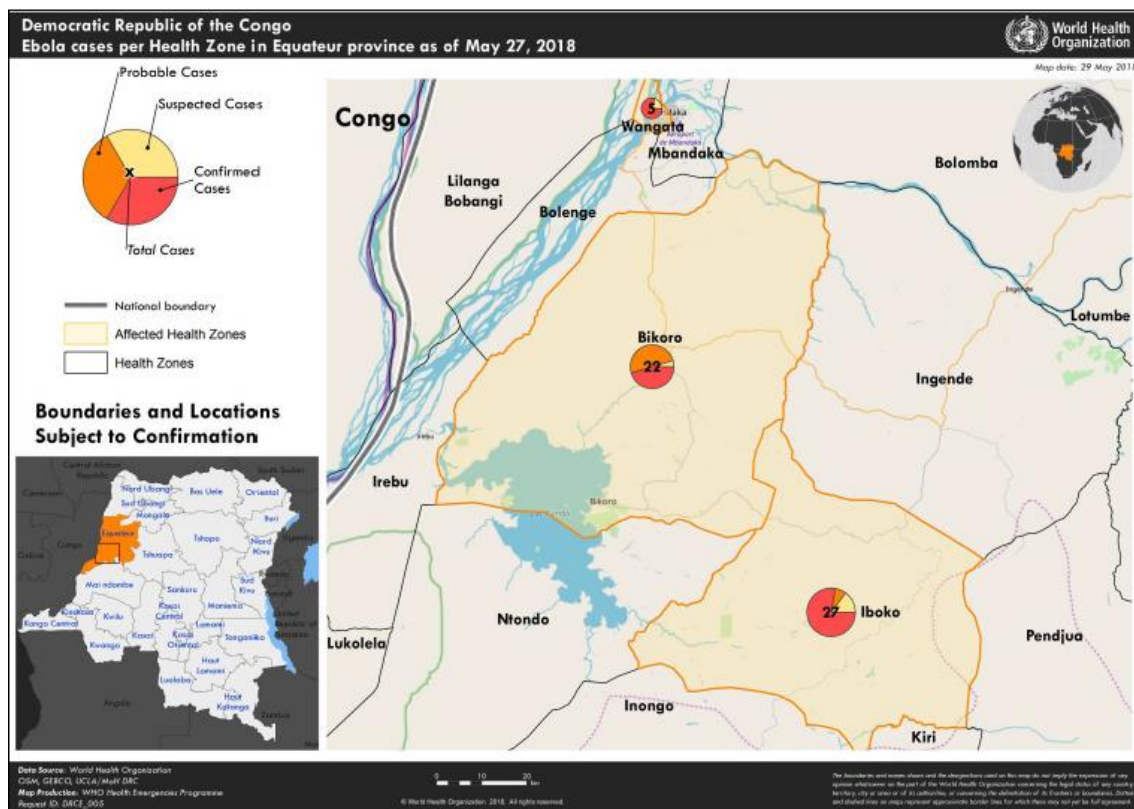


Figure 1: Geographical distribution of Ebola virus disease outbreak in the Democratic Republic of the Congo as of 27 May 2018.
Published in: External situation report 4, Ebola Virus Disease, Democratic Republic of Congo, WHO Regional Office for AFRO, 27 May

¹ WHO Disease Outbreak News. Ebola virus disease – Democratic Republic of the Congo. 14 May 2018

For updates on the outbreak, please refer to the latest information and documents:

- Situation reports (<http://www.who.int/ebola/situation-reports/drc-2018/en/>)
- Disease outbreak news (<http://www.who.int/csr/don/archive/disease/ebola/en/>)
- Key technical information (<http://www.who.int/ebola/publications/en/>)

2. The context

Risk communication and community engagement need to be highly contextualized in order to be effective. This section outlines a non-exhaustive description of key sociocultural and economic issues and information currently available regarding the affected areas.

Location

Ebola was first discovered near the Ebola River in the Democratic Republic of the Congo and this is the 9th outbreak.

The affected area for the current outbreak is Bikoro health zone which is 250 km from Mbandaka capital in an area of the country that is very hard to reach within Equateur Province. Equateur Province is on the shores of Lake Tumba in the north-western part of the country near the Republic of the Congo. The province of Equateur covers an area of 130 442 sq. km and has an estimated population of 2 543 936 people, 16 health zones and 284 health centres.

The affected health area of Bikoro covers 1075 sq. km and has a population of 163 065 inhabitants. It has three hospitals and 19 health centres, many of which have limited functionality. Medical supplies are often provided by international agencies and stockouts are common. Cases have also come from the nearby village of Ikoko-Ipenge which is located 45 km from the central office of the Bikoro area. Additional logistical challenges to access this village include limited accessibility by road and no telephone network coverage. Wangata health zone is adjacent to the provincial port city of Mbandaka (population 1.2 million).

Bikoro is a tropical area that lies to the south of the provincial capital of Mbandaka. It borders the Congo River in the west. Lake Ntomba (765 sq. km) which is an important fishery area is also located in this area. This area hosts one of the largest wetlands, forests, and marshlands in the world. It is also home to the endangered red colobus monkey and the red-tailed monkey. Other animals in the area include hippopotamus, crocodiles and elephants. Large portions of the land area suffered from uncontrolled timber extraction and there have been several initiatives by the government and NGOs to resolve land dispute issues. The inhabitants of the territory are accustomed to eating fish from the lake and fry (mipesu), the pondu, the chikwange (ntuka, ingwele) and the palm nut (mosaka).

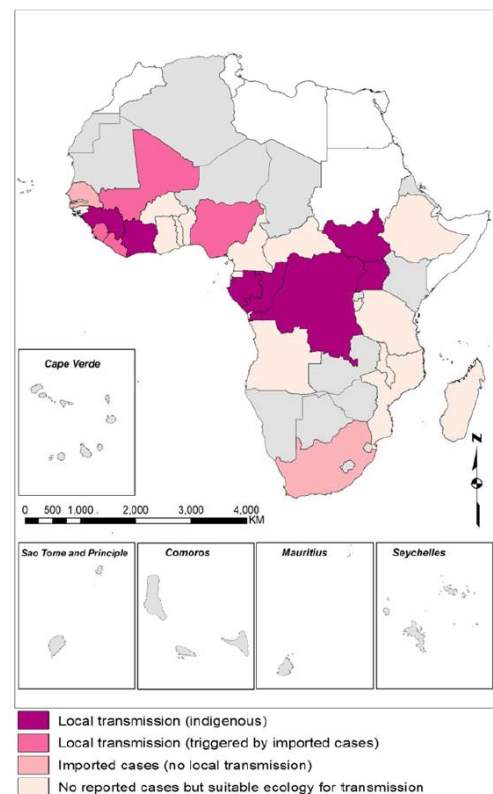


Figure 2: Ebola virus ecological zones (combination of reported cases and potential risk based on environment that may support habitation by the African fruit bat).
Published in: Mapping the Risk and Distribution of Epidemics in the WHO African Region, A Technical Report. WHO Regional Office for Africa. March 2016.

