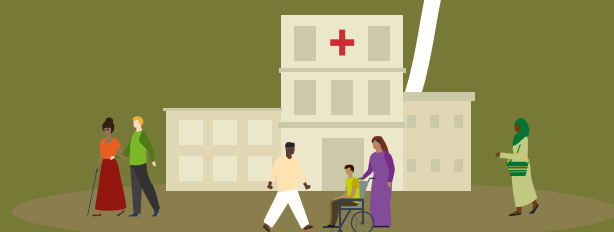


Risk communication and community engagement readiness and response toolkit

Ebola disease



World Health
Organization

Risk communication and
community engagement
readiness and response toolkit
Ebola disease

Risk communication and community engagement readiness and response toolkit: Ebola disease

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Declaration of Interest

All external experts who reviewed the toolkit submitted a WHO declaration of interest disclosing potential conflicts of interest that might affect, or might reasonably be perceived to affect, their objectivity and independence concerning the subject. WHO reviewed these and concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the subjects reviewed.



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Abbreviations

AEFI	Adverse event following immunization
CSO	Civil society organization
EVD	Ebola virus disease
IFRC	International Federation of the Red Cross and Red Crescent Societies
IMST	Incident Management Support Team
IPC	Infection prevention and control
MEL	Measurement, evaluation and learning
NGO	Nongovernmental organization
PPE	Personal protective equipment
PESTEL	Political, economic, sociological, technological, environmental and legal
PRSEAH	Prevention and response to sexual exploitation, abuse and harassment
R&D	Research and development
RCCE	Risk communication and community engagement
SARS-CoV-2	Severe acute respiratory syndrome-coronavirus 2
SDB	safe and dignified burial
SEAH	Sexual exploitation, abuse and harassment
UNICEF	United Nations Children's Fund
VHF	Viral haemorrhagic fever
WHO	World Health Organization



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Glossary

	Behavioural insights	Information about variables that influence behaviours at the individual, community and population levels and that can improve the design of policies and programmes, communications, products and services to achieve better health for all.
	Behavioural science	A multidisciplinary scientific approach that deals with human action, its psychological, social and environmental drivers, determinants and influencing factors. It is applied in protecting and improving people's health by informing the development of public health policies, programmes and interventions.
	Collective Service for RCCE	A partnership among the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the Global Outbreak Alert and Response Network (GOARN) and key stakeholders from the public health and humanitarian sectors.
	Community	Refers to a group of people connected by common characteristics, such as geographic location, age, gender, profession, ethnicity, faith, shared vulnerability or risk, or shared interests and values.
	Community engagement	A collaborative process that involves helping people understand the risks they face and includes communities in developing health and response practices that are acceptable to and workable for them. The goal of community engagement is to empower communities and to develop shared leadership throughout the emergency response cycle.
	Emergency	A situation affecting the lives and well-being of a large group of people or a significant percentage of a population requiring substantial multisectoral assistance. For a WHO response, there must be clear public health consequences.
	Health emergency management cycle	Spans the prevention, preparedness, readiness, response and recovery phases of health emergencies that all organizations and governments should follow to reduce the impact of disease outbreaks, health emergencies and disasters. Countries and communities may be engaged simultaneously in different phases for multiple outbreaks and emergencies.
	Infodemic	An overabundance of information, accurate or not, in the digital and physical environments, accompanying an acute health event, such as an outbreak or epidemic.
	Outbreak	An occurrence of cases of a disease in numbers that exceed what would normally be expected in a defined community, geographical area or season.
	Partners	International, nongovernmental or community organizations that work in a geographic area or health field.
	Readiness	The ability of countries, communities and organizations to respond quickly and effectively to health emergencies from any hazard. Operational readiness is a critical enabler of resilience in communities and health systems, helping them to withstand crisis. Fast-tracking, activating, testing and prepositioning specific functional capabilities are all important functions for enhanced readiness.



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Response	Phase of a health emergency or outbreak activated once the hazard, risk or threat hits, with the implementation of life-saving public health and health interventions to save lives and protect the most vulnerable.
Risk communication	Real-time exchange of information, advice and opinions between experts and people who are facing a risk or threat to their health, social or economic well-being. The purpose of risk communication is to provide people with accurate and timely information and to support them in making informed decisions to mitigate the effects of a threat or hazard.
Stakeholders	Governments and community leaders that have a vested interest in protecting the health of their country, region or community.



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Overview of the risk communication and community engagement readiness and response toolkit: Ebola disease



About the toolkit

This toolkit is a comprehensive set of practical tools and resources designed to support country-level risk communication and community engagement (RCCE) practitioners, decision-makers and partners to plan and implement readiness and response activities for Ebola disease outbreaks.

The toolkit contains:

- information about Ebola disease;
- RCCE considerations on how to approach key issues during Ebola disease outbreaks;
- tools for understanding the context in which Ebola disease outbreaks occur;
- methods for collecting data to inform strategy development and bring evidence into the planning and implementation of activities;
- guidance to support prevention and response interventions; and
- links to existing RCCE tools and training.

It is one of a suite of toolkits on RCCE readiness and response to a range of disease and response areas.

The toolkit has been developed through an iterative and consultative process that has followed several specific steps to identify, collate and refine the information, tools and best practices it contains.

These steps include:

Literature review

An extensive review of existing literature, research papers, published documents and grey literature related to Ebola disease, safe and dignified burials, vaccination, risk communication, community engagement, health emergencies and disease outbreak response was conducted.

A structured search of online databases (PubMed, the Institutional Repository for Information Sharing (IRIS), ReliefWeb and Google Scholar) was conducted to identify publications related to Ebola disease, safe and dignified burials, vaccination, risk communication, community engagement, health emergencies and disease outbreaks, with high focus on haemorrhagic fever outbreaks.

Keywords supplied by the technical teams were used as the foundation of the search to identify relevant documents, from which other specific terms and keywords were extracted. 58 published documents were systematically reviewed for content on key thematic areas, methodologies and definitions relevant to the development of RCCE plans and strategies, including immunization campaigns. This content included but was not limited to clinical information on Ebola disease; behavioural science methodologies related to public health and outbreak response; understanding, preventing and addressing stigma and discrimination; stakeholder engagement and situational analysis; measurement, evaluation and learning frameworks and methodologies; and preventing and responding to sexual exploitation, abuse and harassment (PRSEAH). Retrieved publications were assessed for relevance, uploaded to a database, logged into a tracking sheet, and highlighted for further consideration.

Iterative consultation

The toolkit was reviewed and revised by technical and RCCE subject matter experts at country, regional and global levels through an iterative consultation process between March 2023 and April 2024.

Pilot testing

Draft versions of the toolkit were tested during disease outbreaks and feedback was collected on the toolkit's clarity, relevance and usability.

Peer review

The toolkit was peer-reviewed by independent technical and RCCE experts.

Readiness and response within the health emergency cycle

In recent years, WHO, Member States and partners have engaged in significant efforts to strengthen the architecture for health emergency prevention, preparedness, readiness, response and recovery. Readiness and response are closely connected. Readiness builds on the preparedness phase and is the interface between preparedness and immediate response to an emergency. For example, the approach of a high-risk season, an outbreak of a contagious disease in a neighbouring country, the hosting of a large international event or the declaration of a public health emergency of international concern (PHEIC) can all trigger operational-readiness activities. Experience has demonstrated that countries that systematically ready their health and emergency systems can respond more quickly, cohesively and equitably to threats or emergencies, shortening their duration, curbing their impact and ultimately saving lives.

The role of RCCE in health emergencies and disease outbreaks

Risk communication is the real-time exchange of information between decision-makers, experts and populations exposed to a hazard or imminent threat to their survival, health or economic or social well-being.

Community engagement is the process of developing trusted relationships and structures that engage communities as important partners in the creation of emergency response solutions that are acceptable to and applicable for those they impact.

Informed, engaged and empowered communities are the bedrock of successful readiness and response for outbreaks and emergencies. The principles of RCCE are outlined in the [10 steps to community readiness package](#) (1).

The desired outcome of effective RCCE is to mitigate the potential negative impact of health hazards before, during and after public health emergencies or other unusual events (2). The ultimate goal of RCCE during health emergencies and outbreaks is to reduce morbidity and mortality by empowering communities to confidently participate in leadership, planning and implementation of activities throughout the health emergency response cycle. This is the reason why risk communication is one of the core technical capacities under the International Health Regulations (IHR) (2005) (3, 4) and should be an integral part of all Incident Management Support Teams (IMSTs) in WHO headquarters and regional offices, as well as Incident Management Teams responding to a graded health emergency at the national or local level.

During infectious disease outbreaks, it is imperative to understand why people behave the way they do and what influences the behavioural drivers of disease transmission and risk. Effective RCCE should result in affected communities knowing how to protect themselves and others against the disease; how to seek care, testing, treatment and vaccines; and how to prevent, manage and avoid stigma and discrimination. To achieve this, communities at risk need to be included and consulted in developing strategies and plans and in the implementation of readiness and response activities to outbreaks (5).

WHO response to Ebola disease

WHO works with countries to prevent Ebola disease outbreaks by maintaining surveillance for Ebola disease; by supporting at-risk countries to develop preparedness plans; and by providing overall [guidance for preparedness, alert, control and evaluation of Ebola and Marburg virus outbreaks](#) (6).

This key document was developed on the basis of the experience gained during Ebola and Marburg disease outbreak-control operations since 1995, following informal meetings of the editorial working group held in Burkina Faso (Ouagadougou), the Democratic Republic of the Congo, Gabon (Libreville), and Congo (Brazzaville) between 2004 and 2009, with the assistance of international experts.

When an outbreak is detected, WHO works to support government-led public health responses by supporting coordination, community engagement, disease detection, contact tracing, vaccination, clinical and case management, laboratory services, infection prevention and control, logistics, research, survivor care and training and assistance with safe and dignified burial practices. WHO has a range of advice and guidance for managing Ebola disease outbreaks that can be accessed in Sections 5 and 6 of this toolkit and has supported activities for readiness and response to Ebola disease in countries. When requested, WHO also coordinates necessary surge support, such as technical expertise and partners from the Global Outbreak Alert and Response Network (GOARN), including laboratory diagnostics, capacity building and more.

Recent outbreaks have led to important developments in Ebola disease preparedness and response efforts. The WHO Research & Development Blueprint for Epidemics initiative was created in 2016 to allow the rapid activation of research and development (R&D) activities during epidemics. With support from partners, the work of the R&D Blueprint team enabled the fast-tracking of effective vaccines and treatments in the 2018-2020 Democratic Republic

of the Congo Ebola virus disease (EVD) response. Vaccine trials were launched in 2016 and deployed for the 2018 outbreak in the Democratic Republic of the Congo Équateur Province, and WHO guidelines have helped improve and standardize supportive care (treatment for the symptoms and complications of EVD).

Lessons learned from these recent responses have also informed WHO's work with Member States and communities for improved outcomes. A key lesson from the Democratic Republic of the Congo was that a "one-size-fits-all" approach to community engagement isn't effective. Each community is unique, and communication and engagement have to be very strongly contextualized to affected communities. Because of this feedback, WHO and response partners have worked to integrate local workers into various response teams and have made risk communication, social science and community engagement a cornerstone of WHO response.

Purpose of the toolkit

The purpose of this toolkit is to guide RCCE practitioners, decision-makers, and partners on how to place affected communities at the centre of coordinated efforts to reduce the impact of the disease and end outbreaks of Ebola disease. It provides strategies, best practices and practical resources to: collect and analyse social and behavioural data; use collected insights to inform strategy and implementation; coordinate activities with partners and stakeholders; support the development and dissemination of accurate information to those at risk; build vaccine confidence and demand; address public concerns; and support the participation of communities as essential partners in Ebola disease readiness and response efforts. Adherence to these principles is vital to ensuring that health emergency programmes are more tailored, equitable and inclusive.

