Community-Led Ebola Action (CLEA) Field Guide for Community Mobilisers

Social Mobilisation Action Consortium (SMAC) Field Guide
November 2014

Social Mobilisation Action Consortium
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MINISTRY OF HEALTH AND SANITATION

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Acknowledgements

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SMAC is comprised of BBC Media Action, U.S. Centres for Disease Control and Prevention, FOCUS 1000, GOAL and Restless Development. SMAC works to support the Social Mobilisation Pillar, which is chaired by the Sierra Leone Ministry of Health and Sanitation – Health Education Department and UNICEF.

This training draws substantially from the field experience, testing, workshop input and hard work of the staff of Restless Development and GOAL and the experience of agencies and communities across many countries and contexts.

The CLEA approach builds on a history of Participatory Rural Appraisal (PRA), and takes inspiration from the Community-Led Total Sanitation (CLTS) approach and its success in Sierra Leone.

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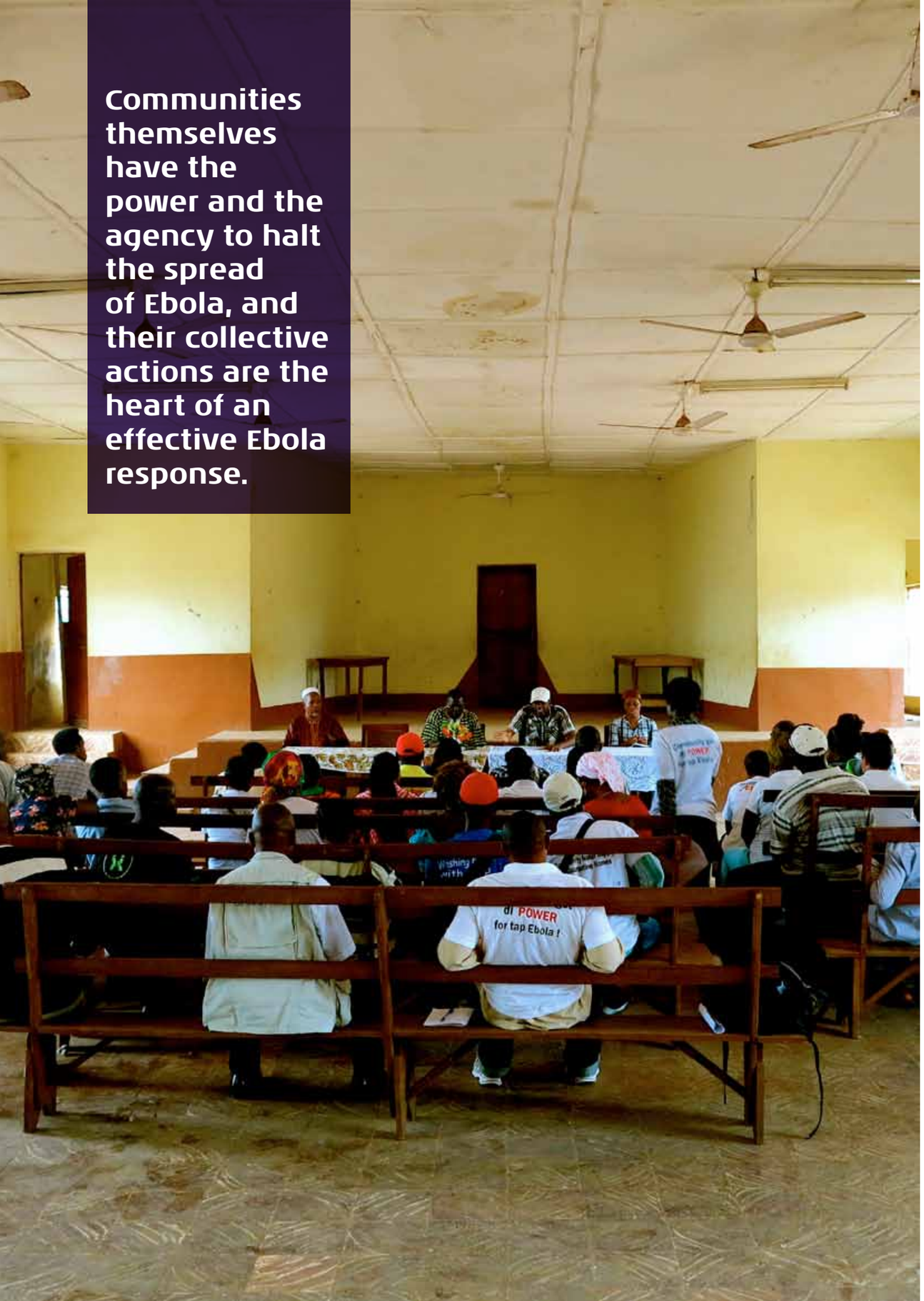
Communities are not only at the frontline of the response.... they are the frontline.

Peter Piot, credited with first discovering Ebola, speaking about HIV epidemic while head of UNAIDS



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1. INTRODUCTION

WHO IS THIS FIELD GUIDE FOR?