Population groups

Ethnic groups that live in the area, in which pygmies are scattered, include:

- The Ntomba (45%)
- The Ekonda (30%)
- The Ngele-a-ntando (15%)
- Pygmies (approx. 10%), however this may be underreported due to discrimination of pygmies.

Major ethnic groups

- The Bantu: Includes different tribal groups such as Mongo (the second-largest ethnic group in DRC and highly influential), Ntomba, Ekonda and other migrant groups.
- Batwa Pygmies (also called Twa/Cwa): The blanket term “pygmy” hides a wide cultural and ecological diversity. Pygmies are a varied and diverse group, are not all hunter-gatherers, few still live in forests, and express diverse social identities and ethnic affiliations.

Language

The primary spoken language in the area is Lingala (90%). Other languages also spoken in the area include Lontomba, Ekonda and Lomongo.

Access to health services

- State services (health, education, water supply) are extremely limited.
- Majority of the population is entirely dependent on traditional medicine consisting of herbal and animal remedies (including porcupine which is believed to prevent illness).

Vulnerable groups

Subordination of marginal groups, including pygmies, women and migrants, is reinforced by forestry laws and lack of access to education opportunities, which undermine their ability to influence those in power.

Batwa Pygmies

- Marginalized, typically poor, illiterate and with limited access to basic services. Often mistreated and considered to be of a lower class and generally hold a socially subordinate position to the Bantu.
- The cost of health care often obstructs this group from getting access.
- Limited rights to land and forest.
- Paid less than Bantus for performing the same work.
- Many Pygmies speak Bantu languages.
- Reportedly are received in wards separate from wards treating the Bantu population.
- Game hunters hunt on behalf of village “patrons;” one part of the game is sold at market for the benefit of the hunter.

Women and children

- Kinship systems within the tribes of the forest region, including in Bikoro, remain patrilineal. Men hold the authority and power.
- Identity and wealth status are linked to power and citizenship in Bikoro, especially benefitting Mongo men.
- Bantu men may marry Twa women, whereas Twa men cannot marry Bantu women.
- According to Bantu custom, women have to take care of the body preparation and funerals of deceased women.
- Widows (also widowers) need to be “cleansed” by the in-laws, who must keep them for a certain period during which they can neither wash themselves nor speak and may be unable to take sick children or family members to the treatment centres.
- Nearly half (48%) of the pygmy population is under 15 years old, according to a 2015 survey across five villages in Bikoro (Moheli, Iyanda, Ebale Mbonge, Iyembe and Mpenda).

Burial practices

- Congolese burial practices vary across ethnic groups but generally involve close and intimate bodily contact.
- When someone dies, small gifts are placed around the corpse so the person will have these items when he or she enters the spirit world.
- Batwa custom:
 - Bury the dead in a hut after digging a small hole and wrapping the corpse in grass.
 - Ceremony involves cleansing the corpse with herbs.
 - Burial ceremony is led by elders and all family members are encouraged to drink herbal extracts to prevent death from claiming them.
 - There may be no outward signs of mourning except for widows.
- Bantu custom:
 - Women have to take care of the body preparation and funerals of deceased women.
 - There may be differences in how people are buried according to gender (e.g. men are buried facing east and women facing west).
- Transporting remains of deceased persons back to their home villages has been documented between Mbandaka and Bikoro by road and motorized boat.
- In the 2014 Boende outbreak (which shared affected ethnic groups with Bikoro and Mbandaka), families were distressed by not being able to accompany the deceased who were taken by burial teams.
- Relatives suspected burial teams to have had taken some body parts before burial – this is related to a belief that body parts can be removed and used to cast spells on living individuals.
- Widows or widowers may need to be “cleansed” by the in-laws which may involve: keeping the widow/widower for a certain period, being unable to wash themselves or speak to other persons and having one’s head shaved.
- In Isiro, burial instructions and limitations on the number of people allowed to see the dead led to rumours that the corpses had been taken for cannibalism/sorcery.

Food consumption

- Primate meat is an important part of the local diet and is believed to bestow powers on those who consume it.
- Primate bones and dander are used in preventive and curative traditional medical treatments.
- In 2014, the director general of the National Institute of Biomedical Research of DRC advised that it was not necessary to cease consumption of bushmeat, rather to avoid animals found dead in the forest – whether monkey, chimpanzee, antelope, porcupine, etc. – and to not touch any animal with an unknown cause of death.

Economy

Agriculture is the most practiced activity in the territory. It occupies a large majority of the labour force and contributes to households' food coverage and provides them with income. Livestock is a negligible source for the population, with some species raised like cattle, goats, hogs and pigs. The main food crop for the territory, which is exported to Kinshasa and other areas, includes cassava, corn, plantains, paddy rice, peanuts and palm oil.

Accessibility

The territory is crossed by the national road n ° 8 connecting Mbandaka. Lake Ntumba also offers access to the territory through the Congo River. The primary modes of population movement are by road and river. Travel by air is possible from Mbandaka, approximately 8 km from Bikoro.

Communication networks: The main communication network operators in the area are Airtel, Orange, Tigo, and Vodacom. Internet signals operate in low speed.

3. The response in DRC

The first multidisciplinary team comprised of experts from WHO, Médecins Sans Frontières and the Provincial Division of Health travelled on 8 May to Bikoro to strengthen coordination and investigations. WHO is working closely with the Government of DRC to rapidly scale up its operations and mobilize health partners using the model of a successful response to a previous EVD outbreak in DRC in 2017.

The objectives of the outbreak response are to reduce mortality and morbidity caused by EVD, prevent the spread of the outbreak within affected areas of Equateur province, and prevent the spread of the outbreak to other provinces of the country as well as neighbouring countries.

WHO recommends the implementation of proven strategies for the prevention and control of Ebola outbreaks and has strengthened coordination across major response interventions:



Response coordination

Multi-level partner coordination is essential to an effective outbreak response. EVD outbreaks are particularly complex as they require holistic and multi-sectoral approaches to contain disease spread, minimize adverse impacts on affected communities, and optimize the strengths and resources of all international and local partners.

Laboratory capabilities

Strengthening diagnostic capacity improves the effectiveness of surveillance and epidemiological investigations. Additionally, timely confirmation of a diagnosis and subsequent access to treatment can help build trust between health-care workers and the affected communities.