Intended audience

This RCCE readiness and response toolkit has been designed for use by:

- RCCE practitioners
- decision-makers and policy-makers;
- national and local health authorities;
- emergency management authorities;
- UN agencies and other international nongovernmental organizations;
- nongovernmental organizations (NGOs) and civil society organizations (CSOs); and
- community leaders.

How to use the toolkit

The toolkit supports coordinated, inclusive and tailored RCCE practices, highlighting approaches that are essential for the successful management of Ebola disease outbreaks and associated immunization campaigns. All tools require contextualization based on local epidemiology, social-behavioural data, available partners, capacity, community-specific needs and the status of outbreak readiness and response activities. The resources in this toolkit should be used at the appropriate emergency management phase, reflecting current conditions.

All those interested in using these tools should coordinate to adapt them for their context using the following three steps:

1. Review all tools

This toolkit contains a range of tools with different aims and objectives. It can be used as a library of resources to meet existing country-level needs; however, not all tools will always be relevant to or necessary for all settings. All provided tools should be reviewed and selected for use based on needs and the priorities outlined in the national plans.

2. Adapt the relevant tools

This toolkit has been developed at a global level. All provided resources should be adapted to local contexts. This can be done by national decision-makers, RCCE practitioners or partners and in line with communities engaged in the response. Adaptations that may be needed include:

- **Language and audience:** Translate the tools into local languages and dialects. Considerations should be made to address literacy and accessibility needs.
- **User:** Adapt and refine the tools according to the needs of those who will be using them. Different stakeholders have different needs and capacities.
- **Ebola disease outbreak context:** Adapt the tools based on the current epidemiological situation and what is known about the context and behaviours of affected populations. Further adaptations may be needed as the situation evolves. RCCE activities are crosscutting and should be conducted in coordination with other outbreak-response pillars, such as surveillance, vaccination, clinical management for treatment and case management, infection prevention and control, vector control and others.



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- **Phase of the emergency:** How the tools in the toolkit are adapted and implemented will depend on the current phase of the health emergency cycle in the local context. Tool 5 (the RCCE readiness and response checklist for Ebola disease outbreaks) can be used to identify different priorities within the different phases.

- **Existing national activities:** Selection and adaptation of tools should be guided by national action plans, strategies and ongoing activities to complement and enhance existing efforts.

3. Use and monitor

Once the tools are tailored to the local context, they can be used to inform strategy and planning and to guide the implementation of RCCE activities. Though the resources within the toolkit provided should guide the work of WHO, they may also be valuable to other engaged partners and stakeholders, including community leaders, local NGOs, CSOs and other local actors to support their activities. The use of tools should be monitored and evaluated continuously to inform improvements.



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Background information on Ebola disease



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This background information is up to date as of May 2024. It is intended to provide RCCE decision-makers, practitioners and partners with the knowledge and understanding needed to effectively respond to Ebola disease outbreaks. Up-to-date information about the local Ebola disease situation should be sought from local outbreak-response leads to establish a full understanding of the local setting.

Overview

Ebola disease is a severe, often fatal illness in humans. Outbreaks usually start when the virus spreads from wild animals to humans, and spreads from human to human through direct contact with infected body fluids. It is often difficult to trace the exact source of each outbreak, but direct contact with uncooked infected bushmeat is often cited as the most likely culprit. To date, six orthoebolaviruses have been identified: Zaire ebolavirus, causing most of the Ebola disease outbreaks being reported until now; bundibugyo ebolavirus, Sudan ebolavirus, Tai Forest ebolavirus, Reston ebolavirus and Bombali ebolavirus. Viruses from the genus *Orthoebolavirus* are classified as follows:

- Ebola virus (EBOV), belonging to the species *Orthoebolavirus zairense*, and causing Ebola virus disease (EVD);
- Sudan virus (SUDV), belonging to the species *Orthoebolavirus sudanense* and causing Sudan virus disease (SVD);
- Bundibugyo virus (BDBV), belonging to the species *Orthoebolavirus bundibugyoense* and causing Bundibugyo virus disease (BVD);
- Tai Forest virus (TAFV), belonging to the species *Orthoebolavirus taiense*;
- Reston virus (RESTV), belonging to the species *Orthoebolavirus restonense*;
- Bombali virus (BOMV), belonging to the species *Orthoebolavirus bombaliense*.

As of the date of publication, EBOV, SUDV, BDBV and TAFV have caused disease in humans. The largest outbreaks were caused by EBOV (7).

The first cases of Ebola diseases were detected in two concomitant outbreaks in Sudan and in Zaire (now the Democratic Republic of the Congo) in 1976. Since then, outbreaks have occurred in the Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, Guinea, Liberia, Congo, Sierra Leone, Sudan and Uganda. In Africa, cases have been imported to Mali, Nigeria, Senegal and South Africa. The 2014–2016 outbreak in West Africa was the largest and most complex ever recorded, with widespread cases and a heavy death toll (8).

The latest occurred in Uganda, where an outbreak of SUDV was declared on 20 September 2022 by the Ministry of Health. On 11 January 2023, the Ministry of Health declared the end of the outbreak, which had affected nine districts (9).

Transmission

It is thought that fruit bats of the Pteropodidae family are natural orthoebolavirus hosts. The virus is introduced into the human population through close contact with the blood, secretions, organs or other body fluids of infected animals, such as fruit bats, chimpanzees, gorillas, monkeys, forest antelope or porcupines found ill or dead or in the rainforest. Orthoebolaviruses then spread through human-to-human transmission via direct contact (through broken skin or mucous membranes) with:

- blood or other body fluids of a person who is sick with or has died from Ebola disease; and
- objects that have been contaminated with body fluids (such as blood, faeces, vomit) from a person sick with Ebola disease or from the body of a person who died from Ebola disease.

Healthcare workers have frequently been infected while treating patients with suspected or confirmed Ebola disease. This occurs through close contact with patients when infection prevention and control (IPC) precautions are not strictly practiced. Burial ceremonies that involve direct contact with



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the body of the deceased can also contribute to the transmission of Ebola disease. People remain infectious as long as their blood contains the virus. After the patient has recovered, the virus may persist in semen or breastmilk of lactating women and may be transmitted through exposure to these fluids. The risk of transmission can be reduced and mitigated through adequate care, follow-up and support to survivors (10, 11).



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Symptoms



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The symptoms of Ebola disease can be sudden and include fever, fatigue, muscle pain, headache and sore throat. These are followed by vomiting, diarrhoea, rash and internal and external bleeding. It can be difficult to clinically distinguish Ebola disease symptoms from those of other infectious diseases, such as malaria, typhoid fever and meningitis. A range of diagnostic tests have been developed to confirm the presence of the virus. The time from when someone gets infected to the onset of symptoms (incubation period) is usually from 2 to 21 days. People with Ebola disease can spread the disease only once they show symptoms. People can transmit Ebola disease for as long as their body contains the virus, even after they have died (10).



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After recovering from Ebola disease, some people may have symptoms for 2 years or longer. These symptoms can include feeling tired, headache, muscle and joint pain, eye pain and vision problems, weight gain, belly pain and loss of appetite, hair loss and skin problems, trouble sleeping, memory loss, hearing loss, depression and anxiety (10).



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Who is at risk

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

- health and care workers;
- family members or others in direct physical contact with infected people;
- mourners who have direct physical contact with bodies during funerals or burial rituals (11).

Health and care workers and community health workers are at greater risk of contracting Ebola disease when they:

- are not wearing correct personal protective equipment (PPE);
- are not applying IPC measures when caring for patients or managing deceased bodies.

Community health and care workers are typically among the first to detect new illnesses within a community, raise alerts and refer those who are ill to a health facility. As the symptoms of Ebola disease are similar to those of many other common illnesses and Ebola disease outbreaks are mostly rare events, the community health and care worker may not immediately recognize the specific signs and symptoms as being caused by Ebola disease and, as a result, may not use the appropriate IPC methods. This close contact with potential Ebola disease patients puts other health and care workers at higher risk.

This is why all health and care workers at all levels of the health system, including hospitals, clinics, health posts, traditional facilities and within communities, should be fully informed about the disease and its modes of transmission and take all recommended precautions (11).

Protective behaviours

In case of an Ebola disease outbreak, people can protect themselves from the disease by taking specific measures that reduce the risk of infection. These include:

- avoiding physical contact with individuals (and their body fluids) who are suspected of having or confirmed to have Ebola disease;
- refraining from handling bodies of persons who have died with symptoms of Ebola disease without taking the appropriate protective measures;
- taking precautions while hunting or handling wild animals;



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- washing hands regularly and thoroughly, following guidance and recommendations by local health authorities;
- following other recommended preventive measures, such as decontamination, cleaning and vaccination, when and where available (10).

During an Ebola disease outbreak, local health authorities will likely recommend that community and family members frequenting health facilities strictly comply with:

- early identification and isolation of patients with Ebola disease symptoms to avoid unprotected direct physical contact;
- correct hand hygiene practices;
- screening at entry points.
- For the safety of the whole community, people are encouraged to follow all recommended preventive measures to reduce the risk of Ebola disease transmission.

Prevention

In case of an outbreak, people can protect themselves from getting the disease by:

- avoiding touching the body fluids of people who have, or may have, Ebola disease and refer to early care;
- adapting traditional burial or funeral practices to avoid any touching or washing or other practices involving direct contact with the deceased (safe and dignified practices);
- adhering to contact-tracing activities for people who have been in contact with Ebola disease patients;
- getting the Ebola vaccine in the event of an outbreak of Ebola virus disease, if they are identified as at-risk individuals.

There are two licensed vaccines, prequalified by WHO, that have been used safely and effectively in many countries, including Guinea and the Democratic Republic of the Congo, to protect hundreds of thousands of

people against Ebola virus (orthoebolavirus zairense) causing EVD. The two licensed vaccines are:

- the Ervebo vaccine and
- the Zabdeno-and-Mvabea vaccine.

The Ervebo vaccine has been shown to be effective in protecting people from Ebola virus (species *Orthoebolavirus zairense*) and is recommended by the Strategic Advisory Group of Experts on Immunization (SAGE) as part of a broader set of Ebola outbreak response tools (10, 12, 13). For other orthoebolaviruses, experts are developing candidate vaccines for further use and research efforts are continuing.

Treatment

People with symptoms of Ebola disease should get medical care immediately. Early care improves a person's chances of surviving. WHO does not advise families or communities to care for individuals with symptoms of Ebola 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 disease (11).

For all orthoebolaviruses, supportive treatments, if administered early, can help save lives and include the following:

- oral or intravenous fluids
- blood transfusions
- medicines for other infections the person may have, such as malaria
- medicines for pain, nausea, vomiting and diarrhoea (10, 11, 13).

There are now two approved treatments that are specific for Ebola virus disease, complementing early supportive care. They are called monoclonal antibodies and are given to both children and adults. They need to be given early in the course of the disease so that they improve survival chances. Treatments for other orthoebolaviruses are in development.



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Tools for Ebola disease outbreaks



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3.1 Gathering information and data

The tools in Section 3.1 Gathering information and data are designed to support the collection, analysis and use of social-behavioural data and community insights to inform the development of evidence-based RCCE strategies and plans. The data and insights collected using these tools promote better decision-making and can allow for stronger risk assessments by bringing a community lens to the understanding of risk during an outbreak. By prioritizing the collection, analysis and use of social-behavioural data and community insights within and beyond RCCE, it is possible to bring broader response strategies and plans in line with community expectations, needs and priorities.