This Field Guide is for Community Mobilisers and others working within the Social Mobilisation Action Consortium (SMAC) and throughout Sierra Leone. It is also intended for use by agencies within the Social Mobilisation Pillar of the Sierra Leone National Ebola Response Centre, led by the Ministry of Health and Sanitation, and other agencies wishing to implement the approach in Sierra Leone and other affected countries.

HOW TO USE THIS FIELD GUIDE?

This Field Guide is a resource book for Community Mobilisers, field staff, and trainers to support planning, implementing and follow-up of Community-Led Ebola Action (CLEA) social mobilisation activities. It provides tools and ideas to empower communities to do their own analysis and take their own action to become Ebola-free.

The CLEA approach recognises that communities alone have the power to stop the spread of Ebola, through their collective decisions and actions. The Field Guide is not intended as a blueprint. Mobilisers should feel free to adapt the facilitation guidance and tools to suit local conditions.

It is intended that Community Mobilisers using the Field Guide should be trained in its use as part of a comprehensive training covering all aspects of working in communities. The agenda for the SMAC CLEA training is included in Annex A.

1.1 Background

The 2014 Ebola outbreak is the largest Ebola outbreak in history. The outbreak has most severely affected Liberia, Guinea and Sierra Leone. These countries have some of the weakest health systems in the world, which have been unable to cope with widespread and intense Ebola transmission.

The first case of Ebola in Sierra Leone was confirmed on the 26th May 2014. As of early November 2014, the Sierra Leone Ministry of Health and Sanitation (MoHS) reported over 4,680 Ebola cases and over 1,100 Ebola deaths, with infections reported across all of Sierra Leone's 14 districts. Despite international assistance and attempts to scale-up control measures, the Ebola incidence in Sierra Leone is high and growing, with large numbers of cases being reported each week and others going unreported due to significant surveillance and reporting gaps. According to the World Health Organisation (WHO), the actual number of cases may be two to four-fold higher than currently reported.

In the face of this unprecedented outbreak, there is hope. Communities themselves have the power and the agency to halt the spread of Ebola, and their collective actions are the heart of an effective Ebola response. The Social Mobilisation Pillar, led by the Health Education Department of the Ministry of Health, has set out a new National Communications Strategy for Ebola Response, which calls for 'evidence based, dialogical and participatory social mobilisation and communication responses'. To deliver on this strategy, the country will need a much more robust and effective approach that puts power into the hands of communities so that they can become Ebola-free.

1.2 Community-Led Ebola Action (CLEA)

The CLEA approach aims to empower communities to do their own analysis and take their own action to become Ebola-free. CLEA focuses on triggering collective action by inspiring communities to understand the urgency and the steps they can take to protect themselves from Ebola. This is done through a process provoked by Community Mobilisers from within and outside the community. Unlike previous mobilisation efforts, which have mainly used health education and one-way

communications to raise awareness among individuals, CLEA focuses on the community as a whole, and on the collective benefits of a cooperative and community-led approach. As in any society, Sierra Leonean communities will modify norms, beliefs and behaviours in response to the conditions around them. CLEA Community Mobilisers simply ignite communities to take these necessary steps.

The CLEA approach encourages the community itself to take responsibility and take their own positive local actions. It starts by enabling people to do their own appraisal and analysis of the Ebola outbreak, its current effects, and the likely future impacts if no action is taken. This helps to create a sense of urgency and a desire to develop a community action plan. Communities themselves can decide how they will protect families, ensure safe and dignified burials, respond to sick people, utilise available health services, and create a supportive stigma-free environment for Survivors, vulnerable children, and others directly affected by the disease.

This shift in approach requires a significant change in the mind-sets and attitudes of front-line mobilisers, institutions and response efforts. Some of these key shifts are summarised in Table 1 below.

TABLE 1: COMPARISON BETWEEN HEALTH AWARENESS AND CLEA APPROACHES

	Typical Health Education/ Information Approaches	CLEA
Unit of analysis	Individuals	Communities and families
Core Activities	Educating households	Listening to communities
	Sharing information and 'key messages'	Inspiring self-realization and self-motivated action
Communications Approach	One-way information sharing	Facilitating dialogue
	Health educators are the 'experts'	Community members are the 'experts'
Emphasis	Top-down	Bottom-up
	Sharing biomedical facts, correcting erroneous local beliefs	Appreciative of other ways of understanding illness Understands that it is possible to hold multiple framings for disease at the same time
Facilitation Style	Teaching, preaching	Listening, learning
	House-to-house	Community-wide
Methods and Tools	Information, Education & Communications (IEC) materials	Participatory Rural Appraisal (PRA) tools to enable communities to analyse their own situation
	Lists of 'Do's & Don'ts'	
Typical Assumptions	'Traditional' beliefs and behaviours are the problem to be changed or solved	Communities have responses that are both health-lowering and health-enhancing
	Communities must be convinced to use health services	Health services must adapt to meet the needs of communities
Key Motivations for change	Awareness of biomedical facts	Urgency to protect each other, builds on social solidarity, cooperation and mutual support
	Rational understanding of transmission routes, etc.	Hope with early treatment
	Self-preservation	Trust in health authorities
Desired Outcomes	Individuals seek external health services and follow the rules	Communities feel empowered to protect themselves using local resources
		Two-way dialogue results in better use of health services that respond to community needs

