CORDS

Connecting Organizations for
Regional Disease Surveillance

CURRICULUM

EBOLA -

INTENSIFIED PREPAREDNESS PROGRAMME

Building capacity in communication and community work to better manage the Ebola outbreak

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Contents

1. Introduction

1.1 About this curriculum

This curriculum is not a conventional curriculum, that is, one that defines key learning objectives of skills, contents and competencies acquired after participating in the training. Rather, it is more like a living document that provides an observation, analysis and reflection framework to learn and better understand the current practice on the ground: the conflicts and frictions between western-style infection control management and African realities. It offers tools to reflect on ways to improve preparedness for, response to and recovery from Ebola virus outbreaks, building on existing community-based infrastructures and a systematic approach for implementing new health and risk management governance.

This curriculum will be updated after each training to reflect advancement in the learning process – yet this process will be on both sides by both parties: 'trainers' and 'participants' are to engage in joint activities to listen and learn from each other and to actively make practical sense of infection control, health care and risk governance in diverse and changing social and cultural environments.

The starting point of this curriculum are the lessons we have learned so far about previous Ebola outbreak management in East and Central Africa; building on the key lesson about the roles of communities and communication (Chapter 1: Introduction) we have developed a framework to reflect the parameters of change in the life cycle of an infectious disease (Chapter 2: Concept) and tools to reflect the dimensions and activities of infectious control governance (Chapter 3: Tools). Each training will collect key learning and action plans for preparedness, response and recovery (chapter 4 and 5) that will be available as online material from our website (www.cordsnetwork.org).

1.2 Background

Ebola outbreak in West Africa

The Ebola outbreak in West Africa is unprecedented in its extent and dynamics. The outbreak started mid December 2013 in a rural community in Guinea and has now spread to five other countries in West Africa: Liberia, Sierra Leone, Nigeria, Senegal, Mali and two Western countries: USA and Spain.

In the most affected countries – Guinea, Sierra Leone and Liberia – the infectious disease outbreak has developed into a crisis and further into a humanitarian disaster where the social and economic impacts of the disease have devastating effects on the countries and the emergency response. These three countries are among the poorest and least developed in the

world. Civil wars, mismanagement and corruption have destabilized communities, and important social sectors (including health, education, public governance, transport and communication) were unprepared to undertake a coordinated and efficient response to public health emergencies. Ebola is not only a medical problem, but affects the whole of societies in affected and not-yet-affected countries. Therefore the biomedically-focused narrative in infection control management is not sufficiently comprehensive.

Western infection control protocol and African realities

International NGOs, UN organisations and leading infection control centres have undertaken robust effort to respond and assist countries' management. However, the effectiveness of western-style infection control management has been limited and has even made communities hostile towards the external aid they urgently needed. There seems to be a clash of cultures: strong, interwoven communities in West Africa have their own organisational, social, cultural and religious structures and rationales whereby the application of western infection control patterns fomented communities' resistance in an environment where cooperation was urgently needed.

Paradigm shift

The Ebola outbreak represents a paradigmatic shift in the way infection control management is understood and performed. It stresses that both the biomedical perspective and western-style infection control management are applied too narrowly to prepare, respond and recover from the current Ebola outbreak in West Africa. It also emphasizes the need for a more appropriate approach to develop more suitable and sustainable solutions on the ground.

1.3 Approach

CORDS approach: Community – Care – Communication

CORDS connects infectious disease surveillance networks globally, working continuously with people on the ground to build trust, strengthen capacity through collaboration and information sharing and engagement through skill-building activities. CORDS applies its wealth of experience working with communities and promotes a risk communication approach that promotes different perspectives and encourages health authorities to engage and work with communities, not against them. This innovative risk management and risk communication approach represents a key landmark in the way infectious disease management is conceptualised and performed. CORDS' work focuses on developing

solutions with and within communities.

Training approach

To enhance and leverage resources and on-going activities, CORDS suggests an ***Intensified Preparedness Programme*** (IPP) for affected countries and not-yet-affected countries, focusing on community – care – communication in order to increase capacity for preparedness and response, build trust between communities and health care workers and the resilience in the communities.