Tool 1: Conducting a situational analysis: The PESTEL tool



A situational analysis can be conducted in either the readiness or response phase to inform activities during an outbreak, or to strengthen prevention and preparedness efforts with regards to immunization. In any of these scenarios, the situational analysis should be regularly updated.

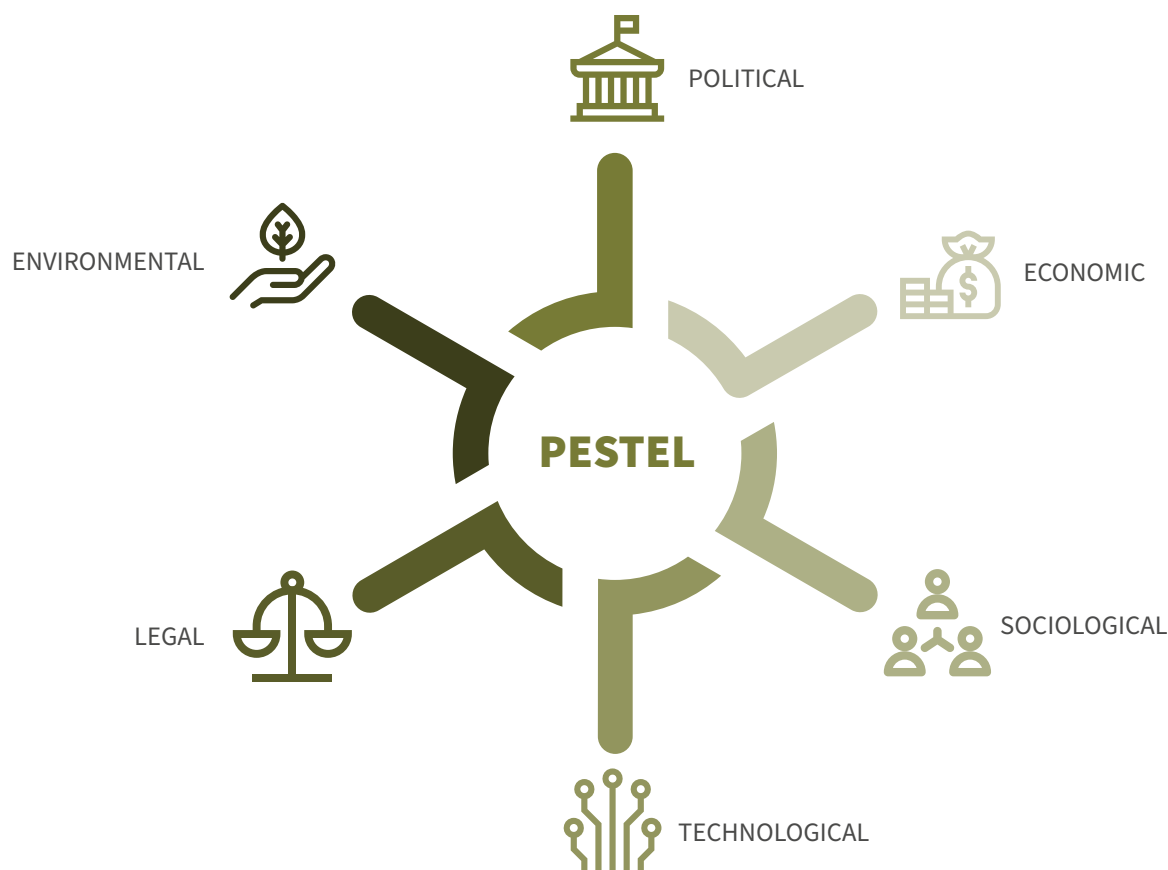
The PESTEL tool is a framework for conducting a situational analysis that helps users understand political, economic, sociological, technological, environmental and legal factors that can influence public health efforts during an emergency, as well as other preventive activities for Ebola disease, as seen in Figure 1 below.

Data collected either directly or from existing sources can be used to gather insights into the six categories of the PESTEL analysis. Information can be collected through these and other sources:

- community surveys, qualitative interviews and focus group discussions, including behavioural science research;
- tools used under the [International Health Regulations](#) (3) to evaluate country capacity, including intra-action reviews, after-action reviews, the Health Resources and Services Availability Monitoring System (HeRAMS), [joint external evaluation \(JEE\) reports](#) (2), etc.;

- lessons learned from previous outbreak responses;
- WHO IMST updates, situation reports, [Disease Outbreak News](#) (14) and daily reports;
- peer-reviewed journals;
- WHO country profiles;
- news reports from trustworthy sources;
- government websites and other official publications.

The information obtained from a PESTEL analysis should be used with detailed behavioural data from Tool 2 and local epidemiological data on the drivers of transmission.

Figure 1. PESTEL analysis framework**Political considerations:**

- government and local policies;
- budgets for Ebola disease readiness and response;
- governmental experiences with previous Ebola disease outbreaks;
- levels of trust in government, partners and other influential voices;
- government and partner public communication activities and style; and
- upcoming elections or potential changes in leadership.

Economic considerations:

- capacity of citizens and communities to participate in economic life;
- access to and supply of health services, including vaccination and treatment;
- feasibility of contact tracing; and
- income of citizens.



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Sociological considerations:

- cultural dynamics and demographics;
- behaviours, beliefs and habits;
- religions and traditions; and
- literacy, languages and dialects.
- Technological considerations:
- level of access to information (print, broadcast or online media);
- mobile phone usage and level of penetration;
- social media usage;
- availability of internet access;
- digital literacy; and
- key online communication channels.

Environmental considerations:

- potential dangers and impacts of climate crises, such as deforestation and human encroachment into animal habitats;
- natural disasters (floods, earthquakes, droughts, etc.); and
- environmental risk level.

Legal considerations:

- laws, rules and plans — including those related to ethics, such as the prevention of sexual exploitation, abuse and harassment;
- existence of treaties or binding legal instruments;
- multiple levels of governance;
- regulations that impact RCCE in emergency situations; and
- coordination and engagement of CSOs, NGOs and non-State actors.





Tool 2: Behavioural analysis

This tool can be used to identify and understand behaviours relevant to Ebola disease outbreaks or pertaining to vaccine uptake and demand that inform and shape RCCE strategies, tools and tactics. Behaviours do not stay static through an outbreak or health emergency. High-risk behaviours are influenced by barriers and enablers that can be identified through social and behavioural data collection. These should be identified as early as the prevention phase and throughout the readiness and response phases, and regularly monitored to understand norms, trends and changes (15).

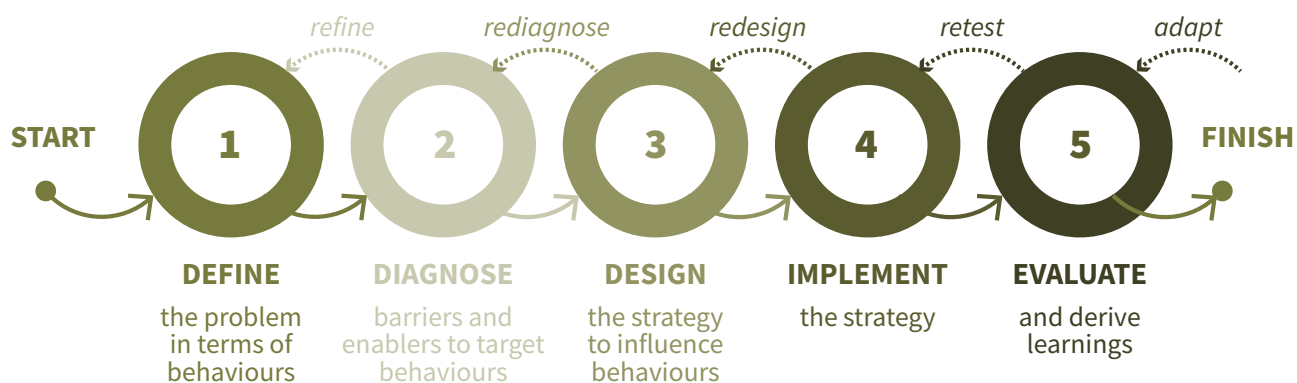
Used together, the findings from the situational and behavioural analyses can help users assess how to engage with communities effectively and co-develop plans and strategies that support people to make well-informed decisions to protect themselves. The importance of including behavioural and social sciences in public health interventions was globally recognized in 2023 by Member States at the [Seventy-sixth World Health Assembly](#) (16). There, WHO acknowledged the contribution of these disciplines to the improvement of health outcomes and called on the increased use of behavioural science to empower communities to better understand public health problems and to design and evaluate interventions to address them.

Behaviours are one factor that can influence transmission, uptake of protective actions and care-seeking practices in outbreaks and health emergencies. It is important to identify and understand risky and protective behaviours in the current context and to use this understanding to shape RCCE strategy, plans and activities. It is crucial to note that changing behaviour is not the only way to end transmission; people need information and opportunities for engagement as well as access to prevention and care to help them make informed decisions that are applicable within the contexts of their daily lives, and which are practical and accessible.

The behaviours that relate to the risk for and prevention of Ebola disease transmission will vary, depending on the local context (e.g. presence of disease reservoir, availability of vaccines, treatment/ care for symptoms, etc.). This information should be obtained from a multidisciplinary team that includes behaviour-change experts and epidemiologists working on the response and from the PESTEL analysis.

The Behavioural Insights checklist below is designed to guide what data to review to inform RCCE strategy and which include inputs from the communities at risk. It is adapted from the [Technical note from the WHO Technical Advisory Group on behavioural insights and science for health](#) (17). This technical note includes additional guidance on behavioural insights, including advice on the principles and application of behavioural science. Please refer to the note for additional guidance. The checklist is based on the define, diagnose, design, implement and evaluate (DDDIE) steps, as seen in Figure 2.

Figure 2. DDDIE steps guide



Step 1: Defining the problem in terms of behaviour: Is the Ebola disease outbreak a problem of behaviours?

Use the data sources available to answer the following questions and complete the table below, Table 1 (e.g. epidemiological data, knowledge from previous outbreaks or other countries, existing social-behavioural data).

During emergencies, data on knowledge, attitudes and practices provide important information (3) for understanding the problem in terms of behaviour and can help health officials understand the following aspects:

1. Does the problem have a behavioural component? Consider factors such as:
 - What is driving transmission?
 - Are people seeking/accessing care or vaccines, if they are available?
 - Are people practicing protective behaviours?
 - Are people practicing risky behaviours?
2. Which behaviour(s) must be changed to contribute to improving or attaining the desired health outcome(s)?
3. What is the target behaviour you are aiming for? Who needs to do what, when, where and how? Try to be as specific as possible while recognizing that behaviours tend to be interconnected and are likely to be part of a combination or sequence of behaviours from multiple key players, happening in different times and places and all contributing to disease transmission.