1.3
Key Principles

CLEA recognises that a more bottom-up, community-led approach can help to build trust between communities and health authorities. For example, by listening to community concerns and considering the social and cultural meanings and practices associated with funerals and burials, the CLEA approach can help ensure that communities have more voice in how burial teams operate. At the same time, CLEA can help ensure strong community ownership of specific actions they can take right now to protect themselves, without having to wait for external resources. When CLEA works well, it should:

- Be based on **collective community decision-making and action by all;**
- Be driven by a sense of **collective achievement and motivations** that are internal to communities, not by coercive pressure or external payments;
- Engage women, men, youth and children in **time-bound specific activities** that will result in Ebola-free communities;
- Lead to emergence of new **Community Champions** and/or new commitment of existing leaders;
- Generate **diverse local actions and innovations** that support protection of communities, safe and dignified medical burials, utilization of health services, and stigma-free environments;
- Build on **traditional social practices of community cooperation** and create new local examples that can be shared with other communities;
- Focus on and celebrate **community-wide outcomes**, such as number of safe burials; number of early-reported cases; and Ebola Action Plans and community committees in place
- **Gain momentum and scales up** to Ebola-free sections, chiefdoms and districts as communities gain confidence and other pillars of the Ebola Response improve;
- Recognise the **rights of communities** to proper, appropriate, free services as outlined by the Government of Sierra Leone;
- Rely on clear, accurate **two-way information flow** that builds trust and positive feedback-loops between communities and health authorities.

The CLEA principles and approach are not entirely new to Sierra Leone. In fact, CLEA draws on successful examples of community participation and the use of Participatory Rural Appraisal (PRA) in HIV and AIDS and other health programming. In particular, CLEA builds on the lessons and experience of over six years of Community-Led Total Sanitation (CLTS), a participatory approach to sanitation improvement that has gone to scale in Sierra Leone, and is already institutionalised within the MoHS national approach.

1.4
Attitudes and Behaviours

As a Community Mobiliser, your attitude and behaviours are among the most essential ingredients for effective community mobilisation of any kind. Communities in Sierra Leone are currently experiencing the fear, confusion, panic and grief associated with exposure to a new, highly contagious and deadly epidemic disease. Too often, communities' mistrust of the government, health authorities, and outsiders has been reinforced by poor communication, conflicting messages, and disconnects between the realities they face and the messages and services they receive.

You must be ready to face communities with a calm, honest, empathetic approach. You must be hands-off, not teaching or lecturing to simply deliver health messages, but rather actively listening and facilitating to enable people to confront incredibly difficult realities on their own terms. You can build trust and encourage progress and hope. You can actively listen and let communities know that you respect their local knowledge and capabilities. **Much more than any tools or methods, it is your attitude and style when interacting with communities that will determine success.**

TABLE 2: KEY ATTITUDES AND BEHAVIOURS

DO	DO NOT
Listen attentively; observe body language and what is not said	Interrupt, talk all the time, impose your ideas
Facilitate their own appraisal and analysis	Educate, lecture or tell people what to do
Trigger self-mobilisation; let people come up with their own actions and activities	Push for, or demand action; prescribe what to do
Stand back, leave it to local leaders; stand or sit at the same level as people	Be in charge; physically dominate people
Be hands-off, stay neutral, allow heated discussions between insiders	Interrupt when the discussion becomes charged; discourage community members from disagreeing with each other
Always encourage women and vulnerable members of the community to participate	Overlook women, children, and others who often get left out; allow one person to dominate
Offer health information and let people know about the services available	Insist on or impose your viewpoint
Be honest, admit if you do not know something, be humble and respectful	Make up answers, defend, doubt people
Be creative and flexible; improvise and adapt	Be rigid, stick to a 'script'
Let go, always let the community do it (draw, map, discuss, prioritize)	Try to control the process or the outcome, be disappointed when things don't go according to your plan
Be patient	Rush

1.5
Sequence of Steps

At community level, the following steps and tools can be used. Remember, this is not a blueprint: you should feel free to adapt and modify the approach to fit the situation.

Step 1.
Preparation

This step involves identifying and mapping communities, gaining permission to enter communities, and planning triggering events.

Step 2.
Triggering

This step involves entering communities and building rapport, facilitating participatory analysis, and supporting community action planning if communities decide to make a plan.

Step 3.
Follow-Up

This step involves supporting and encouraging communities to implement their action plans, and sharing up-to-date information about available health services. This step will include regular phone calls and visits, and can involve support to Community Champions and local Community Boards, referrals and linkages to services, Ebola Survivor welcome-homes, and other encouragement of progress.