This IPP is based on an innovative, culturally sensitive risk management and risk communication approach that supports both the short-term crisis response efforts and the longer-term capacity building that is independent from external aid and relies on networking and communication. The IPP is a multi-format programme that addresses affected and not-yet-affected countries and complements the activities of international organisations through the following services:

- **Trainings** for various target groups in risk management and risk communication (contents and methods);
- Provision of **online material** from trainings and briefing as open resource;
- **Consultancy briefings** for international leaders and executives for on-demand support in risk management decision-making.

Core principles: Community – Care – Communication

The governing principle of our approach is that the community is the basis of care and communication. Building on this principle our training is structured as follows:

1. Introduction: key principles of the approach
2. Concept: parameters of interventions, community-basis of care and communication
3. Analysis and reflection tools: action matrix, change matrix
4. Applications: Preparedness, response and recovery lessons from each training (pilot trainings, in-country training)
5. Implementation: action plans
6. Reflection: next steps

2. Concept

2.1 Parameters of interventions: FASTER – CLOSER – EARLIER – SMARTER

The overall aim is to improve detection and response and minimize the impact of the outbreak on communities. We have identified four parameters where interventions are most effective. To illustrate the parameters of interventions we employ a graph detailing the progression of a typical outbreak, such as Ebola (normal distribution) and the typical public health response (public health curve).