Table 1. Problem and behaviour diagnosis

Step 1: Defining the problem in terms of behaviour	
Does the problem have a behavioural component? If yes, what is it?	e.g. yes; rural communities are not following public health advice for conducting safe and dignified burials (SDBs)
Which behaviour(s) must be changed to improve the desired health outcome?	e.g. unsafe burials of people who die with Ebola disease symptoms, slow uptake of the protective behaviours
What is the target behaviour(s) you are aiming for?	e.g. increased number of family and community members adhering to SDB practices
Who needs to change their behaviour?	e.g. individuals and communities who have lost family or community members with symptoms of Ebola virus
What do they need to do differently?	e.g. contact health professionals and community members in charge of conducting SDBs, and not try to manage the body or burial themselves
When does this behaviour occur?	e.g. when a person with Ebola disease symptoms dies; during burial ceremonies of people deceased with suspected or confirmed status of Ebola disease
Where does this behaviour occur?	e.g. in households, burial places, rural areas

Step 2: Diagnose the barriers to and enablers of target behaviours

A barrier is an obstacle or challenge that impedes the uptake of or adherence to Ebola disease interventions. Enablers are factors that facilitate or support the successful implementation of Ebola disease preventive measures and RCCE interventions. Barriers to and enablers of behaviours can be cognitive, psychological, social, cultural, environmental and religious; they can be linked to perceptions of self-efficacy, risk and efficacy of interventions, as well as to other factors.

Identifying and understanding the barriers and enablers of your desired target behaviour is essential to designing interventions that are effective, practical and culturally acceptable. Use of social-behavioural

science evidence to prioritize and determine what barriers and enablers will be explored further to inform the design of interventions, as seen in Table 2.

It can also be useful to consider whether barriers and enablers are: 1) cognitive/psychological; 2) social/cultural; 3) environmental/structural.

Examples of barriers:

- lack of awareness or knowledge about Ebola disease symptoms, transmission and/or preventive measures (cognitive/psychological);
- cultural beliefs and practices that contradict guidance or discourage people from adopting the desired behaviours (social/cultural);
- limited access to health-care resources, information or services required to follow the desired behaviours (environmental/structural);



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- fear or stigma associated with Ebola disease, making people reluctant to report symptoms or seek care (cognitive/psychological).

Examples of enablers:

- strong community inclusion, support and engagement in promoting interventions (social/cultural);
- accurate RCCE interventions that provide information about Ebola disease and the importance of care, isolation of suspected and confirmed cases, adherence to SDBs or vaccination (environmental/structural);
- positive social norms that encourage and support people to adopt desired (protective and preventive) measures and to avoid risky behaviours (social/cultural);

- engagement of positive role models, such as community leaders and influencers, to advocate for and model the desired behaviours (social/cultural);

- involvement of the private sector to ensure that the at-risk workforce is protected (environmental/structural);

- Availability of accessible and reliable health services (Ebola treatment centres, Ebola treatment units, triages, etc.) to support the adoption of the desired behaviours (environmental/ structural).

Table 2. Behaviour barriers and enablers

Step 2: Diagnosing barriers and enablers		
Risky behaviour	Enablers	Barriers
<p>E.g.</p> <ul style="list-style-type: none"> • going to a traditional healer at the onset of symptoms 	<p>E.g.</p> <ul style="list-style-type: none"> • accurate information about Ebola disease symptoms, treatment and vaccination is readily available • community health workers are a trusted source of information and provide guidance on where to seek medical care • easy access to health-care facilities is available 	<p>E.g.</p> <ul style="list-style-type: none"> • community health workers do not have capacities to detect Ebola disease • the community is not informed about Ebola and risk prevention • there are no treatment units available for isolation of Ebola confirmed or suspected patients at the nearest health-care facility



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Steps 3, 4 and 5: Design, implement and evaluate interventions to address barriers to and encourage enablers of desired behaviours

Steps 1 (define) and 2 (diagnose) provide insights and data that can then be used in steps 3 (design of evidence-based RCCE approaches and interventions aimed at addressing the barriers identified), 4 (implementation of interventions aimed at addressing the barriers identified) and 5 (evaluation) to support Ebola disease readiness and response efforts.

Design and implementation of interventions should be done in collaboration with behavioural scientists, health experts, communication specialists and, crucially, with affected communities and stakeholders to ensure the interventions are effective and culturally sensitive. Tools to support implementation are included in this toolkit.

Evaluation of interventions and of behaviour change is important to drive future learnings about the effectiveness of RCCE strategies. It is possible to measure the impact of interventions on behavioural outcomes by using epidemiological data or direct observations of behaviours. If these data are not available, use self-reported information, such as adherence to preventive measures or uptake of vaccination (when available).



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Tool 3: Mapping and understanding communities

This tool can be used to identify and record key information about communities affected by Ebola disease and who should be included in outbreak response activities. This information should be used to inform RCCE strategy and action plans for the priority communities at risk of Ebola virus infection.



In order to create inclusive RCCE plans and strategies, it is imperative to involve communities in co-designing solutions and interventions aimed at protecting their health and well-being from an imminent threat. Individuals and communities experience outbreaks of Ebola disease differently. Anything from where they live and work to their varying levels of knowledge, awareness, perceptions of risk and specific local contexts in which Ebola disease outbreaks occur can significantly affect their likelihood of falling sick. Understanding these

differences helps health officials identify who is most at risk of the disease and who in the community is best placed to support engagement efforts.

The tool in Table 3 below helps to collect and organize information about key communities at risk and, in combination with Tools 1 and 2, provides a broader context to help tailor RCCE activities to the needs of specific populations.

Table 3. Community assessment matrix

	Priority community 1	Priority community 2	Priority community 3
Demographic information – age range, gender, languages spoken, literacy levels, education, occupations			
Risk level – based on epidemiology and findings from situational and behavioural research			
Perceived risk level – based on level of knowledge about Ebola disease, immunization status, perception of personal and community risk, self and intervention efficacy			
Trusted information channels – note that these may differ from frequently accessed channels			



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Community leaders – advocacy groups, religious leaders, etc.

Influential voices – celebrities, thought leaders, health workers, social media accounts, etc.

Access to key interventions – SDBs, treatment/care, vaccination when available/appropriate, etc.

Rumours and misinformation

Other



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Tool 4: Stakeholder analysis



This tool looks at the various people and groups identified as important in Ebola disease readiness and response activities or affected by the outbreak. It helps to bracket and group their potential roles, capacities and anticipated engagement to support collective efforts to prevent or respond to Ebola disease outbreaks, including immunization campaigns.

A stakeholder analysis goes into more detail and builds on the findings of the PESTEL, behavioural analysis and community mapping. It should be adapted to the local context to provide a precise overview of different stakeholder roles, motivations, anticipated involvement and key milestones to

maximize the impact of RCCE activities, as seen in Table 5. There are four main categories into which stakeholders fall and an associated strategy for interacting with them, seen below in Table 4.

The Stakeholder matrix is available in Table 5.

Table 4. Stakeholder categories

	Stakeholder category	Strategy
Champion	Champions support your activities and do so actively and visibly. These groups/people, e.g. other UN agencies, agree with the proposed actions and goals and are already taking actions on their own to support them.	With champions, continue engaging them in planning and implementing activities; provide them with updates and information to ensure they are up to date; appreciate and acknowledge their contributions and support; and let them champion the cause.
Silent booster	Silent boosters support the planned or proposed activities and goals, but do so privately, voicing little to no public support. These stakeholders need additional motivation to become more active and supportive of the proposed actions.	With this group, the strategy is to educate, enable, inform and motivate. Energize these stakeholders by involving partners and champions they respect and normally engage with to help advocate for the planned activities and goals.
Avoider	Avoiders don't necessarily support your cause but are neither vocal nor visible about their lack of support. They silently oppose aspects of planned activities and passively disagree.	Inform or ignore. With avoiders, it is helpful to engage groups from the champions category to help influence them to support activities.
Blocker	Blockers are groups who are visibly, publicly opposed to the planned activities and take action to encourage others to disagree as well. They can pose an obstacle to the implementation of activities, depending on their influence.	Blockers pose a greater challenge if they are influential. If they are, the best approach is to try to counteract their action by continuing to enlist champions to advocate for your cause and provide facts. If they are not influential, the best strategy is to ignore this group. Regardless, keep track of who they are and who they are influencing.



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Table 5. Stakeholder matrix

Responsible officer: Date: Version:											
Name of organization or individual	Area of work	Stakeholder type	Anticipated involvement or support	Anticipated challenges	Motivation, drivers	Expectations of exchange	Milestones	Activities	Responsible party	Date due	Status
		<i>(Champion, blocker, silent booster, avoider)</i>	<i>What level of involvement is expected and what type of support can this stakeholder contribute?</i>	<i>Known or potential issues, lack of capacities, etc.</i>	<i>Why is the stakeholder invested in the proposed activities?</i>	<i>What is the stakeholder's predicted input?</i>	<i>At what point of the response or planned activities is this stakeholder's involvement required?</i>	<i>What activities directly involve or affect the stakeholder?</i>	<i>Team member(s) responsible for engagement with the stakeholder</i>	<i>Task/ involvement needs to be met by:</i>	<i>Have all the agreed activities been implemented in the foreseen time frame?</i>

3.2 Strategy and planning

The tools in Section 3.2 Strategy and planning are designed to support the development of evidence-based RCCE strategies and plans drawing on social-behavioural data, community insights, epidemiological data and priorities identified by other areas of the outbreak response or in support of immunization campaigns. Strong strategies and plans promote more effective implementation of activities in the long run and provide an opportunity to consider how to work with communities as core partners in all RCCE activities.

Tool 5: Readiness and response checklist

This readiness and response checklist, in Table 6, is designed to assist RCCE professionals and responders to update or activate their plans in the context of readying for or responding to an imminent health emergency or threat. It provides specific guidance for countries on how to implement effective RCCE strategies that will help inform, engage and protect the public's health through the course of a health emergency.



This checklist is adapted from the following documents: [International Health Regulations \(2005\) Third edition \(3\)](#), [COVID-19 Global Risk Communication and Community Engagement Strategy Interim guidance 2020 version 2 \(18\)](#), [Risk communication and community engagement readiness and initial response for novel coronaviruses \(nCoV\): interim guidance, 10 January 2020 \(19\)](#), [10 steps to community readiness \(1\)](#), [RCCE competency framework, Strengthening health emergency prevention, preparedness, response and resilience- the HEPR \(Health Emergency Preparedness Response\) framework \(20\)](#) and [Joint external evaluation tool: International Health Regulations \(2005\) – third edition \(2\)](#).