TABLE 3: STEPS IN THE CLEA PROCESS

Step	Indicative Timeframe	Key Activities	Staff and other requirements
1. Preparation	1-2 weeks	Map & select communities	Field supervisors meet District Health Management Team (DHMT) and paramount, section and village leaders to gain permissions to get background on communities
		Meet local leaders to gain permission to enter	
		Plan triggering schedule, including logistics and timing for each village visit	Agree on suitable times when people will be available to attend
2. Triggering	1 day (4-5 hours)	Community Mobilisers enter communities and conduct triggering activities	Pair of Community Mobilisers
		If ready, community develops an action plan	It is okay if community does not decide to take action at this session, do not go with pre-conceived idea of triggering outcome
3. Follow-up	On-going	Communities carry out their action plans	Pair of Community Mobilisers ensure that momentum is not lost; provide support, but do not force action
		Community Mobilisers make weekly calls and regular visits, including Ebola Survivor welcome-homes	Encourage community monitoring and surveillance
			Provide regular updates to communities on latest progress and health services
		Community Mobilisers available for support/referral at any time	

You should feel free to adapt and modify the approach to fit the situation.

2.
PREPARATION

2.1
Identifying and Mapping Communities

SMAC will support the national Ebola response by reaching all districts with CLEA triggering. The focus is on reaching those communities most affected and most at-risk in emerging Ebola 'hotspots'. **Heavily affected and most at-risk communities in Ebola hotspots should be prioritised first at all times.**

Communities will respond to CLEA triggering in different ways. Some will be inspired to take immediate actions, while others may be resistant, reluctant or indifferent. Strong, supportive leadership is often a critical success factor. The amount of time and extent of exposure to Ebola within the community and surrounding areas can also greatly impact on a community's willingness, openness and urgency. Pilot experience with Ebola social mobilisation indicate a range of social, political, cultural and physical conditions that impact on community responses. These include:

- How long a region has been exposed to Ebola;
- Ebola cases and deaths in the local area, and in the specific community;
- Distance to Ebola treatment centres and isolation units;
- Community experience with health services, including treatment centres, burial and disinfection teams, and contact tracers;
- Presence of Ebola Survivor(s) in the community;
- Time spent under quarantine;
- Experience to violent events since the start of the outbreak;
- Exposure to Ebola sensitisation efforts;
- Presence of health professionals, Community Health Workers (CHW), doctors, and healers in community.

When making decisions about which communities and sections to prioritise, senior staff should consider these types of factors to understand which communities may have more challenging or favourable conditions. Other criteria for prioritising communities includes:

- Communities where chiefs have already requested SMAC agencies to come and do social mobilisation;
- Areas where other agencies are not working on Ebola sensitisation already.

Community Mobilisers themselves should also consider these factors and characteristics. In weekly planning meetings, all staff should discuss the roster of communities for the following week and provide data on these communities in advance to help with planning and orienting CLEA work prior to triggering visits.

2.2
Gaining Consent to Enter Communities

Senior staff must adhere to protocols when arranging access to communities. Experience has shown that failure to consult properly with all parties can lead to problems and confusion later. Senior staff should engage all chiefs/leaders at all tiers of sub-national governance over a period of about two weeks. The importance of taking the time to do this work cannot be over-emphasised. Prior to any triggering visits, senior staff should undertake the following steps:

Step 1:

Kick-off meeting bringing together all district and chiefdom authorities at the district level, to engage and describe the proposed activities and gather relevant data about communities;

Step 2:

Visits to section chiefs, sub-chiefs and religious leaders to discuss the project and expectations;

Step 3:

Visits at chiefdom and community level, to further consult with village headmen and sub-chiefs, to discuss and arrange a triggering day.

Staff can prepare chiefs/leaders at all levels by clearly explaining the goals of the programme, and repeating that the approach does not involve payments of any description to communities or community representatives (other than nominated Community Mobilisers). They should note that Community Mobilisers will enter communities to learn and inspire local action. They should also reiterate that there is no direct employment for district or sub-district people, other than Community Mobilisers selected through a consultative process, however, (unpaid) Community Champions will hopefully emerge based on community recommendations. Staff can answer questions, set expectations, and develop relationships at all levels. They can triangulate data about Ebola exposure and help to build up profiles of target communities. When this work is completed, staff develop prioritised lists of communities and rosters for weekly triggering and follow-up work.

2.3
Planning for Triggering Activities

Prior to the community triggering visit, remind the relevant chiefs/leaders and confirm permission to enter the village. This check-in call is another opportunity to reiterate the objectives of the visit, and stress that the visit is to learn about the situation in the community and how Ebola is affecting the residents. The date, time and venue should be confirmed and it should be requested that a suitable place (comfortable and shady, and large enough to accommodate the community participants) is selected and that community members are informed and invited.

Triggering visits should consist of between 15 – 50 community members. When organising the community visit, request that if possible the following representatives are in attendance:

- Chief/Representative of Community Leader;
- Religious Leader(s);
- Community Health Workers;
- Women's Leader;
- Youth Leader;
- Councillor;
- Community Teacher;
- A combination of elderly and young community members.