Surveillance, active case finding, contact tracing and case investigation

Rapid detection of cases, identification of contacts and case investigation are essential to understanding the extent of the outbreak, informing intervention strategies, and preventing mortality and suffering.

Strengthening case management and health staff capacities

As EVD outbreaks are recurrent in the Democratic Republic of the Congo, it is imperative to build and sustain the capacities of the health workforce and health facilities to provide care for EVD-infected patients. Access to high-quality medical care early in the infective period can reduce mortality and morbidity.



Infection prevention and control in health facilities and communities

Infection prevention and control (IPC) measures maintained in communities and health facilities help to prevent the spread of EVD. Training on proper IPC practices and adequate supply of IPC materials are essential to effective disease prevention.

Risk communication, social mobilization and community engagement

Community and person-centred interventions that are specific to the local context are the key to ensuring that risk reduction practices are effectively adopted. Risk can also be mitigated by listening to community concerns, addressing local needs and empowering the population to prevent transmission.

Mental health and psychosocial support

EVD-affected individuals and their families may experience fear, anxiety, stress or stigma from their community. Additionally, IPC precautions can at times lead individuals to feel isolated and detached from their social networks. It is therefore important that psychosocial care is integrated into the response at the earliest stage.

Research response

Operational response research can provide a platform to rapidly generate knowledge on therapeutics, vaccines and sociocultural intelligence. When integrated into the outbreak response, research can support effective outbreak control through the rapid development and evaluation of social science approaches, diagnostics, clinical interventions and vaccines, such as the candidate Ebola rVSV vaccine.

Operational and programme support

The Equatorial region shares borders with the Republic of the Congo and the Central African Republic, with continuous movement of populations by land and through the Congo River; there is therefore a high risk of importation of EVD. The Bikoro Lake is directly connected to the Congo River, which also borders the north-west of Angola. Considering the risk of cross-border transmission of EVD, it is imperative that neighbouring countries enhance surveillance and increase readiness for early detection, investigation and response to potential cases of imported EVD.

Strengthening the capacity of health staff to respond to EVD outbreaks

With the recurrence of EVD outbreaks in the Democratic Republic of the Congo, it is important that the response to the ongoing outbreak also builds the capacity of health personnel in epidemiological surveillance, IPC and case management.

Operational readiness in neighbouring countries

Equateur province shares a border with the Republic of the Congo and is connected through travel by land, air, and river with multiple neighbouring countries within central Africa. Increased surveillance and readiness measures implemented in neighbouring countries are critical to preventing the importation of potential EVD cases internationally.

4. Readiness in neighbouring countries

Although the cases are reported from remote locations that are difficult to access, the proximity of the affected area to the Congo River, which links to the Republic of the Congo and the Central African Republic, increases the risk of cases occurring in neighbouring countries. WHO has commenced preparations to conduct EVD preparedness and readiness activities in neighbouring countries, namely Angola, Burundi, Central African Republic, Republic of the Congo, Rwanda, South Sudan, Tanzania, Uganda and Zambia. This includes sensitization of stakeholders on EVD preparedness, an assessment of country capacities and gaps, identification of priority activities, and potential resources for strengthening country preparedness and readiness for EVD. WHO continues to monitor travel and trade measures in relation to this event.²

² External situation report 1, Ebola Virus Disease, Democratic Republic of Congo, WHO Regional Office for AFRO, 11 May 2018.

III. WHAT YOU NEED TO KNOW ABOUT RCCE ISSUES IN THIS EBOLA OUTBREAK

1. The role of RCCE in the established package of interventions

Risk communication and community engagement are essential for any disease outbreak response. This is particularly critical during outbreaks of EVD which may create fear in the public and frontline responders alike due to severe presentation of symptoms, misunderstanding of the causes of illness and high fatality rates. This was a key lesson learned during the Ebola outbreak in West Africa in 2014, which, in many ways, has transformed the way in which epidemic and pandemic diseases and other health emergencies are viewed and responded to both at the national and international levels, and redefined the thinking on global health security issues.

Why is RCCE work so important? The answer includes the following:



1. People have a right to be informed and understand the health risks they face, in addition to receiving practical advice on how to protect themselves and their loved ones.
2. The perception of risk in affected and at-risk populations often differs from that of experts and authorities – effective RCCE can help bridge that gap by determining what people know, feel and do related to Ebola, as well as what they ought to know and do to bring the outbreak under control.
3. Effective RCCE helps transform and deliver complex scientific knowledge which is understood by, accessible to, and trusted by populations and communities.
4. Effective RCCE uses community engagement strategies to involve communities in the response and develops acceptable yet effective interventions to stop further amplification of the outbreak and for individual and group protective measures.
5. RCCE is essential for surveillance, case reporting, contact tracing, safe and dignified burials, caring for the sick and clinical care, ring vaccination and compassionate use of the investigational Ebola vaccine, gathering local support for the logistic and operational needs of the response, providing support for survivors and their reintegration into their communities, and much more.
6. RCCE helps build trust in the response and increases the probability that health advice is followed. It minimizes and manages false rumours and misinformation that undermine the response and may lead to further disease spread.

2. Setting a baseline for RCCE work

Like any public health intervention, RCCE requires baseline information to implement evidence-based activities. This includes finding out from existing information sources (e.g. recent surveys, research studies, policy documents, etc.) everything about the area in which the outbreak occurs and any social, cultural and economic data that can inform potential risk factors for infection, how the disease might spread or how the response could be implemented. Some of the key information that could provide insight into the current or potential outbreak and response are in domains that include:

1. population numbers, ethnicity, religion, education level, local languages, economic activity, climate and terrain;
2. health services data, health facilities and their capacities, health workforce, access to health care services, immunization coverage, existing causes of mortality and morbidity;
3. transport, roads and other infrastructure, remoteness and access to main transport routes, hubs, sources of power, water sanitation, waste management;
4. preferred communication: formal and informal networks, providers, mobile phone and internet access, preferred and trusted sources of information (use of radio, TV, newspapers, traditional methods such as town criers, road shows and street drama via religious or community leaders);
5. identification of key influencers of behaviour for different groups in the community; and
6. specific “risk behaviours” for the spread of Ebola: resources for frequent handwashing, traditional funeral practices that increase exposure to infection, health seeking and giving behaviours, migration and travel, special beliefs and cultural practices, use of traditional healers for treatment.

This information needs to be gathered and analysed to inform response interventions. Where knowledge is outdated or absent, social science approaches should be used, such as running a mini Knowledge, Attitudes and Practice survey (KAP), to obtain the insights required for strategic and targeted RCCE based on specific change objectives.