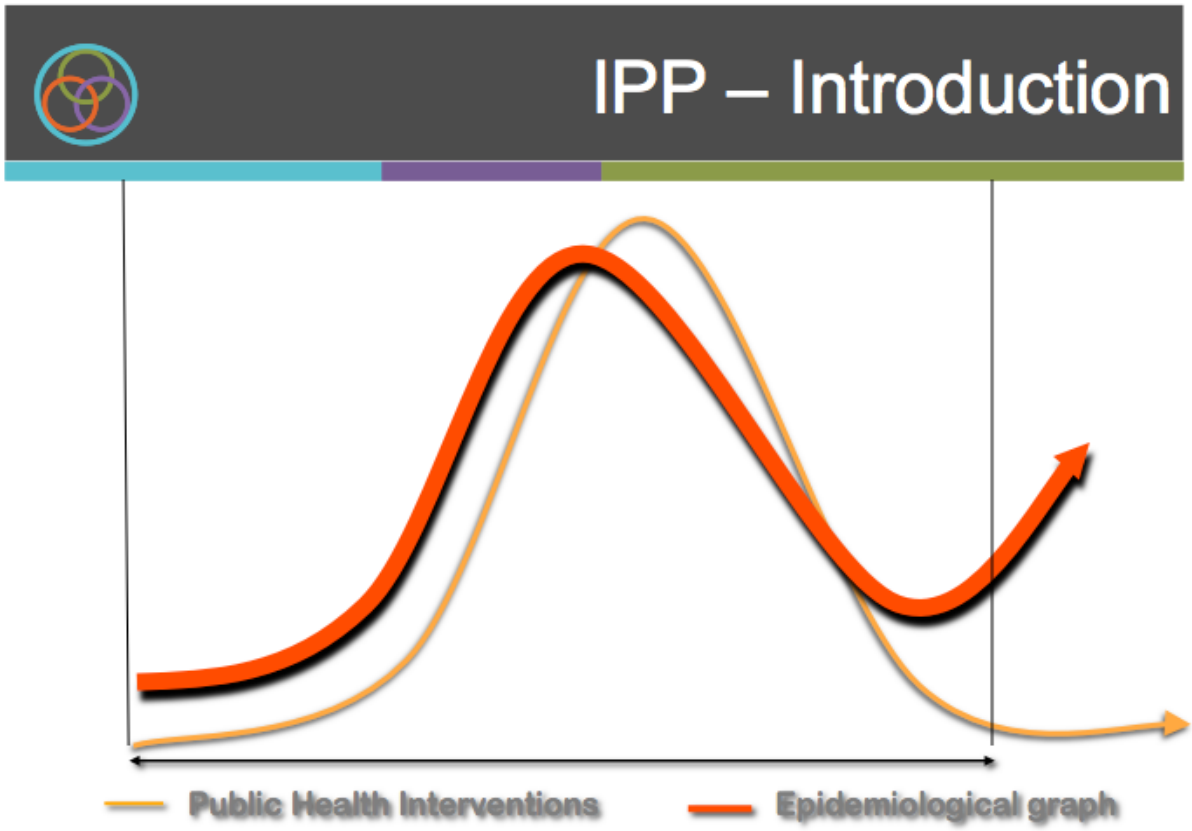

Figure 1: Outbreak and public health interventions

The infectious disease outbreak starts slowly somewhere, develops and accelerates with more cases, peaks and abates; the public health interventions usually start when the outbreak is detected and response interventions commence with some delays, peaking and returning to normal. We identified four relevant parameters where we would like to improve preparedness, response and recovery:

Faster response

First, in the routine epidemic situation, there is a **time lag** between the onset of the outbreak and the activation of public health activities – this can lead to the disease spreading faster

without intervention (1); in case of Ebola virus this time lag plays a pivotal role for the success of infection control.

Our training supports public health personnel to reduce the time lag between the start of an outbreak and the activation of public health activities; response becomes FASTER. The sharing of information among communities and countries, especially in cross-border regions, can produce a faster response. Information received of an outbreak in one region can lead to a faster, more prepared and more effective response in other regions. Listening to rumours and activation of rapid response teams are other critically important components of a faster response.

Closer to the communities

Secondly there is a gap, **a distance** between infectious disease activities on the ground and public health activities – this can lead to mistrust between the public and health officials and, as a result, contribute to further spread of the disease when people lack knowledge and distrust health recommendations (2).

CLOSER: Our training supports public health authorities to get closer and become more connected with their communities and fight the disease on the ground. By engaging with communities from the beginning and involving communities in key decisions and key solutions, public health personnel and medical professionals are getting closer to their communities.

Earlier reporting

Thirdly, communities usually face a protracted process for reporting an outbreak to district, national and international levels (e.g., WHO) in order to: 1) comply with national and international health regulations, and 2) request further assistance in the management of an outbreak (3). Having an established information system, trustful interpersonal communication and a cross-border communication infrastructure sharing information and collaborating among neighbouring countries is crucial for EARLIER reporting to higher administrative levels and increase impact.

Leaving a legacy

Fourth, while the majority of attention is often focused on response and crisis management, people and countries *do* recover from Ebola. Infection control governance must reflect and propose ways to integrate survivors back into the communities, create support systems for

orphans and ensure that major lessons from this health emergency leads to development of a sustainable health system and health knowledge in the communities that enables them to learn from and apply lessons in future outbreaks. (4).

Our training supports communities and countries to leave a legacy by building and increasing capacity for knowledge and response in the community. Communities become SMARTER.

These four parameters of intervention provide a framework to analyse and reflect on changes to the current situation in order to improve preparedness, response and recovery by being faster, closer, earlier and smarter.