The day before the triggering visit, call again to remind the chiefs and ensure that everything is in place. Be sure that you have relevant phone numbers, so that you can call to inform the community that you are approaching (or if you are delayed). Review the Preparation Checklist to be sure that you have all of the materials you need (see Table 3). Before entering the community, remember to run through who will do what and decide who will be the Lead Facilitator and the Co-Facilitator for each activity.

Remember, your safety and security during community mobilisation is of the greatest importance. Be sure to follow all of the **Safety and Security Protocols and Code of Conduct** at all times.

Your safety and security during community mobilisation is of the greatest importance.

TABLE 4: COMMUNITY MOBILISER PREPARATION CHECKLIST

WHAT TO TAKE

Materials for Triggering

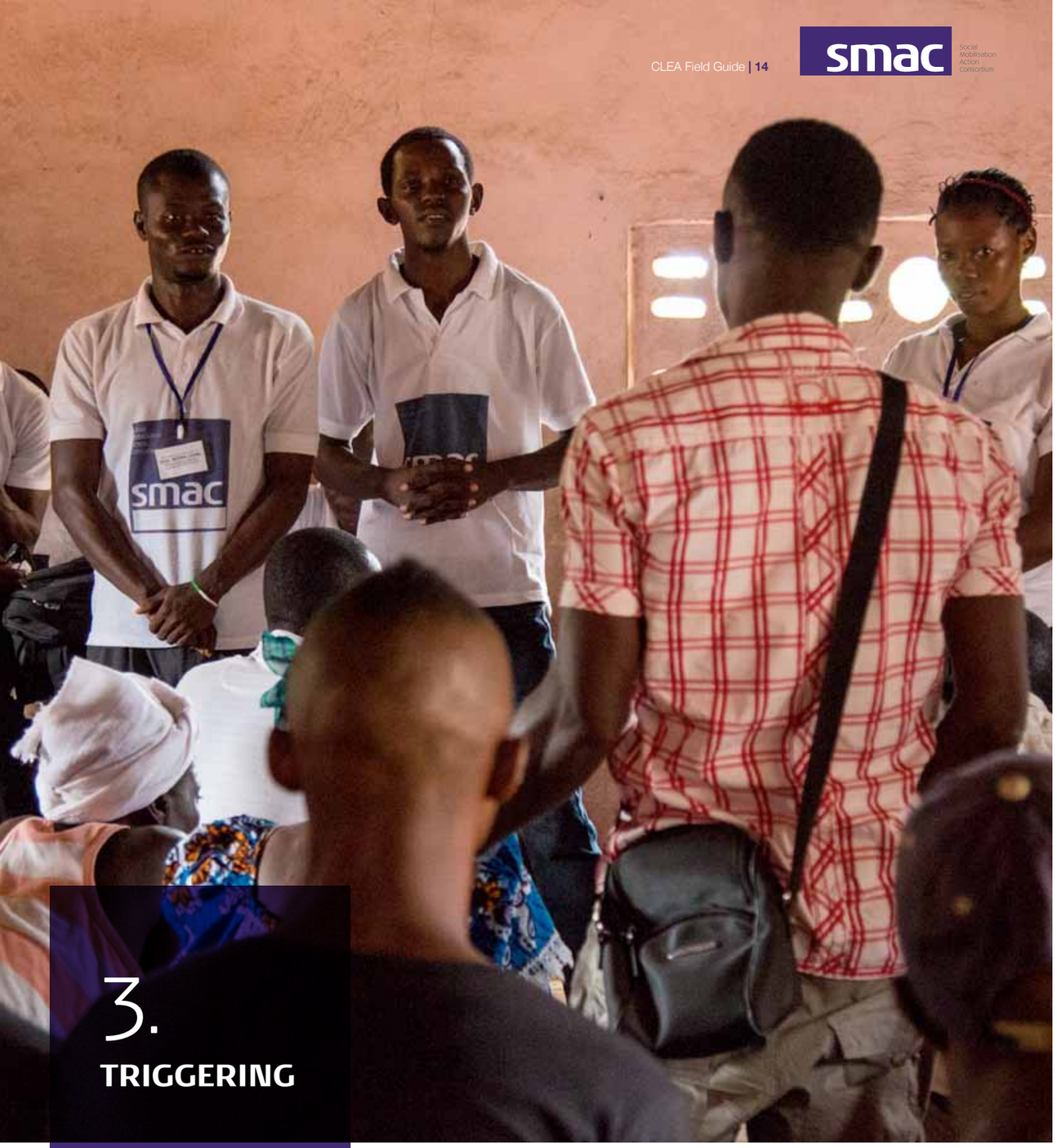
- Flip chart paper
- Coloured markers
- Coloured cards (enough for all exercises)
- Masking tape
- Scissors
- Community Visit Monitoring Forms (see Annex B)
- Community Mobiliser pack (Social Mobilisation SOP, Approved IEC Materials, Key Messages Document, Burials SOP, Safety and Security/Key Contacts Information)
- Danger Discussion cards (laminated – see Annex C)
- Ebola Survivor Poster (laminated – see Annex D)
- Safe and Dignified Medical Burial flyer (laminated – see Annex E)

Other Supplies and Equipment

- Hand sanitizer
- Funds for purchasing water in the community
- Money for transport and emergency