Areas of specific relevance to an Ebola outbreak include:

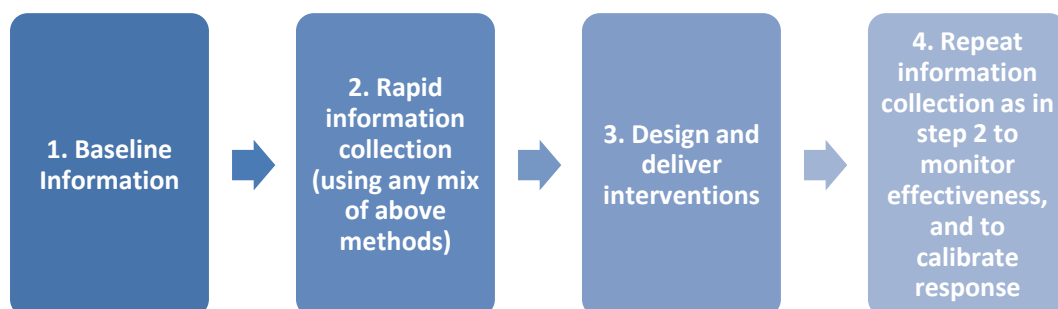
- What do people know and believe about the disease, its cause, and its prevention/treatment/cure?
- How does the community see illness and death – what is their health belief model?
- What actions are they engaged in that increase their risk of exposure to the disease?
- How do people in the affected areas take care of the sick? Whose help do they seek when they are sick? Traditional healer/community worker/hospital?
- How does the community view how care is provided in hospitals and health facilities? Are hospitals or other health facilities trusted?
- How are burials and funerals conducted?
- What are the power dynamics in the community?
- Whom does the community trust for information and advice?
- What is their preferred medium of communication/oral, written, visual?
- How do they view vaccination?

There are several approaches to gain insights into concerns, stigma, fears and beliefs, and their knowledge levels and practices:

- ✓ KAP surveys and mini KAP surveys (used in emergencies)
- ✓ Focus group discussions
- ✓ Community walk-throughs
- ✓ Key informant interviews
- ✓ Social media monitoring
- ✓ Media monitoring
- ✓ Community-based surveys on risk exposures, behaviours and practices

In emergencies such as an Ebola outbreak, we use a mix of these methods to get the best possible information under difficult circumstances. The main objective is to do as much analysis as possible in order to develop targeted interventions for key at-risk populations.

This kind of information gathering should be dynamic and repeated throughout the outbreak. Social science experts, community engagement personnel and volunteers, and the use of social science approaches are essential for this stage.



3. Target audiences

RCCE work for the current Ebola outbreak can be particular to two key populations:

- a. Populations in affected health zones:
 1. Hospital personnel and community health care providers
 2. Paramedical staff
 3. Drivers and transportation volunteers (ambulances, taxis, buses, boats, motorbikes and other means of transport)
 4. Personnel in pharmacies and dispensaries
 5. The nearly half-a-million resident population (Ntomba 45%; Ekonda 30%; Ngele-a-ntando 15%; Pygmies 10%) – 90% of whom speak Lingala
 6. People who are sick, and their families and contacts
 7. Contacts of those who have already died and are suspected to have contracted Ebola
 8. People who have come into contact with dead bodies – funeral service providers, families, mourners
 9. Volunteers and frontline response teams, local and international agencies and organizations already on the ground or travelling there
 10. Traditional healers, and religious and community leaders
 11. Schools, administrators, teachers and personnel
- b. Neighbouring countries:
 1. Resident and visiting populations
 2. Medical and paramedical personnel in hospitals, health centres
 3. Frontline health care workers, midwives, traditional birth attendants
 4. Personnel from pharmacies and dispensaries
 5. Traditional healers, and religious and community leaders
 6. People who transport others – taxis, buses, airplanes, boats, ambulances, etc.
 7. People involved in managing dead bodies, organizing funerals, mourners
 8. Volunteers and response teams
 9. Decision-makers – Ministry of Health (MoH) and in all relevant sectors
 10. People involved in managing cross-border travel, airports, ports, land crossings, etc.
 11. All relevant response stakeholders (government, civil society, NGOs, international organizations already in the country)
 12. Others



Communication and engagement strategies must be tailored for each target group. Generic messages – except at a very broad awareness-raising level – are unlikely to be effective and can lead to detrimental results. For example, the use of “Ebola kills” messages extensively and for prolonged periods during the West Africa Ebola outbreak of 2014 in hindsight was found by several different and independent studies to have influenced adverse behaviours, such as the refusal of families to bring people sick with Ebola-like symptoms for proper clinical care and the continued secret practice of traditional funeral ceremonies ignoring health advice, thus exposing hundreds of people at a time to the deadly virus.

For each audience, a message map is needed for every strategic communication and/or behaviour change outcome that is desirable. See the sections below on developing strategic objectives and message maps for each target audience.

The most common questions people ask in disease outbreaks

Regardless of audience, everyone wants to know three things during an emergency:

1. **The event:** What has happened? How bad is it? Who is affected? Who is responsible? What do you know for certain?
2. **The risk:** Is this dangerous? Are my loved ones and I at risk? Who is most affected? What increases and decreases my risk?
3. **The action:** What can be done to prevent getting sick? What is being done? What can I do to protect myself and my loved ones? What should I do if I or a family member is sick? Who will take care of me or my family member if he/she becomes sick?

4. Risky behaviours and setting behaviour or practice change objectives

Identifying and addressing risky behaviours related to a particular infectious hazard (Ebola virus in this case) is central to using risk communication as a public health intervention.

The main risks of infection arise due to the following common methods of exposure and behaviours:

- ☒ contact with bodily fluids (blood, urine, vomitus, stools, sperm, etc.) of a person infected with and showing signs and symptoms of Ebola in everyday life;
- ☒ contact or exposure to the bodily fluids of an infected person while a person is showing signs and symptoms of Ebola, during clinical care, while taking samples for laboratory diagnosis or while handling infected samples in laboratories, ambulances and hospital reception sites;
- ☒ handling personal items used by a patient or someone who has been infected, and during cleaning of treatment centres, hospitals, vehicles, places of work and homes of Ebola-infected persons;
- ☒ participating in traditional “unsafe” funerals and rituals when rituals involve touching body fluids of the deceased conducted for a person who has died from Ebola; and
- ☒ not observing safe sex (ie. through correct and consistent condom use and hygiene) with a male survivor for 12 months from onset of symptoms or before their semen has twice tested negative.



Therefore, specific behaviour changes are needed to bring an Ebola outbreak under control. Changes in behaviour may need to be adopted long-term (e.g. proper handwashing, safe clinical practice, safe sex practices, etc.) while some are temporary behaviour changes that should be adopted during the outbreak (e.g. funeral practices, visiting crowded places, etc.)