Table 6. RCCE readiness and response checklist¹

Area of work	Steps	Activities
Systems and coordination	Readiness	<input type="checkbox"/> Establish or strengthen RCCE coordination mechanisms, including by establishing an inter-agency task force or crisis communication centre as well as technical working groups for key areas of work, and by ensuring content clearance and information-sharing protocols are approved. <input type="checkbox"/> Review and update existing RCCE strategies and plans using surveillance, epidemiological and social-behavioural data and ensure these are linked to broader emergency preparedness and response operational plans (EPRP). <input type="checkbox"/> Set up or strengthen an RCCE team and define members' roles and responsibilities. <input type="checkbox"/> Map RCCE expertise at all levels, including specific focal points such as PRSEAH. <input type="checkbox"/> Conduct or update PESTEL situational analysis and stakeholder analysis. <input type="checkbox"/> Develop a budget, with funding options and a human resource plan, and include plans for surge support, if needed.
	Response	<input type="checkbox"/> Convene and coordinate the RCCE response with government, stakeholders, partners and across technical areas/pillars. <input type="checkbox"/> Activate the inter-agency task force or crisis communication centre and ensure content clearance and information-sharing protocols are followed. <input type="checkbox"/> Revise and update RCCE strategies and plan according to need and current surveillance, epidemiological and social-behavioural data, new evidence or learnings. <input type="checkbox"/> Implement approved operational budget and human resource plan, including deployment of surge staff.
Community data for action	Readiness	<input type="checkbox"/> Conduct a review of social-behavioural data (see Tools 1 and 2) to identify vulnerable populations, risk factors, priority behaviours and potential barriers and enablers for an effective response. Use this knowledge to inform decision-making. <input type="checkbox"/> Ensure mechanisms for community listening are established (both online and offline) and respond to rumours and misinformation proactively (see Tool 6 to support tracking of rumours and misinformation). <input type="checkbox"/> Analyse gaps in available social data. A mix of quantitative and qualitative data is best - including community feedback, community listening, polling and survey data to understand community knowledge gaps, perceptions and behaviours. Conduct appropriate research to fill in any identified gaps. <input type="checkbox"/> Set up a framework for measurement, evaluation and learning to track the efficacy of RCCE activities and their impact. Use findings to tailor and adjust the RCCE strategy and plans accordingly.
	Response	<input type="checkbox"/> Continuously conduct data collection among at-risk and affected populations to track any changes in knowledge, attitudes, perceptions, behaviours and other social-behavioural variables. <input type="checkbox"/> Regularly conduct community listening (see Tool 7). Use the findings to develop, adjust and implement RCCE interventions that address concerns, misconceptions, rumours and barriers to uptake of protective behaviours or vaccines. Address any unacceptable behaviours, including sexual misconduct. Include affected communities throughout this process. <input type="checkbox"/> Continue to monitor the impact of response activities on communities (see Tool 7). Ensure plans are in place to manage potential or unexpected impacts (changes to health-seeking behaviours, impacts on job and food security, other economic or social impacts) and update accordingly. <input type="checkbox"/> Share data back to communities and update local response activities as new social, behavioural and anthropological data become available

¹ RCCE: risk communication and community engagement; PESTEL: political, economic, sociological, technological, environmental, and legal factors; PRSEAH: preventing sexual abuse and harassment; CSO: civil society organization; MEL: measurement, evaluation, and learning.



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Area of work	Steps	Activities
Risk communication	Readiness	<ul style="list-style-type: none"> ☐ Ensure that the highest levels of government are ready to release information to protect the public's health in a rapid, transparent and accessible manner. ☐ Create or review a repository of existing RCCE materials, such as message banks, tools, products and templates. ☐ Map and prioritize trusted and commonly used communication channels and platforms. Assess these for accessibility to people in remote areas; to people without digital skills or with limited access; and to people with low literacy skills or who may not speak the dominant language, etc. ☐ To reach all pockets of society, identify alternative communication channels, such as street radio, mobile announcers, voice messages for health centres, etc., and identify partners who can potentially support dissemination of key messages through these methods. ☐ Identify spokesperson(s) for all key partners at all levels; list their areas of expertise in relation to the disease or health emergency threat and, if necessary, train them. ☐ Coordinate communication activities and use standard operating procedures for clearance and sharing. ☐ Ensure that a crisis communication template is developed and there are clear protocols for reporting adverse events following immunization (AEFIs), in situations where vaccines are available.
	Response	<ul style="list-style-type: none"> ☐ In collaboration with affected communities, continuously develop, adapt and test messages as the situation and science evolve. Ensure that messaging on the prevention of and response to sexual misconduct is included in messaging, where appropriate. ☐ Update interventions and messaging, based on the measurement, evaluation and learning (MEL) framework and as recommended public health social measures (PHSMs) change and new tools (vaccines, treatments, tests, etc.) become available. ☐ Continue sharing regular and updated information and dialogue using trusted and commonly used channels. ☐ Engage regularly with members of the news media and other communication partners to ensure public information is adapted and consistent with the latest science and current context. ☐ Activate spokespersons and other influential individuals, including those from other agencies and stakeholders, to align messaging and to broaden the reach of RCCE activities. ☐ Provide guidance to media outlets on how to access reliable information and manage misconceptions.
Community engagement	Readiness	<ul style="list-style-type: none"> ☐ Hold discussions with communities to understand socio-cultural contexts and power dynamics of key audiences. ☐ Identify what type of engagement is safe, feasible and acceptable for different communities. ☐ Identify existing platforms (community leaders, CSOs and key influencers, particularly those accessed by people at risk) and engage communities in decision-making processes. These may include organizations working within the context of Ebola disease, including survivor care. ☐ Establish or strengthen community feedback systems to ensure community beliefs, questions, concerns and suggestions are heard. ☐ Co-develop priority actions (risk-and-needs assessments, strategies, plans, guidance, messaging, etc.) with affected groups to strengthen readiness, build trust and encourage uptake of protective behaviours and vaccines. ☐ Design and co-implement interventions and strategies with communities. ☐ Train community engagement teams, including volunteers, and establish surge capacity mechanisms. ☐ Ensure capacities are available to translate all RCCE materials into local languages and dialects. ☐ Anticipate special information and engagement needs for people who are disabled, illiterate or marginalized.
	Response	<ul style="list-style-type: none"> ☐ Update and co-implement RCCE interventions and strategies with communities. ☐ Ensure continuity of community feedback systems and close any information gaps. ☐ Launch or strengthen an alliance of influencers and stakeholders who can listen, advocate, educate, address rumours and misinformation and promote health literacy using evidence and data. ☐ Ensure representation of civil society and vulnerable groups. Work closely with other committees and advisory groups. ☐ Engage relevant sectors (government, social and private sector) to manage service and supply needs, assess barriers and strengthen referral systems, such as mental health, gender-based violence and PRSEAH. Ensure affected communities are linked to referral systems



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Area of work	Steps	Activities
Capacity building	Readiness	<ul style="list-style-type: none"> <input type="checkbox"/> Conduct a needs assessment that includes mapping of existing RCCE human resource capacities and capabilities. <input type="checkbox"/> Develop a capacity-building plan with stakeholders based on the result of the needs assessment. <input type="checkbox"/> Build the capacity of RCCE teams and other key stakeholders based on the plan developed. <input type="checkbox"/> Create standard operating procedures to drive consistency and quality across RCCE interventions and collaboration with partners. <input type="checkbox"/> Initiate a continuous peer-to-peer support system for community mobilizers, responders and networks.
	Response	<ul style="list-style-type: none"> <input type="checkbox"/> Adapt capacity-building tools, as needed. <input type="checkbox"/> Identify and train emergency RCCE staff and potential surge staff on plans and procedures. <input type="checkbox"/> Provide refresher or on-the-job training for RCCE responders and spokespersons as interventions and strategies change. <input type="checkbox"/> Continue to provide orientation to media professionals and communication networks as the response evolves.
Measurement, evaluation and learning (MEL)	Readiness	<ul style="list-style-type: none"> <input type="checkbox"/> Develop/review the MEL framework, including monitoring and evaluation indicators based on the developed RCCE strategy, planned activities and expected outcomes (see Tool 8) <input type="checkbox"/> Develop/strengthen a real-time monitoring system using existing/adapted tools, such as mobile and manual data-collection methods, interactive dashboards and automated data analysis. <input type="checkbox"/> Train the RCCE team on the use of relevant tools/monitoring system. <input type="checkbox"/> Promote community participation in developing the measurement, evaluation and learning process. <input type="checkbox"/> Develop a system to store, manage and share information and key datasets.
	Response	<ul style="list-style-type: none"> <input type="checkbox"/> Continuously revise the MEL framework to ensure it is capturing the data needed to measure results and impact (see Tool 9). <input type="checkbox"/> Use established, real-time and participatory monitoring and evaluations systems, such as mobile or application-based reporting, where possible. <input type="checkbox"/> Generate evidence and data that allow regular assessment of strategy implementation and impact. <input type="checkbox"/> Include CSOs and community groups in monitoring, reporting and joint accountability efforts to increase the likelihood of broad community uptake and responsibility for new interventions. <input type="checkbox"/> Maintain and strengthen systems to manage and share information, document lessons learned and gather best practices. Disseminate lessons and best practice widely.

Tool 6: Activities tracker

This tool in Table 7 is designed to assist RCCE decision-makers, practitioners and partners to track activities, once identified, using the readiness and response checklist (Tool 5).



Table 7. Activities tracker

Area of work	Task/ activity	Responsi-ble indivi-dual	Budget	Links	Deadline	Status
e.g. commu-nity engage-ment	Review suitability of existing community feedback system for Ebola disease	e.g. health ministry; name, email, phone number	-	e.g. to any working documents	-	e.g. complete, in progress, incomplete

3.3 Implementation

The tools in Section 3.3 Implementation are designed to support activities conducted as part of evidence-based RCCE strategies and plans. While the projects and activities that need to be implemented will vary in each context, based on needs and strategy, these tools offer ways to approach some key components of most RCCE plans. Communities should be considered key implementing partners for RCCE activities during Ebola disease outbreaks or vaccination campaigns.

Tool 7: Community listening and feedback systems for Ebola disease outbreaks



This tool is designed to provide support for collecting and using community listening data, including social listening and community feedback for Ebola disease outbreaks.

Community listening encompasses various approaches to collecting data to identify current narratives, questions, rumours, misinformation, levels of trust and other relevant factors from at-risk populations. It can help to identify newly emerging concerns and to track and monitor trends and changing attitudes towards health authorities and interventions.

Online and offline sources should be used for community listening. Offline sources can include collection of qualitative and quantitative data, focus group discussions, findings from social-behavioural research, polls and insight from traditional media monitoring. Online sources can include social media, websites, etc. All community-listening sources have advantages, biases and limitations, which should be documented when reporting data. Setting up a dedicated online social-listening system involves defining objectives, selecting relevant social media platforms, identifying Ebola disease-related keywords and hashtags, setting up a taxonomy, monitoring these keywords using tools like Google Trends, conducting data analysis and reporting the findings to stakeholders. The system should be regularly reviewed and, based on the findings, adjusted, such as by adding new keywords and hashtags or by identifying new platforms of concern.

To collect community feedback on Ebola disease, identify community representatives who are closely involved with readiness, response and immunization activities or who are from or represent affected

communities. CSOs that are already involved in related health advocacy or service provision (i.e. setting up mobile immunization campaigns, development and distribution of information, education and communication (IEC) materials can be good sources of community feedback, as these groups can provide targeted input and help reach specific demographics more effectively. In support of collecting relevant feedback and conducting structured and effective conversations with communities, WHO has developed a Community conversation kit (21) to help people who have a leadership role speak with people in their community about how to protect themselves from health threats.

During an Ebola outbreak, a community-listening and feedback system can be an effective approach to detect a lack of information about the outbreak and the response, as well as any concerns about the Ebola disease outbreak interventions (22), among other things.

To effectively use community listening in managing an outbreak of Ebola disease, health authorities and all involved partners should use the full range of online and offline tools to collect, monitor and analyse public narratives and conversations related to Ebola disease. These tools may vary significantly from context to context and may be based on specific community needs, access and norms. Particular attention should be given to key populations and themes of misinformation, and should identify information voids, such as a sudden increase in searches for “Ebola symptoms” or “how do you catch Ebola?”



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Setting up a dedicated online social listening system involves defining objectives, selecting relevant social media platforms, identifying Ebola-related keywords and hashtags, setting up a taxonomy, monitoring these keywords using tools like Google Trends, conducting data analyses, and reporting the findings to stakeholders. Based on the findings, the system should be regularly reviewed and adjusted, such as by adding new keywords or hashtags or identifying new platforms of concern.

The data sourced through both social listening and community feedback systems can be triangulated with epidemiological data, research and programme data to gain additional insights to inform strategy and planning.

The development of community listening and community feedback systems for Ebola disease readiness and response will depend on existing platforms and resources, but should be considered an essential part of any RCCE planning. The following resources can be used to inform these activities, as can the matrix below in Table 8.