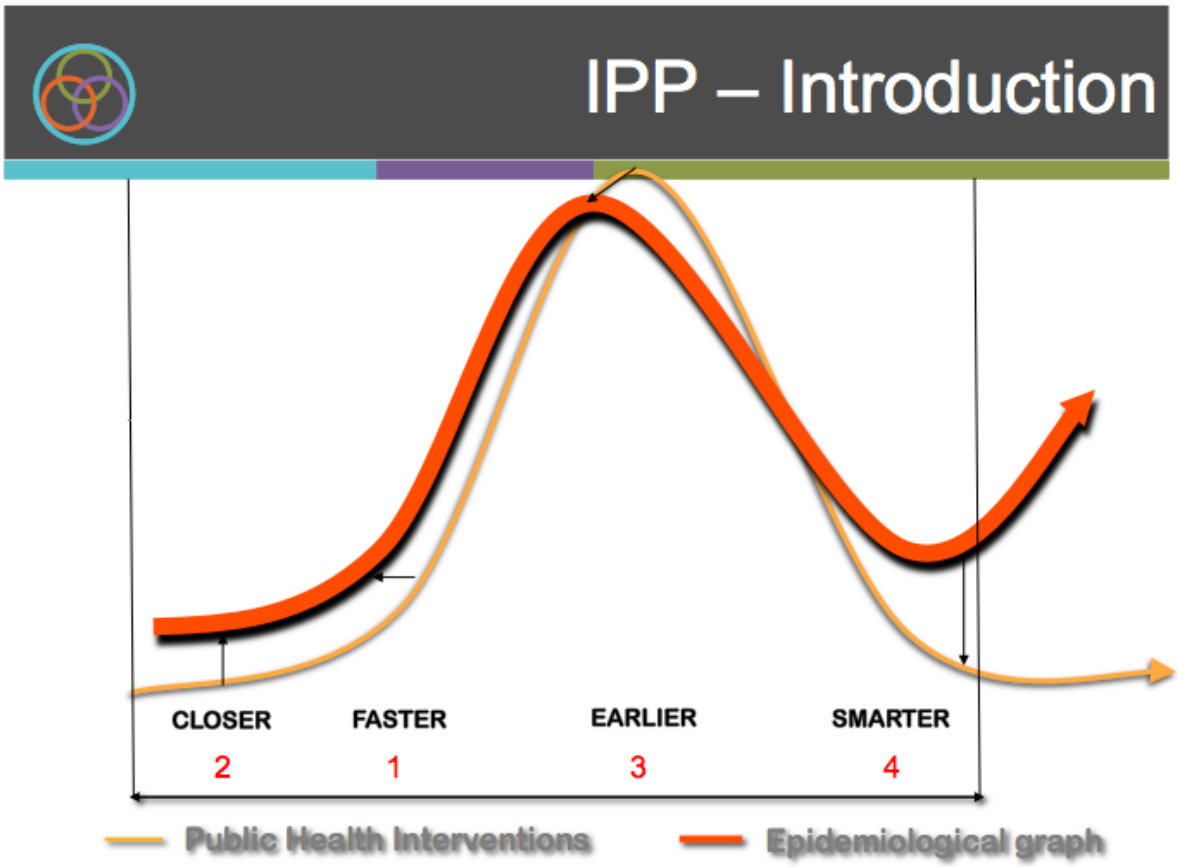

Figure 2: Four parameters of intervention

2.2 Community basis of care and communication

Drawing on the lessons learned from previous Ebola outbreaks and from evidence made during this current outbreak, much of the health advice and recommendations from western institutions simply do not translate well to the realities in Western African countries, and, thus, become major impediments to infection control and containment. This disconnect

between values, understandings and beliefs of African cultures and western infection control practices has been most apparent in three significant areas:

1) Traditional burials: many African people place higher priority on traditional burial of the deceased than on infection control. The particular problem with Ebola is that, unlike with other infectious diseases, the corpses of those who died of the disease are highly contagious. Traditional burials are potentially major disease-spreading activities. Finding a way to make burials safer is a key objective of infection control management.
2) Care: For many Africans it is a core part of their cultures to look after sick relatives. Giving the health message to not touch someone who is infected with Ebola is unacceptable for families. Therefore, identifying safer methods of patient care, for instance by introducing barrier nursing principles that can be done at community level, will be a more sustainable approach.
3) Isolation: isolation measures imposed by foreigners are more difficult to implement than community-driven activities. Lack of trust in health authorities is sometimes well justified given a history of civil war and social unrest, but it is not constructive when fighting an infectious disease outbreak.

These areas are only three examples where the clash of cultures is evident; often this disconnect is labelled as communication, but it is much more than communication; it relates to culture and mind set.

2.3 Lessons learned

More systematically, CORDS' colleagues in East and Central African identified three key lessons for Ebola outbreak[1]:

- Lesson 1: COMMUNITY
- Lesson 2: COMMUNICATION
- Lesson 3: CAPACITY BUILDING

Community: work with the community – not against them

East and Central African colleagues have drawn the conclusion that infectious disease management will only work when it is established with and within the community and not imposed on it. This requires community engagement that includes infection control measures, as well as the dissemination and promotion of these measures. Infection control procedures are generally perceived as intrusive and, as such, often interfere with local social, cultural and

[1] These key lessons will be published as an independant paper.

religious practices. The recommendation, for instance, to avoid physical contact with a sick person is simply outside the behavioural norms in most communities. Effective engagement at the community level entails negotiating solutions that are acceptable for communities and, at the same time, follow the general principles of infection control. 'Protect yourself when caring for a sick person' would, for example, be a more suitable recommendation, and a better alternative from a community perspective than avoiding all physical contact with the infirm. Building on this process of finding the right, appropriate containment measures, communication and health promotion work best when they involve community and religious leaders, traditional healers and other advocates.