WHAT TO WEAR

- SMAC T-shirt
- Identification (I.D) Card
- Long pants
- Close-toed shoes (NO slippers)
- Fully cover all cuts on skin



3. TRIGGERING

Triggering is about stimulating a collective sense of urgency to act in the face of the threat of Ebola, and realise the realities of inaction or inappropriate action. It is assumed that communities are by now aware of Ebola, and you will know whether or not a particular community has had reported cases before you enter. The objectives of the Community Mobiliser are to: 1) facilitate analysis so that community members can decide for themselves that Ebola poses a real but preventable and treatable risk, and 2) help communities gain clarity on available health services such as burial and treatment, and discuss how these services can be better suited to community needs. It is then up to community members to decide how to deal with the problem and to take action.

When you first enter a community you will need to be very clear: you are going there as learners, not teachers. Communities will teach you, and you will listen and support them. Your attitude and facilitation skills are critical. Remember to stress that you are an outsider to the community, and that it is up to the insiders to analyse and take their own decisions. You are there to learn, and it is up to them if they do not wish to take any action.

3.1 Triggering Basics

Remember to keep in mind the key attitudes and behaviours (Table 2). In addition, here are some tips for effective CLEA facilitation.

- **Remember that Ebola is a very sensitive topic;** emotion, tension, and conflict are likely to arise in a group setting. This is normal and to be expected, so be ready to handle it appropriately. It is your role to help people find common ground when conflicts arise, and recognise when to agree to disagree. Try to avoid taking criticism or resistance personally.
- **Use the tools just as a guide.** Your attitude and behaviours, and your facilitation skills, are much more important than the tools or exercises you cover.
- **Be flexible.** Every community is different, and if communities are really owning the process, they may drive things in all kinds of directions.
- **Give up control:** you do not own this process. Avoid dominating by controlling who speaks or who is given markers to draw. Lay everything out and allow community members to do all of the drawing, mapping and recording themselves.
- **Where possible, facilitate in the local language.** Ask for and use the local words, especially words to describe illnesses and sickness. It is very likely that there are already words for ‘epidemic’ diseases or ‘isolation’. Try to understand these concepts and use the local words to describe them. Do not use complicated medical terms that will be difficult to understand. Use the local word(s) for Ebola at all times.
- **Keep your eyes and ears open.** Listen to what participants have to say, even when you are not formally conducting an exercise. Pay attention to body language.
- **Be careful that your body language** does not reveal that you either approve or disapprove of what community members are saying. Do not be judgmental. Never respond with astonishment, impatience, or criticism. Remember, your job is not to convince people of biomedical facts.
- **Keep in mind the triggering objectives**. Ask probing questions during and after you have completed the activity. Remember that doing an exercise, such as a map, is only the first step. The discussion that follows is the key opportunity for learning.
- **Observe and listen for examples of health-enhancing practices,** that is, things that a community is already doing that can protect people from Ebola. Listen also for health-lowering practices, things that create Ebola risks. Listen for examples where people have modified their behaviours in the past (e.g. burying someone away from the village because it was not possible to return their body).
- **Be honest.** Allow people to voice their frustrations and concerns about the health services they have received. You do not have to defend the health authorities.
- **Be aware of people who dominate the process,** as well as people who are not participating. Try to bring those who are quiet or shy into the process, but take care not to make anyone feel uncomfortable of pressured to talk about something if they do not want to. Remind them that they can choose not to answer any question or not to participate at any time.
- **Allow silences to happen.** The person who was speaking may continue, or another person may decide to talk.
- **When using a specific tool, don’t limit yourself to the procedures of the tool;** the procedures have been provided as a guide to help you. Remember that spontaneous discussion among the participants is good and should be encouraged because it can provide useful insight.

3.2
Introductions & Building Rapport

When you arrive at the community, introduce yourself and explain the purpose of your visit. Explain that you are there to understand more about what is happening in the community. You may need to wait until all of the chiefs, sub-chiefs, and other leaders have been assembled before beginning. Relax and don't rush. Make informal conversation and generally try to make people feel comfortable while you wait. In rural districts, when formal protocols begin, take care not to speak until you have been invited by the chief to do so. Explain why you are there. Make it clear that you are not there to prescribe or enforce any behaviours or practices, but rather to learn and listen. There is a chance you might be asked immediately for funds or other material resources. Be clear that you do not have any money to offer, but that you can help to link them to free treatment, burial and other services offered by the health authorities. Ask for permission to facilitate a discussion with the broader community. Hopefully, this group will already be assembled, but if not the town crier or a community member may be sent around to gather people while you wait.

There are many different ways of initiating a discussion about Ebola. This is a topic first and forefront on people's minds, and it is affecting nearly every aspect of daily life across the country. You could begin by asking generally about the experiences in this community, or asking more broadly about the latest news they have heard. Once everyone is assembled, consider an energetic ice-breaker. This is also a good opportunity to observe whether everyone appears to be in good health. At this stage, you may also want to do some environment-setting, for example, asking participants if they would like to set any ground rules, such as turning off their phones during the session. As always, you are responsible for observing the safety and security protocols at all times while in the community.