In addition, to control the spread of EVD, other actions are needed. Some of the most common include:

- ✓ reporting to health authorities or health units if you or someone in your care/household has symptoms of Ebola;
- ✓ reporting contact with anyone who has been diagnosed as or suspected as having Ebola;
- ✓ agreeing to provide samples for laboratory diagnoses;
- ✓ advising and/ or taking those with symptoms to go to Ebola treatment units safely;
- ✓ adhering to safe and dignified funerals during the outbreak;
- ✓ practicing safer sex and hygiene for an advised period of time after recovering from Ebola;
- ✓ not stigmatizing people who have survived Ebola;
- ✓ consenting to receive the investigational Ebola vaccine, if so advised; and
- ✓ mobilizing one's community to adhere to health advice to prevent and protect from Ebola.



In order for behaviour or practice change to be adopted, a specific and targeted change objective has to be articulated with a strategy developed together with the community to ensure its implementation. If not, interventions will not be adopted, advice will not be heeded, and “community resistance” and even violence may erupt, in addition to the further amplification of the disease.

5. Message maps for each change objective

Message maps, not messages, are more useful in disease outbreaks and emergencies. Here is the basic template. Once filled in for each change objective (to change knowledge, attitudes or practices), the map can be used for developing any communication and engagement product or process – from talking points for the media, to developing one or more Information, Education and Communication (IEC) materials, or for effective conversations in the community or with just one person or family.

Change objective: Change domain: Knowledge/Attitude/Skill: Select 1, 2 or all 3 Target audience: General population of affected/at-risk areas Date: XX/XX/XXXX (state this clearly as the message map will change with time as an outbreak evolves)		
Message 1	Message 2	Message 3
✓ Sub point	✓ Sub point	✓ Sub point
✓ E.g. Fact	✓ E.g. What does this mean?	✓ E.g. More information to elaborate on main message
✓ E.g. Example	✓ E.g. Why this is important	✓ E.g. How or a demonstration

Use the example below to develop the relevant message map:

Change objective: Describe how to prevent Ebola Change domain: Knowledge/Attitude/Skill: All 3 Target audience: General population in the affected community Date: XX/XX/XXXX		
Message 1: Ebola is infecting people in your community.	Message 2: Ebola spreads easily amongst people.	Message 3: We can protect ourselves and our loved ones from Ebola.
This disease has occurred in the country several times before, but this outbreak is new and serious.	Ebola is a dangerous disease which can kill one in two people who are infected. But knowing the symptoms and getting treatment early can increase your chances of survival.	Because Ebola is caused by a virus and spread by coming into contact with the bodily fluids of someone who is infected or someone who has died from Ebola, there are things we can do to protect ourselves.
XXX people are sick and XX have died. Many more could be sick, and people who travel from here to other places can carry the disease to other villages and countries.	The Ebola virus spreads from person to person through the bodily fluids (urine, stools, blood, vomitus, sperm) of infected persons. If a person does not have the symptoms of Ebola (XXXXX), they are not able to pass the disease to you.	The best ways of protecting ourselves include: Always washing our hands (as advised) with soap and water, and frequently. Being alert to notice the symptoms of Ebola early on (explain symptoms) and calling the hotline or going to the Ebola Treatment Unit. Not participating in traditional funerals and encouraging everyone to adopt the safe and dignified funeral practices.
The government is mounting a response with our national and international partners. That's why you will see us in the community to bring this deadly disease under control.	Everyone is at risk of getting Ebola during an outbreak. But the most likely ways of getting infected with Ebola occur when you have close contact with or provide care to someone who is infected with Ebola, or by handling the body of someone who has died from Ebola.	We now have a vaccine that has been used with good effects in the African context to protect from the deadly disease. Please take the vaccine if you are asked to do so. If you have been in contact with someone else who is suspected of having Ebola, health workers will want to make sure that you have not contracted the disease, and if you have, provide you with the best treatment possible.

	<p>You must be especially careful in these instances and follow the advice you are given.</p>	<p>Please cooperate with them. They will want to know how you are feeling, will ask you to stay at home and will be in contact with you for 21 days.</p> <p>Please call the hotline if you have any questions.</p>
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6. Implementing RCCE

RCCE is a core stream of work in the Ebola outbreak response. It is often called community engagement, social mobilization or risk communication. Whatever it is called, RCCE work must be implemented under the leadership of the government response, and in close collaboration with partners, NGOs, civil society and communities themselves.

Setting change objectives, using baseline and new social science and public health data and information, and developing strategies, approaches, interventions and products allows RCCE to be implemented effectively and be measured against key performance indicators. It is essential that the knowledge generated from RCCE work be integrated into the overall response to calibrate interventions over time.



For the implementation of RCCE during a disease outbreak, the following five domains must be covered and can be used as organizing principles:

- i. develop a strategy and plan for the RCCE response;
- ii. coordinate partners and all stakeholders;
- iii. provide effective public communications (that reach the target audiences, follow language and communication preferences (oral, written, etc), and use trusted channels and interlocutors);
- iv. engage with communities and establish two-way dialogue by listening to community concerns, receiving feedback about the response operations, and continually refining the response across all pillars according to community needs; and
- v. monitor and proactively address misinformation and rumours.

The implementation of RCCE in an outbreak response requires the training and preparation of large numbers of volunteers and working within multidisciplinary teams. Annex II provides a checklist for RCCE considerations in all pillars of the response, from surveillance and contact tracing to clinical care and safe and dignified burials.

7. Coordinating partners

Coordination among partners and stakeholders is essential for a coherent and consistent RCCE response. Coordination must occur at the national level as well as the provincial/regional/local levels and between them. For effective coordination, leadership, membership, decision-making, lines of communication and command, etc., have to be clarified and fit into the overall response.

8. Managing misinformation and rumours

Ebola outbreaks have been associated with misinformation and false rumours. In the context of RCCE, rumours refer to unsubstantiated information, claims or beliefs about what is causing the disease or how it can be treated/cured. If not proactively addressed in culturally appropriate ways, misinformation and rumours can lead to the further rapid spread of the disease and unnecessary deaths, severe disease, suffering, and societal and economic loss.



There are many ways to track and manage rumours and misinformation. These include but are not limited to:

- ✓ media and social media monitoring
- ✓ tracking community radio conversations
- ✓ hotlines
- ✓ feedback from operational partners and frontline responders and volunteers
- ✓ data from surveys and focus group discussions.

In Annex III, you can find a tool for tracking and managing rumours and misinformation.