- [Community Engagement in Humanitarian Action Toolkit \(CHAT\)](#) (23)
- [IFRC Community Feedback Kit](#) (24)
- WHO/UNICEF [How to build an infodemic insights report](#) in six steps (25)

- [WHO Infodemic management 101 \(OpenWHO\)](#) (26)
- [Infodemic Management: Defining a taxonomy for social listening \(OpenWHO\)](#) (27)

During an Ebola disease outbreak, management of rumours and misinformation is a key component of successful RCCE interventions. Ebola disease may incite fear among the public and frontline responders alike due to the severe presentation of symptoms, misunderstandings about the causes of illness and high fatality rates (28). It is crucial for a given community to have accurate knowledge about modes of transmission and to observe correct practices for the prevention and control of Ebola disease (29).

For outbreaks where vaccination is an option, specifically outbreaks of EVD, negative messages about Ebola vaccine or their safety may emerge and can include distorted, false or misleading opinions, misinformation and disinformation, and expressions of anti-vaccine sentiment. Though not all messages warrant a response, it is important to set clear protocols to determine their relevance and impact as well as the appropriate response, if one is needed, from the health ministry, WHO, or other partners. You may wish to refer to the matrix above to standardize the protocol of reporting rumours and misinformation and to respond accordingly.

Table 8. Rumours, misinformation and event tracker

Issue / event / Date	Country of origin	Platform (print, web, social media, official statement, etc)	Level of risk (low or high)	Facts (what really happened, scientific explanations, etc)	Respond YES/NO	Initial response (IF YES) of WHO (key messages)	Cleared by:
							Date:
							Date:
							Date:



Tool 8: Developing key messages and content

The tool in Table 9 is designed to guide the development of key messages based on data collected, social-behavioural insights, epidemiological surveillance and best practices. Key messages are the main points of information you want to convey so that the audience will understand and remember the risk of contracting Ebola disease and the benefits of timely immunization.

These should be clear and concise statements that explain key concepts and factual information in lay language. Key messages should also support your desired communication outcomes – the change you want to see in the behaviour of the affected population.

Key messages for Ebola disease outbreaks should focus on key areas related to reducing risk of transmission, adhering to contact tracing and investigation, early care and isolation, and vaccination, if available, including:

- signs and symptoms;
- how it is spreading in the area/community;
- who is at risk (both of catching it and of displaying more serious symptoms);
- how to protect yourself and others;

- prevention and treatment;
- what to do if you get ill;
- benefits of immunization; and
- availability of/access to vaccines.

Key messages need to be adapted based on the local context (see Tool 1: Situational analysis: PESTEL), epidemiological surveillance, what is known about key audiences (see Tool 3: Mapping and understanding communities), enablers and barriers of key behaviours (see Tool 2: Behavioural analysis) and what is being learned through community listening (see Tool 7: Community listening and feedback systems). Below in Table 9, you will find a checklist containing key points to be considered when developing messages for your audience. Additional information on how to test your messages can be found [here](#) (30).

Table 9. Ebola disease key messages template

Process for developing key messages

- ☐ Identify and target key behaviours and influences.
 - ✓ Identify specific behaviours to target so there is a clear call to action for the public.
 - ✓ Draw on situational analysis (PESTEL), social-behavioural insights and other research to determine the key influences (cognitive, social and environmental) on those target behaviours.
 - ✓ Aim for the messages to utilize or address these key influences.
- ☐ Test messages (key and supporting) with the public before releasing them.
 - ✓ If possible, conduct quantitative testing of messages to identify best performers before mass roll-out.
 - ✓ If time is limited, undertake rapid qualitative testing to optimize content and presentation and to minimize risk of being misunderstood.

Language and content of key messages

- ☐ Include a clear action that directly conveys what people should or should not do.
 - ✓ This action should be prominent, so the reader knows what to do after a quick glance.
 - ✓ Use a rule of thumb or dos and don'ts.
- ☐ Make content easy for the public to understand.
 - ✓ Use clear and simple words.
 - ✓ Use as few words as possible, while still conveying the importance of the matter.
- ☐ Draw on positive social framing, where appropriate.
 - ✓ Use framing that encourages people to undertake a behaviour for the benefit of others. For example, framing the benefit of getting the vaccine as a way to “protect our livelihoods”.
- ☐ Include a reason why people should adopt the desired behaviour.
 - ✓ Provide a brief explanation or reason why a behaviour should be performed.
- ☐ Translate materials into multiple languages, where appropriate.
 - ✓ Provide multiple versions of messages in languages that are spoken in the target population.

Table 10. Ebola disease key messages and supporting messages template

Key message	The bodies of all deceased persons who had Ebola disease-like symptoms should be handled and prepared for burial only by a well-trained team using appropriate IPC measures
Target behaviour	SDBs
Supporting message 1	If a loved one has died from suspected or confirmed Ebola disease, do not touch the body, as the virus can still spread to others when the body is handled without protective measures.
Supporting message 2	If you have attended a burial ceremony of someone who is suspected or confirmed to have died from Ebola disease, wash your hands with soap and water or alcohol base handrub if hands are not visibly soiled) before and after the burial and after touching any surfaces in the area where the burial took place.
Supporting message 3	If a loved one has died with Ebola disease-like symptoms, you should follow the guidance provided by burial teams and local health authorities. Do not handle the body on your own.



Tool 9: Measurement, evaluation, and learning (MEL)

This tool will help enhance the accountability and effectiveness of RCCE through measuring, evaluating activities and constantly learning from your audiences how to improve or adapt interventions to achieve expected health outcomes.

A MEL framework recognizes the importance of (1) measurement to collect evidence; (2) evaluation and systematic analysis of results; and (3) learning to gain insights and new knowledge that can be applied in future planning and strategizing. MEL should be used throughout all phases of the emergency management cycle and should include community participation to support sustainability and joint accountability and, ultimately, to increase the effectiveness of RCCE strategies, plans and interventions (31).

Once you have determined if the problem you are tackling is of a behavioural nature or if it is another type of barrier, such as environmental or structural, you will be able to design effective interventions. There are many different models that can help design and structure a MEL framework that are based on priorities or targeted behaviours. Within the MEL manual, WHO proposes the Theory of Change and Program Logic Models. For detailed information on these tools, and others, access *The MEL Manual* [here](#) (31).

The Theory of Change and Program Logic Models help explain logically how a given intervention might be expected to lead to a desired behaviour change and how to measure progress toward that change along the way. The theory of change involves two key steps:

- identification of all the possible interventions and/or stimuli that can lead to a change in a particular context; and
- examination of the evidence and assumptions that support such beliefs.

The program logic model helps demonstrate the theory of change by linking activities with outputs, short-term and longer-term outcomes (See Table 11). The next step is to develop specific, measurable, achievable, realistic and time-bound (SMART) objectives and indicators to measure the progress and impact of the intervention. Indicators should be identified and collected at each stage of RCCE activities and aligned with national Ebola disease control plans to reflect priority actions and desired outcomes. The tools and examples provided below can be used to inform the identification of such indicators that are fit for the local context.

Below, Table 11 provides a template for structuring and planning your MEL framework.

Table 11. MEL framework template

The theory of change (programme logic model)						
E.g. people are unaware that the SDB interventions limit the spread of Ebola disease.	E.g. people are informed about the key benefits of conducting SDB interventions.	E.g. people form an opinion about SDBs and feel empowered to adhere to SDB interventions, such as the use of body bags, decontamination, safe management of potentially contaminated items/ areas and handwashing.	E.g. people are consistently engaged in online and offline conversations about SDB interventions against Ebola disease.	E.g. people acknowledge the value of preventive and responsive interventions.	E.g. people support SDB interventions against Ebola disease.	E.g. people are practicing SDB interventions to limit the spread of Ebola disease.
What do you need to complete MEL				When and how should you report on findings?		
<ol style="list-style-type: none"> 1. Situational analysis (PESTEL) 2. Behavioural analysis 3. Community listening 4. Stakeholder analysis 5. Community feedback mechanisms 6. Social listening reports 7. Access to Google analytics or other analytic tools related to social media 				<p>Here you should briefly outline your reporting plan, including reporting intervals, format, general content and more.</p>		



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What will you track?		
Inputs	Metrics and indicators	Methods
<i>e.g. data and insights collected through different research can qualify as inputs</i>		
Activities	Metrics and indicators	Methods
<i>e.g. producing and distributing RCCE products based on the collected data and insights</i>		
Outputs	Metrics and indicators	Methods
<i>Reaching and engaging audiences</i>		
<i>e.g. communities adhering to SDB interventions</i>	<i># of IEC materials developed</i>	<i>Log of materials in circulation (quantitative)</i>
	<i># of radio/tv programmes broadcast</i>	<i>Log of radio and TV announcements (quantitative)</i>
	<i># of posts on social media</i>	<i>Content analysis and social media reports (qualitative)</i>
Short-term outcomes	Metrics and indicators	Methods
<i>Assessing audiences' initial reactions, response to RCCE activities</i>		
<i>People form an opinion about the SDB and feel empowered to implement SDB interventions, such as use of body bag, decontamination, safe management of potentially contaminated items, areas, handwashing</i>	<i># of people adhering to SDB interventions</i>	<i>e.g. conducting knowledge, attitude and practice (KAP) surveys</i>
Long-term outcomes	Metrics and indicators	Methods
<i>Evaluating what sustainable effects RCCE activities had on audiences</i>		
<i>People acknowledge the value of conducting SDBs against Ebola disease</i>	<i># of people aware of the value of SDBs (should see the number increasing over time)</i>	<i>e.g. conducting longitudinal study</i>
<i>People support SDBs against Ebola disease</i>	<i># of SDB refusals (decreasing over time)</i>	<i>e.g. conducting response activities analysis</i>

Impact	Metrics and indicators	Methods
Evaluating the results achieved, in full or in part, by RCCE activities		
People practice SDBs when someone dies with Ebola disease symptoms	# of people infected during funerals and burials	e.g. conducting response activities analysis

The Collective Service has developed the [Risk communication and community engagement indicator guidance for COVID-19](#) (32), which provides

useful support that can be applied to other areas, including Ebola disease outbreak.

Tool 10: Checklist for preventing and responding to sexual exploitation, abuse and harassment



This tool, in Table 12 below, is designed to help RCCE decision-makers, practitioners and partners identify and include key activities for PRSEAH in planning and implementation. This tool should be used together with the principles for managing PRSEAH that are described in Annex 1.

Sexual misconduct, such as sexual exploitation, abuse and harassment (SEAH) and sexual violence violate the rights and well-being of the people we serve and the people with whom we serve. Such behaviours are in direct opposition to WHO's values and our abiding responsibility to do no harm. WHO's workforce and collaborators are prohibited from engaging in such acts, and therefore they will lead to disciplinary action when they occur.

WHO has zero tolerance for any form of sexual misconduct, inaction or retaliation against those who raise complaints or bear witness. Our work prioritizes the rights and needs of victims and survivors.

Sexual misconduct can occur in all communities. In the context of an outbreak of Ebola disease, victims of sexual misconduct can face the additional threat of exposure to HIV or to other infectious diseases or conditions.

Please note that it is your obligation to report any wrongdoing you become aware of or witness directly through established complaint mechanisms. Do not conduct the investigation yourself; only investigators are mandated and trained to do so.

If you work for WHO and become aware of wrongdoing, please alert officials to the wrongdoing by writing directly to investigation@who.int or access the [integrity hotline](#).