TIP

Remember – you are there to trigger community action, not to collect data. Do not pull out the Community Visit Monitoring form and begin filling this in straight away. The Co-Facilitator should be responsible for discretely noting down the important information emerging from participatory analyses, and ensuring that these notes and results are summarised in the monitoring tool.

3.3
Tools for Community Triggering Visit

The aim of the participatory analysis is to facilitate the community's appraisal and analysis of practices and impacts of Ebola in their community, using PRA (Participatory Rural Appraisal) tools and methods. The order of the activities is not important, and you may not wish to use them all. You can use your own best judgement to decide what you think will work in a particular setting.

Remember, the goal is to help communities build their own self-awareness of what is happening and reach a collective decision to take action. This may happen very quickly for some communities, or not at all in others.

Body Mapping

Objectives	• Identify key symptoms of Ebola, what parts of the body it affects, and how it compares to other sicknesses • Explore different perceptions about transmission routes into the body • Explore understandings of how Ebola affects different types of people (e.g. male, female) and what types of people are most likely to catch it
Materials	• Smooth, dry surface for drawing in the dirt and a stick (or flip chart paper and markers) • Blank cards and markers
Duration	• About 30 minutes
Timing	• Early in the triggering process

A non-threatening way to begin the triggering is with a body mapping exercise. A body map is a picture of the body that can show different things, for example parts of the body, areas where disease can enter, and so on. Some general steps for creating the map below.

1.
Begin by asking for a volunteer to draw an outline of the body on the ground or paper. For fun, you could have someone stand up and draw around their shadow.

2.
Place some cards and markers near the body map.

3.
Ask volunteers to draw some general symptoms of Ebola. They can use the cards and markers you have set out, or they can use a stick to draw directly on the body map. Ask them to show the parts of the body that are affected by the symptoms.

4.
Discuss the symptoms and what kind of illness this is: it is an 'easy to understand' illness, or a 'difficult to understand' illness? How do they know this illness is Ebola? Where does it come from? Do the symptoms change over time? How?

5.
If someone mentions the symptom 'fever,' probe more to understand whether it is an 'ordinary fever' or a 'big fever'? How do they know it is not another type of illness (malaria)?

6.
Next, ask how the disease comes to affect the body. Ask people to use the cards to draw some pathways or agents (for example, the wind, body fluids, mosquitoes)

7.
Then ask for volunteers to draw lines from these cards to show how it gets into the body (for example, through the eyes, through the skin, through the hair)

8.
Throughout the discussion, ask if there are any differences between men and women, young and old. Who is most likely to catch Ebola and why?

You should never suggest the symptoms or the pathways for infection. Let people discuss, identify, draw/write. If there are any misunderstandings or myths, try to illicit alternative opinions from the other community members. When someone says that they are passing the illness by touching sick people and dead bodies and their fluids, bring them to the front to tell everyone. Do not say it before they do. Once one of the communities has said this publicly, you can repeat it from time to time. Do not say it before they do. It has to be what they have said as a result of their analysis, not what you have come to tell them.

TIP

At this stage, you may begin hearing about different sources or origins of Ebola. It may be associated with sorcery, and with 'Western' sorcery. Ebola is a disease of the social, of those who look after and visit others, and of those who attend funerals. It is a disease that affects people who are doing things that are considered socially 'good'. They might be associated with a sorcerer's disease, or a Western sorcerer's disease. You may begin to hear that treatment units are the source of this sorcery, that patients are not being looked after, and that their body parts and blood are being taken by Westerners. Listen and allow community members to discuss these things. You do not need to respond at this stage.

Danger Discussion

Objectives	• Explore knowledge and attitudes about risk levels for different practices • Understand differences between male and female attitudes towards risky or dangerous practices • Explore who in the community is most likely to practice risk behaviours (male, female, certain roles/kin, certain groups e.g. unemployed males doing burial) • Discuss the most 'dangerous' behaviours and what can be done to reduce these risks and protect oneself
Materials	• Smooth, dry surface for drawing in the dirt and a stick • Pathway cards from body mapping activity (if already done) • Danger Discussion cards
Duration	• About 30-45 minutes
Timing	• Early in the triggering process

Note: If you decide not to do the body mapping exercise, move straight into the Danger Discussion by spreading the Danger Discussion cards out on the floor.

Depending on the order in which the tools are used during the triggering session, if people have had a chance to discuss broadly the symptoms, and pathways for transmission, you can ask them to begin ranking these different pathways. At this stage, be sure to have your Danger Cards ready for use.

1.
Alongside the body map (if completed), draw a line on the ground. Explain that this is the danger line. At the bottom end is 'No danger of Ebola infection', at the top end is 'High danger of Ebola infection'.

2.
Ask volunteers who have drawn pathway cards in the body map exercise to pick up their cards and place them on the danger line according to the level of danger they think is involved. Be sure to use the community's hand-drawn cards first.