Previous outbreaks occurred as isolated events in rural communities and were managed at district levels with the involvement of national rapid response teams. National and cross-border Ebola outbreaks are a new development, and engagement with various communities has presented a particular challenge throughout the current outbreak. A key aspect of this engagement is to devise and provide solutions for infection control that are consistent with local realities and practices. International health and aid organizations are well aware of the cultural ramifications and sensitivity of their work, but they must strive to work in concert with communities to find adequate infection-control solutions. International organisations need to reflect continually on their strategies, practices and performance, as well.

Communication: share early, listen to beliefs and read rumours

Early sharing of information and surveillance data among professional groups has been thought to lead to clear benefits. The countries of Central and East Africa learned from previous outbreaks, and they have established infectious disease surveillance networks that operate in cross-border regions. Trainings on risk communication and One Health promote early communication among neighbouring professionals, across sectors and with the public. Such openness contributes to trust building that is necessary for public health institutions and communities to work with each other, and this multi-sectoral collaboration is key to early detection and faster response.

The risk communication approach also encourages public health professionals to engage with their communities to gain a better understanding of community values, opinions and beliefs. A major lesson involved, for instance, burial practices: participants explained that for local people, a traditional burial is more important than protecting themselves from an infectious disease they have not yet encountered. Therefore, the well-intended infection control messages went unheeded because they were not perceived to be relevant to completing a

sacred ritual. A more compassionate understanding of these social, cultural and religious realities and priorities could provide the foundation for mitigating infectious risks by finding acceptable compromises. Traditional burial practices can hardly be stopped through the imposition of infectious control measures ("Don't touch/wash"), but they could be made *safer* by integrating protective steps into the rituals, such as using gloves and burying the deceased rapidly. International organizations may need to redesign their communication strategy to prioritize the communities' needs, rather than their own requirements.

Communities have their own communication networks and rumours are very prominent and strong. In the context of infectious disease outbreaks, there are two kinds of rumours: rumours about possible *cases* and rumours about community explanations of *causes*. Rumours are conventionally seen as noise or distraction from the health message, thus creating the need to debunk them. Outcomes from CORDS' meeting with East and Central African colleagues suggest that reframing rumours may allow health experts to more effectively communicate with the public. The two main types of rumours are important indicators for i) guiding case detection and ii) understanding where communication efforts go wrong. Speaking from experience, public health experts advised the assembled group to take into account both kinds of rumours. To improve public health communication, practitioners should consider using a case detection rumour book to provide guidance for quick response and follow-up response. Additionally, a rumour diary could serve as a record of the community explanations of why infectious disease cases are being transmitted, and, as such, may help establish a starting point for community engagement.

Capacity building: avoid blind spots by addressing the first detectors

In the group's collective experience, cases typically appear in communities before medical attention is sought. The initial detections of cases in a community represent the "blind spots" of capacity building. Awareness raising in the community and building capacity by training health professionals at the local level must be continuous. The lack of support, guidance for case handling and provision of personal protective equipment (PPE) for health care workers contribute to a climate of fear and distrust among community and professional groups.

The Ebola outbreak of 2014 underscores the current need for awareness raising and capacity building in West African communities, among health care workers and officials at district and sub-district levels. Moreover, local and international institutions should focus on building a base of expertise in field epidemiology, outbreak intelligence and management. The overall

aim of these capacity-building activities is to create the knowledge and legacy that position personnel to manage outbreaks more effectively, now and in the future.

These key lessons reveal important drivers of infection control in local realities and can support the revision of the international response strategy with a greater focus on community engagement, communication and capacity building.

3. Tools

3.1 Introduction

This training is based on an innovative, culturally sensitive risk governance and risk communication approach and combines two general discoveries: 1) We identified four areas where interventions are most effective to improve preparedness, response and recovery from Ebola and other infectious disease outbreaks: faster, closer, earlier and smarter (see chapter 2.1). 2) We learned from previous lessons that interventions are most effective when they address communities, communication and capacity building.