Table 12. PRSEAH checklist

For best results, RCCE practitioners should identify and coordinate with the PRSEAH focal point on the following activities:

- 1. Contribute** proactively to the SEAH risk assessment and implementation of the risk-mitigation plan.
- 2. Identify** trusted networks within communities to engage them in becoming more aware of and addressing sexual misconduct concerns.
- 3. Contribute** to the development and dissemination of clear and consistent PRSEAH messages adapted to local contexts and preferences. These must include: i) aid, including medical interventions and services is free and must not be exchanged for anything; ii) what to expect from development and aid workers, including health providers; iii) how to safely report any wrongdoing; and iv) how victims can access services.
- 4. Support** the dissemination of PRSEAH materials during RCCE interventions with and through CBOs, CSOs and public information stakeholders.
- 5. Ensure** prevention and response to sexual misconduct components are included in training curricula and other key materials.

Principles and considerations for Ebola disease outbreaks



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This section contains additional considerations for RCCE strategy, planning and implementation during Ebola disease outbreaks. More on RCCE principles can be found in the [10 steps to community readiness package \(1\)](#) from the RCCE Collective Service.

What we have learned from previous Ebola outbreaks

RCCE coordination is established by the technical and/or sub-technical working groups, depending on key subfunctions within the RCCE. During the 2021 EVD outbreak in Guinea, the RCCE coordination members were selected from multisectoral profiles, including Prefecture Department of Health (DPS), the Collective Service core agencies and dedicated interagency coordinator, international NGOs, local NGOs, local elected actors, faith-based organizations, women and youth organizations, traditional-influential leaders (Zowos), radio producers, journalists and social media influencers.

Since EVD outbreaks in West Africa and the Democratic Republic of the Congo, the RCCE architecture has been enriched with specific and multisectoral expertise to enhance the interventions and avoid duplicative efforts. Building on this experience, the RCCE team is coordinated around working groups on different topics such as: strategic coordination and planning, content development, capacity building, rumours management and community feedback mechanisms, media partnerships, data analysis and evidence generation, etc.

In the Democratic Republic of the Congo (2018), a group of RCCE experts was selected and trained as trainers to help cascade RCCE capacities from national to local levels.

During the 2022 SVD outbreak in Uganda, the RCCE East and Southern African Region technical working group, which was established in the wake of the COVID-19 pandemic[2], integrated Ebola outbreak activities through a dedicated Ebola technical working group at regional level. This experience brought out new ideas of coordinating RCCE activities during an Ebola disease outbreak at all levels: global, regional, national and subnational.

The experience from the 2014 Ebola virus disease outbreak in West Africa, “reinforced that context and culture matter and clearly demonstrated the interdependent and reciprocal relationship between

health service providers, responders and health service users, their families and communities” (33). Over time, engaging with affected communities has been found to be a key intervention for readiness, preparedness and response (34) and important to building communities’ resilience. Engagement means adapting the response on a case-by-case basis by listening and learning so that complex social and political relationships can be taken into account (35). Credible, trusted, relevant, timely, accessible and actionable health information is crucial for the acceptance and adoption of life-saving interventions (34). It is key to understand that:

- Communities experience most intensively a disease outbreak.
- They are the first and final responders.
- They will live with the consequences of death, disease, disability, suffering and societal and economical loss and community engagement offers methodologies for response teams and communities to work together to stop an outbreak.
- Communities will not automatically trust strangers (foreign or national).
- Response teams, therefore, need to work with established community engagement networks and trusted interlocutors.
- Community engagement should involve more than a token effort, one that goes beyond telling communities what to do (34).

Furthermore, RCCE as a function during an Ebola disease outbreak is intended to ensure that the community is considered in all steps, meaning “early and ongoing engagement with the affected communities. In addition to being ethically important, community engagement is essential to establishing and maintaining trust and preserving social order” (36). Therefore, the RCCE experts must remain prepared to respond to an Ebola disease outbreak anywhere and at any time in an integrated approach within the Incident Management System and considering the needs of the community.

Experience with RCCE interventions has demonstrated the importance of listening to communities. Efforts to contain the spread of Ebola in the eastern Democratic Republic of the Congo during the 2018–2020 epidemic faced major challenges in gaining community trust and participation. This affected the implementation of community alerts, early isolation, contact tracing, vaccination and SDBs (21).

A strong and effective community feedback mechanism helped RCCE practitioners gather evidence for more widespread and frequently updated RCCE regarding cases, deaths and survivors, as well as EVD symptoms; it also helped them address concerns, misconceptions, rumours and misinformation surrounding Ebola disease (22, 29, 37).

Misleading information and perceptions can increase the chance that community members will refuse Ebola disease outbreak interventions. 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 (28). Therefore, strategies to implement RCCE interventions should include considering integrated approaches for effective community listening. Experience from Ebola outbreaks has found that community feedback should be systematically collated, analysed, presented and integrated into activities of relevant national task forces to ensure that concerns implicating other pillars can be responded to and acted upon (37).

During the 10th Ebola virus disease outbreak in the Democratic Republic of the Congo (2018–2020), a study showed that the mistaken belief among some people that vaccines reactivated diseases in vaccinated individuals accounted for 19.7% of Ebola vaccine refusals and the misconception that vaccines cause death accounted for 13.4% of vaccine refusals among the community members polled (38). Rumours and misinformation pose a major challenge during Ebola disease outbreaks, negatively affect risk perception and cause fear among patients, healthcare personnel, and even decision-makers (39).

Addressing uncertainty and maintaining trust

Managing uncertainty is an important function of RCCE during outbreaks and health emergencies. The readiness phase of an Ebola disease outbreak is an opportunity to gather data to understand how people who may be at risk of Ebola disease understand the various modes of transmission and personal protective behaviours and are receptive to vector-control measures and immunization, where and when available. Settings or communities that have not previously experienced Ebola disease outbreaks may experience higher levels of uncertainty.

Approaches to managing and addressing uncertainty should be included in RCCE strategies and plans to maintain trust throughout the outbreak. Key steps for managing uncertainty include:

- assessing the situation to understand what is known and unknown;
- identifying key uncertainties that may affect community understanding and response;
- listening to and responding to community concerns;
- understanding what health-care workers and affected community members think and expect regarding the efficacy of the control measures proposed or applied so far;
- identifying community resources that would enable the promotion of contact tracing and early isolation of patients or other preventive interventions;
- providing relevant and up-to-date information to health workers and other partners involved in the response who are trusted by the affected community;
- being transparent and honest;
- setting realistic expectations;
- acknowledging that what is known may change;
- explaining what has been done so far and what are the anticipated next steps; and
- being prepared to adapt (40).

Other potential uncertainties may include responding to specific events related to vaccination, including AEFIs. Side effects and AEFIs from Ebola disease vaccination are rare. However, it is inevitable that some people will make negative claims about the safety of Ebola disease vaccines. The response should depend on the potential impact of the claim and Table 13 provides a general timeline. Events that meet at least one of the following criteria will require a response:

- **The AEFI is genuine.** The primary role is to protect the health of the public. Responsiveness is essential. Dismissing people's safety concerns as mere anti-vaccination claims can lead to harms at a population and clinical level if the AEFI is not taken seriously and investigated.
- **The event or story is gaining attention.** Based on evidence from community feedback or social listening, it is clear that the event is gaining attention and exposure, particularly among the population groups prioritized for Ebola disease vaccination.
- **The alleged adverse event is unsubstantiated** but publicised by a group of individuals drawn together by a shared belief, for example, that the vaccine has negatively affected their life or the lives of their loved ones in some way.
- **A respected opinion leader who is trusted in the community is advancing a view.** A major concern in vaccine safety is when a medically trained person publicly advances a theory. They may influence health-care workers and their confidence in recommending vaccination, and thus may have an impact on the wider community.
- **The confidence of health-care workers is likely to be affected.** Vaccine safety concerns that amplify existing hesitancy in health-care workers or that trigger new concerns require a rapid response. Confident, committed doctors and nurses are vital for vaccination programmes to succeed. In the case of Ebola disease vaccines, they are recipients, providers and champions of the vaccine.
- **The issue or event touches on moral foundations that highly influence vaccine acceptance.** For example, claims based on religious beliefs are strongly correlated with vaccine rejection. These can include claims about the vaccine ingredients (purity/degradation) or claims about some level of coercion in vaccine programmes, either real or perceived (liberty). The suggested approach to resolving possible public outrage driven by any of the above claims or issues is to apply the below principles and timetable.

Table 13. Timeline for RCCE activities following AEFI report

Timing	Action
Before AEFI	<p>Conduct situational analysis (PESTEL), behavioural research, community listening, stakeholder analysis.</p> <p>Develop "Rumours, misinformation and event tracker".</p> <p>Assemble background information about AEFIs.</p> <p>Prepare materials (Q&As, fact sheets, talking points, etc.).</p> <p>Build relationships with members of the news media, partners and local health authorities.</p> <p>Provide ongoing information to the news media about immunization plans.</p> <p>Train relevant staff and spokespersons.</p>



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<p>During AEFI</p>	<p>Immediately:</p> <ul style="list-style-type: none"> • Identify what has happened and verify the report. • Gather information and analyse data. • Alert other pillar leads from the IMST and relevant partner focal points. • Decide the level of risk and whether to communicate forward. <p>Within 24 hours:</p> <ul style="list-style-type: none"> • Prepare response with inputs from technical officers and regional or headquarters colleagues. • Prepare talking points and background data. • Coordinate response with the Ministry of Health, local health authorities and partners, as relevant. • Select the potential communication channel based on local context (radio, TV, print, etc.) <p>Within 72 hours:</p> <ul style="list-style-type: none"> • Consider issuing a press release. • Consider holding a joint-press conference (WHO, Ministry of Health, other involved partners). <p>Ongoing:</p> <ul style="list-style-type: none"> • Provide information to healthcare workers, partners, media and the public. • Update with interim information until definitive results available.
<p>After AEFI</p>	<ul style="list-style-type: none"> • Evaluate communication approach and efficacy of applied protocols; adjust as needed. • Provide ongoing information to media and the public about the immunization programme.

Other tools and products for Ebola disease outbreak readiness and response



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Guidance	
<p><u>Infection prevention and control guideline for Ebola and Marburg disease, August 2023</u> ⁽⁴¹⁾</p>	<p>This comprehensive guideline is based on GRADE methodology and uses the best available evidence to ensure patients with Ebola or Marburg disease can be safely cared for while preventing transmission within health facilities and promoting health and care worker safety. This guideline includes 11 new recommendations and 10 new good practice statements. Nine recommendations from previously published IPC documents have been carried forward and are included in this new document. This guideline replaces three previously published IPC guidance/guidelines from 2014 and 2016.</p>
<p><u>Ebola and Marburg virus outbreak toolbox</u> ⁽⁴²⁾</p>	<p>This toolkit compiles key documents, case definitions, data-collection tools, information on laboratory confirmation and other response tools and resources.</p>
<p><u>Ebola and Marburg virus disease epidemics: preparedness, alert, control, and evaluation</u> ⁽⁶⁾</p>	<p>The main target audiences of this document are district-level health-care workers (doctors, nurses and paramedics), as well as intermediate- and central-level health-care workers responsible for epidemic control, and International Health Regulations (IHR) National Focal Points. The objective of this document is to describe preparedness, prevention and control measures that have been implemented successfully during previous epidemics. These measures must be implemented during the following four phases: (1) pre-epidemic preparedness; (2) alert (identify, investigate, evaluate risks); (3) outbreak response and containment operations; (4) post-epidemic evaluation.</p>
<p><u>Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease</u> ⁽⁴³⁾</p>	<p>To save the lives of mothers and their babies, mitigate complications and limit the spread of disease, it is critical that recommendations are made on the prevention, treatment and surveillance of women who are exposed to EVD, acquire EVD during pregnancy or breastfeeding or survive EVD with ongoing pregnancies. These guidelines are the first to provide such recommendations.</p>



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Therapeutics for Ebola virus disease ⁽⁴⁴⁾

The WHO Ebola virus disease clinical management: living guidance contains the Organization's most up-to-date recommendations for the clinical management of people with EVD. Providing guidance that is comprehensive and holistic for the optimal care of patients with EVD throughout their illness is important.