9. Tips for community engagement

- ✓ Use existing and trusted community engagement networks and interlocutors – brief them, train them, bring them on board and work through them.
- ✓ Have the capacity to work in the local language and dialect of the community.
- ✓ Observe good practice for entry and exit from the community.
- ✓ Always get advice and follow the instructions of security experts and use your own situational awareness skills to stay safe.
- ✓ Ask about and be cognizant of hierarchies and dynamics within the community.
- ✓ Know the spectrum of engagement activities. Do not stop at inform. Move towards consult and co-decision-making.

- ✓ Provide feedback to the community and be honest about uncertainty.
- ✓ Don't over-reassure or overpromise.

The table below summarizes the continuum of community engagement:

	Inform	Consult	Involve	Collaborate	Empower
Public participation goal	Balanced and objective information – understand problem, alternatives, opportunity, solution	Public feedback on analysis, alternatives and/or decisions	Work with the public to ensure that public concerns are consistently understood and considered	Partner with the public in decision-making, develop alternatives, identify preferred solutions	Decision-making in the halls of the public
Promise to the public	Keep them informed	Inform, listen, acknowledge concerns, provide feedback	Concerns and aspirations directly reflected. Alternatives developed and feedback provided on how public influenced decision	Actively look for advice and innovation in forming solution. Incorporate your advice into their decision	We will implement what you decide
Example techniques	Fact sheet Website Radio TV	Focus group Public meeting Survey	Workshop Deliberative polling	Participatory decision-making Consensus building Citizen advisory group	Delegated decision

10. How to communicate during health emergencies

To build trust, which is the basic currency of risk communication, RCCE interventions should be linked to functioning and accessible services, be transparent, timely and easy to understand, acknowledge uncertainty, address affected populations, link to self-efficacy, and be disseminated using multiple platforms, methods and channels.³

WHO's Guideline on Communicating Risk During Public Health Emergencies highlights that there are several factors, including messages and actions of response agencies and teams, that could lead to a higher level of trust, especially:

- ✓ acknowledging uncertainty in messages, including forecasts and warnings;
- ✓ being transparent and not concealing negative information, such as rates of casualties;
- ✓ speedily disseminating information and intervening;
- ✓ creating scientific communication in an easy-to-understand manner;
- ✓ seeking input from the public and encouraging a dialogue;

³ Communicating Risk in Public Health Emergencies: A WHO Guideline for Emergency Risk Communication (ERC) policy and practice.WHO.10 January 2018.

- ✓ ensuring coordination between different health authorities and the media along with a uniform message;
- ✓ avoiding rapid changes in information and preventing the dissemination of conflicting information from different agencies; and
- ✓ disseminating information through multiple platforms.

There is evidence that communication by authorities to the public should include explicit information about uncertainties associated with risks, events and interventions, and indicate what is known and not known at a given time.

All communication with and communication products for affected communities and stakeholders must be adapted to their:

- ✓ levels of education
- ✓ languages or dialects of their choice
- ✓ preferred means of communication (e.g. oral, written, visual, etc.)
- ✓ trusted channels and interlocutors.

They also must be tested before use and prior to mass production.

11. Humanizing the response

It is important to reflect on the impact you and your team have on the response. If you are already from the community, you have to be cognizant of pre-existing perceptions about you, your credibility and your trustworthiness in the eyes of the community. If you are from another country or region, think about how you are perceived. Volunteers and personnel who work in community engagement are often the “gate openers” for the rest of the response.

The impression you make, the tone you set and the respect you inspire will affect the entire response.

From past responses to Ebola virus disease outbreaks, we have learned many lessons. One of the biggest lessons is that we must “humanize” the response.

This means we should:

- ✓ use existing trusted interlocutors when we seek entry into a community;
- ✓ be dressed in a non-threatening manner that makes the community comfortable (e.g. never make the first entry into a community in full PPE);
- ✓ make introductions face to face and be aware of positive body language that shows we care about the community and preventing avoidable deaths and suffering;
- ✓ use language that the community can connect with;
- ✓ be mindful to use common terms and phrases, not technical jargon:
 - use “sick people” instead of “cases”
 - use “people who have died from Ebola” instead of “deaths”

- use “people who may have Ebola” instead of “suspects;”
- ✓ show respect when dealing with people, living or dead; pay special attention to observing respectful practices when removing the corpses of people who have died from ebola;
- ✓ be empathetic and take time to reflect on how the community views us, the response and the disease itself;
- ✓ acknowledge people’s fears and suffering;
- ✓ listen before we talk; and
- ✓ not contradict people’s explanations, beliefs and perceptions; instead, create conversations to contextualize health messages according to local beliefs so that we can use culturally acceptable explanations to achieve public health outcomes.
- ✓ never make promises that may not be kept, ensure you act by your words and keep promises (including being on time, providing support as expected, etc.).
- ✓ consider that an individual other than yourself may be better placed to engage with the community (e.g. an older individual, a female instead of a male, etc.)

Regardless of your good intentions, people can have founded or unfounded perceptions about you. Be patient and stay calm. Seek the support of your community interlocutors to prepare and support you.