The major purpose of this training is to apply identified areas of focus and properly framed intervention and, from these, to elucidate the settings where local solutions make sense. To advance this approach we designed the training as interactive small working groups that reflect and deconstruct common practices, beliefs and assumptions. We provide a set of analytical tools to facilitate and frame the reflection process of the groups and enable them to rebuild their preparedness and response strategy in a creative, alternative way. Applying this approach allows groups to develop their own 'curriculum' as a set of important areas in which they identify the need for changes and suggest local solutions. This approach is context-sensitive and sustainable: local people and solutions are the most familiar and make the most sense.

We provide three tools to facilitate this process:

- **Action matrix** to identify key areas in preparedness, response and recovery;
- **Change matrix** to identify key drivers and interventions to develop alternative, local solutions; and
- **Work planner** to systematise and coordinate the next steps.

3.2 Action matrix

The Ebola outbreak follows the usual pattern of infectious disease outbreaks. These patterns are:

- Preparedness period including surveillance and detection mechanism;
- Response; and
- Recovery period

Each period is subdivided into five areas of activities; these are

- Information
- Communication
- Community
- Care
- Coordination

The four parameters (faster – closer – earlier – smarter) build the foundation of identifying areas where interventions are most effective.

Training participants work with an action matrix that helps structure their thought process. Their task is to identify key areas of interventions in a) preparedness, b) response and c) recovery.

	BEFORE **Ebola outbreak** **PREPAREDNESS / DETECTION**	**DURING** **Ebola outbreak** **RESPONSE**	**AFTER** **Ebola outbreak** **RECOVERY / LEGACY**
CLOSER - FASTER - EARLIER - SMARTER **Identify key areas**			
Information			
Communication			
Community			
Care			
Coordination			

Figure 3: Action Matrix

3.3 Change matrix

In a second step they are asked to use these identified areas of intervention and reflect on how to induce change. For this purpose we have developed a change matrix that identifies the current situation, gives room to outline a desired situation and helps to identify indicators of change. Interventions can then be designed to target this change process.

Example/Area	**Current Situation**	**Desired Situation**	**Indicators of change**	**Interventions**
Information				
Communication				
Community - Practice - Belief - Emotions				
Care				
Coordination				

Figure 4: Change Matrix

3.4 Work planner

In a final steps key areas and interventions can be systematised and coordinated using the work planner. This tool provides a matrix of short-, mid- and long-term actions, reflection their blocking and facilitating factors and sums up a strategy for implementing an alternative approach.

	ACTIONS	**Blocking factors**	**Facilitating factors**	**Strategy/Solutions**
Short-term (days)				
Mid term (weeks)				
Long-term (months)				

Figure 5: Work planner

4. Applications

This training and materials promote the belief in and dependence on the creativity of its participants and their local knowledge, expertise and experience. In order to avoid a biased approach we provide blank matrixes and offer facilitation of the working groups.

4.1 Training agenda

The training is designed for a two-day course based on small interactive group work, group work presentations and plenary discussion.

Day 1	
09:00 – 09:30	**General Introduction**: Team & participants
09:30 – 09:50	**Concept of training:** key principles of community-based interventions; interactive training methods; **Introduction to workshop**: key principles of biomedical approaches and major lessons learned from previous Ebola outbreaks; Analytical tools: action matrix and change matrix
09:50 – 10:00	*Group formation*
10:00 – 10:45	**Working group 1a: Preparedness:** Identifying key attributes of information, communication, care, community and collaboration activities
10:45 – 11:00	*Tea/Coffee break*
11:00 – 11:45	**Working group 1b: Preparedness:** Identifying drivers of change
11:50 – 13:00	*Presentation* and discussion of key attributes and drivers of change in **Preparedness**
13:00 – 14:00	LUNCH
14:00 – 14:45	**Working group 2a**: **Response:** Identifying key attributes of information, communication, care, community and collaboration activities
14:45 – 15:30	**Working group 2b**: **Response:** Identifying drivers of change
15:30- 15:45	*Tea/Coffee break*
15:45 – 17:00	*Presentation* and discussion of key attributes and drivers of change in **Response**
17:00 – 17:15	DAY 1 SUMMARY
from 19:00	WORKING DINNER WITH FEEDBACK SESSION