The living guidance is available in both pdf format and via an online platform in both French and English and is updated regularly as new evidence emerges.

Optimized supportive care for Ebola virus disease: clinical management standard operating procedures ⁽⁴⁵⁾

These guidelines focus on the delivery of supportive care measures to patients in Ebola treatment units where health-care resources are limited. They could be relevant to other infectious diseases with clinical syndromes similar to Ebola that are managed in isolation facilities. The target audiences include health workers, governmental and nongovernmental health agencies, public health organizations, local and clinical facility managers and health policy makers at all levels.

Q&As, key messages and fact sheets

Ebola virus disease key facts and overview ⁽¹⁰⁾

Information about EVD, including key facts, symptoms, treatment and prevention

Ebola Virus disease: Q&A ⁽¹¹⁾

Frequently asked questions on Ebola virus disease, including transmission and risk

Ebola Virus Disease: Key questions and answers concerning water, sanitation and hygiene (WHO, UNICEF) ⁽⁴⁶⁾

This question-and-answer document provides practical, evidence-based recommendations on minimum requirements and best practices for water, sanitation and hygiene (WASH). It was originally developed in 2014 during the West Africa Ebola outbreak and was updated in 2021 to reflect lessons learned and new operational research data. The key recommendations on WASH remain the same.



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Ebola Virus Disease: Key questions and answers concerning health-care waste, water, sanitation and hygiene (WHO, UNICEF) (47)

Safe handling, treatment and disposal of health-care waste are important tasks within the broader activities of stopping an Ebola outbreak. This is especially true considering the large amount of waste generated, including disposal of PPE. The main objective of this document, jointly developed by WHO and UNICEF in 2014 and updated in July 2021, is to highlight specific public health issues concerning health-care waste in the context of low-resource settings.

Surveillance and Contact Tracing—Ebola Virus Disease (EVD) (48)

This document provides frequently asked questions and answers regarding the surveillance and contact tracing of EVD and is aimed at health professionals and decision-makers. These questions and answers complement information already published in various WHO guidance and documents.

Sexual and Reproductive Health and Ebola (49)

A disease outbreak does not change women's and adolescent girls' fundamental human right to sexual and reproductive health care, including evidence-based care during pregnancy and childbirth. These resources support women to make informed reproductive health-care choices for themselves and their children. Women living in an Ebola outbreak should have access to all relevant reproductive options, regardless of economic, cultural, racial or religious status, including contraception and safe abortion, to the full extent of the law.

Vaccination

Ebola virus disease: Vaccines (12)

Key information about vaccines for the prevention of EVD, vaccine eligibility, protection and more.

Health products and standardization: Ebola virus vaccine (50)

An overview of the development process and vaccine standardization.



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International Coordinating Group (ICG) on Vaccine Provision ⁽⁵¹⁾

An overview and background on the ICG, which manages the global stockpile of Ebola vaccine doses



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Other resources and reference tools



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How to put on and how to remove personal protective equipment – posters/infographic ⁽⁵²⁾

Posters with detailed instructions for health-care professionals on how put on and how to remove PPE before and after visiting a treatment centre or isolation unit.



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Community engagement: a health promotion guide for universal health coverage in the hands of the people ⁽⁵⁾

At its core, community engagement enables changes in behaviour, environments, policies, programmes and practices within communities. There are different levels, depths and breadths of community engagement which determine the type and degree of involvement of the people.



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This guide is intended for change agents involved in community work at the level of communities and healthy settings.



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COMMUNICATING WITH COMMUNITIES IN EPIDEMICS AND PANDEMICS: Risk Communication and Community Engagement (RCCE) Readiness Kit. Strengthening Preparedness to Respond to Outbreaks in Humanitarian Settings ⁽⁵³⁾

This document, referred to as the RCCE Readiness Kit, is designed to guide NGOs through a series of readiness actions to help them prepare and plan effective communication and community engagement in emerging epidemics and pandemics. Recommended readiness actions link to practical tools that support their implementation.



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Ebola disease training resources



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WHO has the following trainings that will help you learn more about Ebola disease. Note that most of the following resources are currently (as of February 2024) under revision.

Note: This list can change as new training packages become available on [Ebola WHO online courses](#)

Training	Overview
Ebola: Introduction (54)	This introductory session explains the basic principles of Ebola virus disease and ways to protect yourself and others. By the end of this lecture, you should be able to: describe Ebola disease and how it is transmitted; recall basic measures to prevent Ebola disease; and list key public health concerns during an Ebola outbreak. This course is available in English, French, Kiswahili and Lingála.
Ebola: Clinical management of Ebola virus disease (55)	This comprehensive, intermediate-level course is for clinicians caring for patients with suspected or confirmed Ebola virus disease (EVD). Modules provide information on screening and triage, infection prevention and control, laboratory diagnostics, organization of the Ebola treatment centre, clinical care of patients in the Ebola treatment centre, and investigational therapeutic agents. This course is available in English, French and Kiswahili
Ebola: Knowledge resources for responders (56)	Decision-makers and frontline responders will find a set of resources on Ebola disease here. These resources can be used as refreshers for experienced personnel or as an introduction to the topic for everyone else. Most of the materials are available in English and French and can be downloaded for offline use. Versions in Lingála and Kiswahili are also available.
Ebola: GO 2.0 (57)	All personnel responding to Ebola outbreaks need to have basic knowledge and skills in order to mount an effective response. The GO training package was developed for WHO deployees so they can work safely and effectively as part of the teams bringing outbreaks under control. The learning package consists of seven modules, which include video lectures and downloadable presentations that have been updated with the latest information and developments. It begins with an introduction to Ebola disease before moving to the response strategy and essential information related to working for WHO. The GO materials are designed to complement the ePROTECT training.



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EVD Rapid Response Teams Training Package ⁽⁵⁸⁾

The Ebola Virus Disease (EVD) Rapid Response Team (RRT) training package is a structured, comprehensive collection of training resources and tools enabling relevant training institutions to organize, run and evaluate face-to-face training for national RRTs. It aims at reinforcing the capacity and skills of multidisciplinary RRTs and their individual members to early detect and effectively respond to a potential EVD outbreak.

The EVD RRT training package was designed and developed by the WHO Regional Office for the Eastern Mediterranean Region, the WHO Regional Office for Africa and the WHO National Capacity Alert and Response Department, in collaboration with the Egyptian Society of Epidemiology.

Target audience: National professionals (including epidemiologists, clinicians - doctors and nurses - laboratory experts, communication officers, social mobilization experts, anthropologists, logisticians, psychosocial support experts, data managers, IPC specialists and environmental experts who are likely to be deployed as members of RRTs when an alert is given on a suspected EVD case in their country.

SocialNet: Empowering communities before, during, and after an infectious disease outbreak ⁽⁵⁹⁾

Communities are at the heart of every response. Effective RCCE supports communities and individuals in understanding the risks they face and making informed decisions about how to protect themselves and the people around them. Accurate information, provided to communities in ways they understand and respect builds trust and supports the success of prevention, response and recovery efforts.

Social sciences – including sociology, psychology and anthropology, among other disciplines – are an important part of developing effective RCCE interventions that are sensitive to the cultural, historical and behavioural perspectives of communities. In this course, you will learn about how to apply social sciences to build trust and ensure that communities are equal partners in developing solutions before, during and after emergencies.

References



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Annexes



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Annex 1. Guidance for practitioners on the prevention of and response to sexual exploitation, abuse and harassment

*This guidance is a rapid reference point for RCCE practitioners working before and during health emergencies. For more in-depth resources, please refer to the WHO PRSEAH webpage **Preventing and Responding to Sexual Exploitation, Abuse and Harassment (who.int)**. Please work closely with the country focal point for PRSEAH for context-specific guidance.*



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- Refresh your knowledge and understanding of PRSEAH prior to your engagement with communities.
- Engage with communities based on need and without any discrimination based on gender, sexual orientation, nationality, ethnicity, religion, age or political affiliations.
- Ensure clear communication with community members on the reporting mechanisms at their disposal. Make it clear that reporting will not prevent them from receiving the support they are entitled to and that victims/survivors of sexual misconduct have a right to services regardless of their willingness to cooperate with an investigation.
- Be aware that victims and survivors of SEAH are often afraid and ashamed of reporting and may be at risk of further harm or stigmatization. Therefore, whenever possible, make sure RCCE work includes the identification of trusted community networks, organizations or leaders, especially women's networks that can provide safety and support to those at risk or to those who have already experienced SEAH.
- In your RCCE work, gather intelligence on trusted channels of communication, the languages, literacy levels and preferences of those most at risk, and integrate such intelligence in designing awareness campaigns and other PRSEAH actions.
- Your actions as an RCCE practitioner must be guided by the principles of do no harm, confidentiality, transparency, accountability and duty to report, prevention, non-discrimination and equality. Treat the populations you serve with respect and protect them from sexual exploitation, abuse and harassment by development and aid workers both during and outside working hours.
- Responders cannot demand or accept any sexual favours from community members, as a condition of employment or in exchange for assistance due to communities. If you are working for or on behalf of WHO, comply with WHO's policy on preventing and addressing sexual misconduct at all times.

Country focal points for PRSEAH will, in many cases, also have information about local contexts, including dedicated hotline numbers established by the United Nations Country Team for reporting sexual misconduct.

Annex 2. Draft outbreak announcement

Background: an outbreak announcement is released to inform the public of a public health concern or threat. It aims to engage, reassure and provide early guidance to health-care workers and the public, particularly to those communities that are most-affected.

****Remember the importance of timeliness and transparency in building and maintaining public trust****

This sample can be adapted to your local context:

On **[date]**, a **[country]** resident tested positive for Ebola disease after developing **[describe symptoms: e.g. a rash, fever, muscle aches, etc.] [number of days]** prior. The case was immediately isolated and, as of **[date]**, extensive contact tracing has been undertaken to identify exposed contacts. These individuals will be followed up for 21 days from the date of the last exposure to the case.

The case(s) identified so far has (have) been of the **[name strain or orthoebolavirus]**. The risk of onward transmission related to this case (these cases) is currently **[low as the case was (the cases were) immediately isolated and contact tracing undertaken/high because we have not been able to trace all of the individual's (individuals') contacts]**. We do not yet know the source of infection. There therefore remains a risk of ongoing transmission in this country.

[Country-specific response – describe what you are doing]

Example: We have initiated public health interventions **[details on the type of interventions launched]** to rapidly stop the spread of the disease and to better understand the situation; these efforts have included launching studies into the disease epidemiology and virus characteristics. We are also implementing control measures, such as case finding and contact tracing, as well as providing supportive care for patients.

[Country-specific response – define where the public can find information]

Example: Over the coming days and weeks and as we find out more, we will regularly share information regarding risks associated with Ebola disease and advice on how to avoid infection and protect your health. Please check **[a variety of places where members of your community access news and health information, e.g. the health authority website, social media accounts, the national public service broadcaster, etc.]**. Members of the public can also call **[specific health service number, if one exists]** if they have any questions regarding the disease.

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