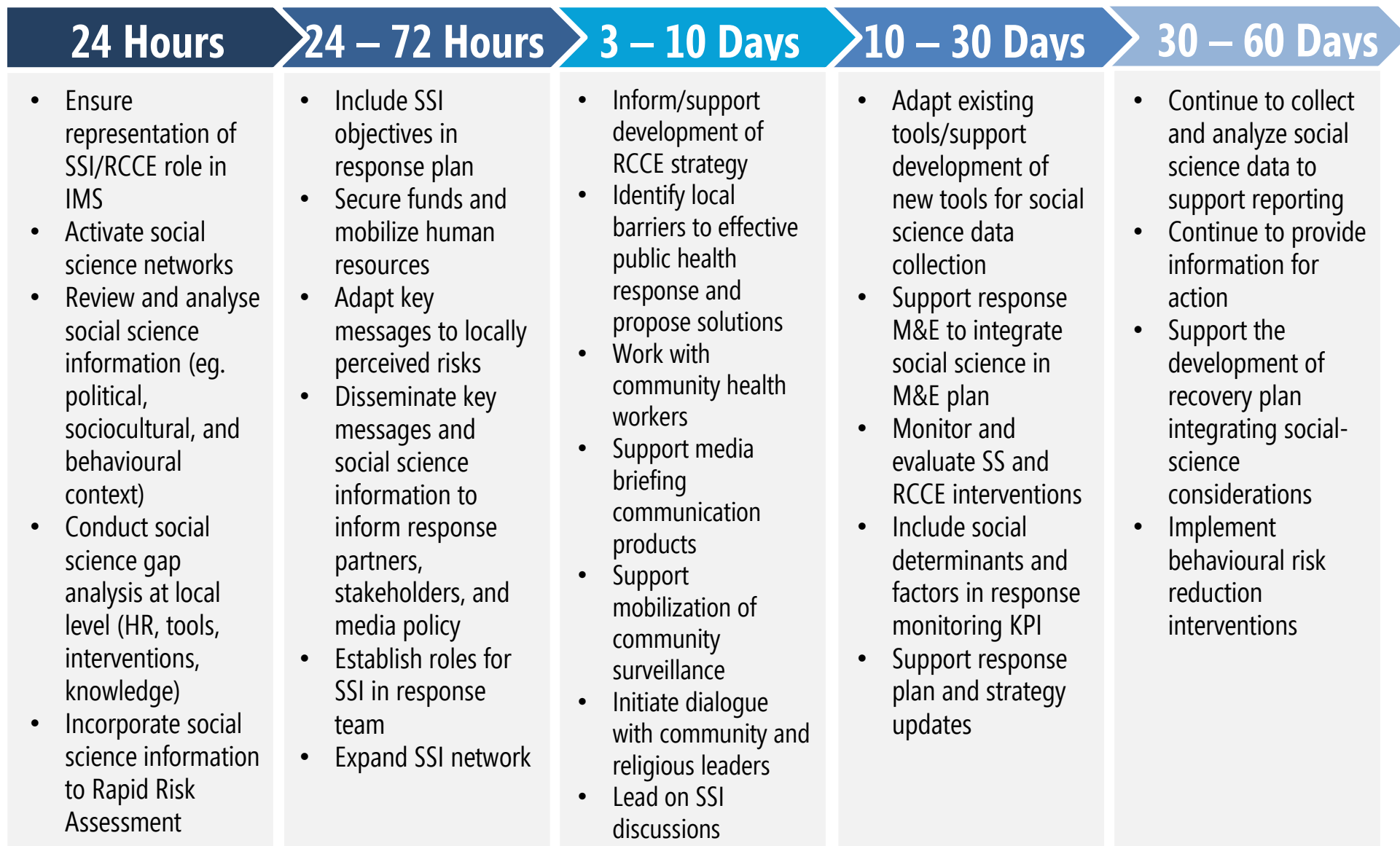
12. Role of social scientists and social science interventions in the response

The importance of social scientists and social science interventions (SSI) is increasingly being recognized as essential for the entire response but has particular relevance for RCCE work.

Multidisciplinary social science tools and methodologies are useful for many response needs such as:

- ✓ understanding and addressing socioeconomic, political and behavioural risks;
- ✓ creating systematic, evidence-based approaches for RCCE and locally appropriate public health response measures;
- ✓ prioritizing local cultures, risk perceptions, behaviours and needs throughout the emergency management cycle;
- ✓ implementing participatory approaches to consider population beliefs, cultures, religions, norms and values;
- ✓ recognizing the importance of local context in a health emergency;
- ✓ improving emergency response effectiveness and adaptation to local context;
- ✓ addressing social factors (e.g. cultures, norms, beliefs, attitudes) as integral parts of public health response;
- ✓ mitigating impacts of social, economic and political risks; and
- ✓ promoting positive health behaviours.

The cross-cutting work of SSI promotes collaboration and connects different actors and stakeholders throughout critical time periods of the response.



ANNEX I. RESOURCES AND INFORMATION SOURCES

1. OpenWHO

Ebola knowledge and training resources for responders

English: <https://openwho.org/courses/knowledge-resources-ebola>

French: <https://openwho.org/courses/ressources-connaissances-ebola>

2. Website

Technical information for the Ebola event in DRC is available on the WHO website (English version):

<http://www.who.int/csr/resources/publications/ebola/en/>

Key technical documents are consolidated into a one-pager with links to the documents:

<http://www.who.int/ebola/publications/key-technical-documents/en/>

The main Ebola webpage has the latest up-to-date information: <http://www.who.int/ebola/en/>

Fact sheet: <http://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease>

Vaccine Q&A: http://www.who.int/medicines/ebola-treatment/q_a_vaccine_trial_guinea/en/

Ebola Q&A: <http://www.who.int/csr/disease/ebola/faq-ebola/en/>

3. Partner resources

Social Science in Humanitarian Action: <http://www.socialscienceinaction.org/>

Ebola Response Anthropology Platform: <http://www.ebola-anthropology.net/>

To join the global coordination calls for risk communication and community engagement (RCCE) for the ongoing Ebola response in DRC, contact riskcommunication@who.int.

ANNEX II. KEY RCCE CONSIDERATIONS FOR OUTBREAK RESPONSE PILLARS

Leadership and response coordination

- Align risk communication and community engagement interventions across different components of the EVD outbreak response pillars.
- Ensure response teams are informed on the key cultural and social considerations, as outlined in this document. Request that social scientists and risk communication officers review strategies and continually adapt them to the local context.
- Consider the context and implications of all response interventions on vulnerable populations – advise response pillar leads when actions may lead to increased stigmatization, potentially negative reactions from the community or fear.
- Be mindful that a proportionate effort to support the health system is maintained to address other health issues during the outbreak response period.
- Consider impacts of remuneration for health-care workers, volunteers and response staff – consider staff payments with fairness as appropriate across agencies.
- Ensure supervisors are informed of fair staff management plans (e.g. payments, compensatory time off, psychosocial support, etc.), especially when hiring from local community workers.

Case management, IPC, and specimen collection

In the community or at the treatment centre...

- Do not wear full PPE in the community, except while intervening with a patient or for decontamination. It may be difficult to establish trust with sick patients and/or family members when wearing PPE. Make sure to speak to patients in a tone that is customary for providing comfort and building trust when speaking to family or community members.
- While wearing PPE identify yourself to the patient and family verbally or visually for example – by stating your name, using a name tag, taping a picture of yourself, etc.
- Ensure appropriate information is provided to patients and their families on the importance of collecting samples, interpretation of laboratory test results, treatment, the care they will be provided with and isolation if this measure is necessary. Keep in mind that the majority of Batwa pygmies are entirely dependent on traditional medicine when ill – engage with traditional healers to explain patient care to individuals or family members if appropriate.
- Ensure regular and timely communication with and feedback to family, friends or other relations of patients who are admitted regarding their health status.
- Do not make promises regarding whether or not a family member will recover – this may lead to mistrust if the patient does not recover.
- Maintain fairness when providing treatment to patients. Due to marginalization of vulnerable populations, appearing to favour or disfavour a certain ethnic group over another may encourage social tensions and rumours.