Day 2	
09:00 – 09:15	**Recap of Day 1**: Team and participants
09:15 – 10:00	**Working group 3a: Recovery:** Identifying key attributes of information, communication, care, community and collaboration activities
10:00 – 10:45	**Working group 3b: Recovery:** Identifying drivers of change
10:45 – 11:00	*Tea/Coffee break*
11:00 – 12:30	*Presentation* and discussion of key attributes and drivers in **Recovery**
12:30 – 13:30	LUNCH
13:30 – 14:30	**Working group 4: Work plan and implementations**
14:30 – 15:15	*Presentation* and discussion of key attributes and principles of **implementation**
15:15 – 15:30	*Tea/Coffee break*
15:30- 17:30	***Feedback session: Discussion and agreement on core principles*** - Lessons learned for actions and implications
17:30 – 18:00	DAY 2 SUMMARY: NEXT STEPS
from 19:00	WORKING DINNER WITH FEEDBACK SESSION

Figure 6: Agenda

First Pilot

In the first pilot course we invite people from CORDS networks countries to test this approach, provide feedback and further input. The pilot course also serves the purpose of creating a cohort of trainers that are able to disseminate this training further in various countries and settings.

As we are planning to develop a living document we will report the results from training in the following subchapters

- **Preparedness**
- **Response**
- **Recovery**

As an example – before the first pilot – the action, for instance, resembles the following (Figure 6 Acton matrix with baseline examples):

		BEFORE **Ebola outbreak** **PREPAREDNESS / DETECTION**	**DURING** **Ebola outbreak** **RESPONSE**	**AFTER** **Ebola outbreak** **RECOVERY / LEGACY**
CLOSER - FASTER - EARLIER - SMARTER **Identify key areas**				
Information	**Gathering** Formal (reports) Informal (rumours)	*Examples* Detection Surveillance	*Examples* Surveillance Rumour registry	*Examples* Surveillance Rumour registry
	Assessing	Rumour registry	Rapid response	Community contacts
	Sharing	Community contacts Cross-border information sharing	Community contacts Cross-border information sharing	Cross-border information sharing Lessons learned
Communication	**Communications (actions: flyer, website, etc.)**	*Examples* Risk communication in various formats (e.g. community radio, local groups, traditional healers, etc.)	*Examples* Risk communication in various formats (e.g. community radio, local groups, traditional healers, etc.)	*Examples* Risk communication in various formats (e.g. community radio, local groups, traditional healers, etc.)
	Key messages / Content	*Examples* Developed by communities: *safer* Relate Ebola to other, familiar diseases e.g. HIV/AIDS	*Examples* Developed by communities: *safer*	*Examples* Developed by communities: *how communities become smarter*
	Strategy / Methods	*Examples* Community engagement Making things *safer*	*Examples* Community engagement Making things *safer*	*Examples* Community engagement: *Being smarter*

Community	*Examples* Trust between public/community and health Communication between public/community and health Engagement Capacity and competence	*Examples* Trust between public/community and health Communication between public/community and health	*Examples* Stigma Orphans Migration Food shortages Political instabilities
Care	*Examples* Capacity building: Community based 'barrier nursing' Understanding of the situation Treatment centres vs. community based treatment options	*Examples* Diagnostics, eg bedside tests Isolation Care for sick relatives Burials Convalescent serum/Treatment options Treatment centres	*Examples* Survivors Convalescent serum
Coordination	*Examples*: Rapid response capacity	*Examples*: Rapid response capacity teams	*Examples*: Lessons-learned with local, national and international stakeholders Building networks for information sharing, communication and collaboration Share best-practices

Figure 5: Action matrix with baseline examples

The results of the pilot training and further in-country training will be document below.

5. Implementation

In this section, the implementation strategy and action plans of the pilot and futur trainings will be reported.

5.1 Action plans

6. Reflection

In this section, the reflections and lessons learned of the pilot and future in-countr will be reported.

7. Resources

Working group material 1 – 5

Tool 1-3

Agenda