- Keep in mind that different ethnic groups may be accustomed to or expect to receive different access to health services. For example, Batwa pygmies do not frequent rural health centres. Instead, they are received at the general referral hospital at Bikoro. At the Bikoro general hospital, pygmy patients may be received in wards separate from those of Bantu patients.
- Make considerations for family or community members who are admitted to ensure they can receive information or interact with their admitted members as per appropriate IPC protocols.
- If a patient dies, be sure to inform the family as soon as possible. This information may need to be relayed through a trusted family member, traditional healer or community representative in a manner that respects local customs of death and grieving. Delays in communication may lead to mistrust or rumours linking treatment centres to death, which can prevent people from seeking help.
- Store body bags in an appropriate location. During a previous outbreak in Boende, the presence of body bags kept communities away from health care centres as the presence of body bags meant death was inevitable.

When collecting specimens...

- Consider the cultural or social context during specimen collection, especially when collecting bodily fluids or samples from deceased persons. Women from the community may need to be engaged in the burial process when a female family member has died.
- Ensure patients are provided with clear, appropriate and timely information regarding the collection of samples and the testing process.
- If collecting patient specimens in the community, make sure to provide clear and appropriate information to family or community members on the specimen collection process to reduce fears. Ethnic groups in the affected area maintain beliefs that certain body parts of the deceased can be removed to cast spells on living family members.
- Timely relay of test results to patients, clinicians, and family members is key to maintaining community trust.

Surveillance and contact tracing

- Engage the community members in the process and ask for their support to help with the situation. Identify cultural sensitivities that might arise when working in the community and discuss potential solutions with key members of the community.
- Consider hiring contact tracers and other volunteers from the local community. Be sure to pay careful attention to minimize marginalization of vulnerable groups and tensions between ethnic groups.
- Ensure the community and religious leaders and traditional healers are aware of contact tracing activities in their communities. Address community concerns, rumours and misperceptions.
- Explain clearly the reasons for contact tracing with contacts and the community. Appropriately communicate the specifics of contact follow-up, including timing and duration of follow-up, who will conduct follow-up visits or phone calls if relevant, when contacts can expect the follow-up period to be completed, and details about who can be contacted if they or a family member falls ill during or after the follow-up period.

- Remember that contacts are dealing with stress, fear and stigma – treat them with respect and try to understand the reasons behind their behaviours or reactions. If contacts refuse follow-up, work with trusted community or family members to clearly communicate the importance of contact tracing and address any concerns.
- Engage with psychosocial and social mobilization teams so that they can provide mental health and psychosocial support to the contact(s).
- Consider providing compensatory packages with food and basic items for contacts to support them during the 21 days follow-up period. Be sure to pay careful attention to minimize marginalization of vulnerable groups and tensions between ethnic groups.

Safe and dignified burials

- Ensure adequate, clear and timely communication with the community and community representatives around safe and dignified burial procedures.
- Discuss local burial practices with local faith and community leaders to understand specific needs for appropriate burial and grieving practices. Burials should be adapted to consider local customs in addition to following infection prevention protocols.
- Make sure to explain to family members the need for immediately conducting a safe and dignified burial – families who typically wait a certain period of days post death for mourning or until family inheritance is settled may not agree with the timing of the burials.
- Ask the family if there are any specific requests with regard to a dignified burial and follow the latest burial guidance and protocols. Ensure community leaders, elders and influential community members are engaged in the burial process according to local customs.
- Identify trusted family or community members, traditional healers, and faith and family representatives to participate in the burial rituals according to local custom.
- Plan logistics and burial supplies in accordance with local religion, customs and beliefs. Provide coffins or body bags as per local customs.
- Discuss alternatives with community members regarding accompanying deceased family members who are taken by burial teams. During the 2014 Boende outbreak (which shared affected ethnic groups with Bikoro and Mbandaka), families were distressed by not being able to accompany the deceased who were taken by burial teams.
- Give the family an opportunity to view the body and consider alternatives to body preparation practices (e.g. sprinkling water over the body, reading a scripture, placing the written scripture verse on the body before closing the casket or body bag, women involved in funerals of deceased women, differences in how people are buried according to gender such as men being buried facing east and women facing west).
- Make sure to provide access to psychosocial support services for safe and dignified burial teams. Ensure teams are managed fairly (e.g. through payments, compensatory time off, etc.).
- Verify that the grave is dug. If this is not the case, send selected people to dig the grave at the cemetery or at the area identified by the family. This site should be agreed upon by the local authorities and neighbours.
- Propose to one or two family members to witness the preparation activities of the body of the deceased patient on behalf of the other family members.

- Ask the family witness if there are any specific requests from the family or community, for example, about the personal effects of the deceased. The family should decide what to do with the personal effects of the deceased (burn, bury in the grave or disinfect).
- Allow the family witness, family members to take pictures of the preparation and burial. At the request of the family, the Burial team may take pictures on their behalf.
- Ask the family if they want to prepare a civil, cultural or religious item (e.g. identity plaque, cross, picture of deceased) for the identification of the grave.

Partner coordination

- Ensure that partners are updated on the activities across all relevant response pillars.
- Ensure that rumours, concerns and other issues from the community reported by partner agencies are addressed within the risk communication, social mobilization and community engagement pillar.
- Ensure that all partners fairly compensate volunteers and team members, particularly when hired from the local community.
- Be careful with incentives provided to family members, contacts, survivors or field teams (e.g. food, allowances, etc.) to ensure fairness, limit stigmatization and reduce marginalization of vulnerable populations.
- Ensure standardized and coordinated interventions to maintain fairness. Keep in mind that stigmatization will also affect the contacts and families of people sick with Ebola and their villages or communities.

Risk communication and community engagement

- Establish mechanisms to listen to and address community concerns, rumours and misinformation. Keep the community updated on the response. Involve trusted community influencers as much as possible to disseminate information.
- Make sure to involve traditional healers, community leaders and influencers in the response as much as possible.
- Ensure that the changing needs of the community are communicated back to key social mobilization, risk communication and community engagement focal points and are addressed through the overall response.
- Inform and advise outbreak response pillars about cultural or social specifications to consider for implementing the response.
- Ensure standardized and coordinated messaging, community engagement and risk communication interventions across response pillars and partner agencies.
- Continually adapt the risk communication and social mobilization strategy to address community concerns and rumours.

Ring vaccination

- Explain to community members what the ring vaccination is about, who will be considered for the vaccine and how it will be administered in their community. Refer to the Frequently Asked Questions on the Ebola Virus Vaccine document.
- Provide information to the community through different community entry points, such as local healers and community gatekeepers, and maintain sensitivity to local complex forms of leadership.
- Explain why vaccination is only being given to contacts and contacts of contacts, health workers and frontline responders in affected areas, and health workers and frontline responders in areas at highest risk of outbreak.
- Clearly provide information to persons being considered for the vaccination before discussing their consent.



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