3.
Take out the additional Danger Discussion cards and spread them out on the ground. Invite anyone to come up, take a look at the card, announce what it is, and place it on the danger line (Danger Discussion cards include a mix of 'high' and 'low/no' risk behaviours, e.g. sharing a toilet with a sick person, going in an ambulance, touching a dead body, hugging an Ebola Survivor, etc.)

4.
Invite volunteers to explain their decisions, and encourage other participants to discuss and say if they agree or not. If they do not agree, the volunteer can place the question mark card ('?') on the card and leave it where it is.

5.
Return to any cards marked with a question mark or put in the wrong place on the line. Ask if everyone agrees with these cards. Try your best to illicit alternative opinions from the group. If no one can answer correctly, you may give additional information about the true level of danger involved in the behaviour (but this is a last resort).

Through the discussion, community members will most likely begin to discuss what it means to be 'protected' from these dangers, and start to discuss and compare different types of protection, e.g. hand washing. Let this conversation on how to protect yourself from dangers flow naturally. Community members may also begin to discuss the realities of caring for the sick: how is it possible not to touch your sick loved ones? What if you need to get them to the treatment centre? What if someone dies in the house? How can it be managed? Allow and encourage this type of discussion amongst community members, but do not interfere or interrupt. When the activity is complete, encourage participants to discuss what the danger line has shown. Were there any great surprises or strong disagreements? What can be done to reduce people's level of danger? Listen and collect these ideas.

If it has not come up yet, by now someone will probably be saying that this is a disease of contact spread by touching sick people and dead bodies and their fluids. Remember to shine a light on this explanation as soon as it is mentioned by the group (but do not say it yourself first).

TIPS

- Community members may be anxious or not want to admit dangerous behaviours they have experienced in the past (for example, if they attended a burial of an Ebola patient). Be aware of this. Allow enough time for discussion and questions. Be discrete: participants may wish to come forward after the session to ask what to do.
- This is an important opportunity to share accurate information about Ebola transmission. If a participant puts a card in the wrong place (for example, putting 'going in an ambulance' as most dangerous), you should first encourage them to talk about their decision, but if they cannot find anyone who has the correct information, you may also give them the correct information – for example, by explaining in a supportive way that this is actually less dangerous. But remember that many of these dangers will depend on how the participants interpret and explain the pictures. For example, some might say that going in an ambulance is very dangerous if there is a person sick with Ebola in the ambulance and you do not have Ebola. Listen to how participants explain their decisions to better understand how the danger is perceived. The community understanding of danger could look a bit different in each community; allow the community to decide.
- Be sure to use active listening and effective questioning in this session. Probe on whether or not people would continue these practices and why or why not.
- Use the danger discussion to flow into a further discussion on how to protect against dangers. Take note of what is said here, as it may be useful for action planning.
- If you do not know the answer to any questions – such as exactly why a behaviour is dangerous – be honest and offer to find out more information.
- You may not have time to discuss every mode of transmission in great detail. Once the group has established that Ebola is a disease of contact, focus on the most dangerous activities: caring for the sick and burying the dead. People may want to debate these: why, for example, do some people who have done these behaviours not catch Ebola, and others do? This is an important question that needs to be discussed. Step back and allow discussion to flow between community members. If asked directly, you can be honest about what is known and not known about disease immunity.

Burial Role Play

Objectives	• Explore understandings of what a typical burial in the community would entail, including the funeral and burial protocols and who is involved at each step • Show the new Safe, Dignified Medical burial flyer/video to describe what MoHS says should happen and discuss whether this is acceptable to the community and if not, how it can be adapted • Discuss previous experiences with burial teams (positive, negative) and what can be done if burial services are not adequate
Materials	• Safe, Dignified Medical burial flyer/video
Duration	• 45 minutes – 1 hour
Timing	• Later in the triggering process

This is one of the most critical activities of the triggering visit. Use your best judgement on when to introduce the discussion around burials. This will usually come later in the triggering, after the community members have discussed and established handling of dead bodies as a dangerous practice.

1.
Begin by reminding community members that you are an outsider, and that you are keen to learn about the specific practices here in this community related to funerals and burials.

2.
Ask community members if they could act out a typical burial using role play (or, if this does not feel comfortable, if they could describe it).

3.
Use the role play/description to ask probing questions related to burials:

- If someone from this community is sick, where is the best place for them to die? If a death happens in the 'bush' or outside the village, what will happen? What if a death happens away from home and a body cannot be brought back? What should be done?
- What do descendants need to do to ensure that the funeral is done properly? What do women do? What do men do? Which family members play roles?
- What are the reasons you might touch a body after death? Can they show you how the body is handled? How is it wrapped?
- When should it be buried? How long after death? At what time of day (sunset, sunrise)?
- Who should be buried outside the community? Who inside? (types of death, types of people)? Do women/men who married into this community need to be buried in their home village? Where should graves be dug?
- Are there any special procedures for certain types of deaths (e.g. prominent person? First born? Pregnant women? Uninitiated girls?)
- If funeral/burial cannot be done properly, how can a 'fault' be repaired?
- How do you decide the cause of death? (anything special done to determine why?)
- How are debts settled after death? How is property and inheritance settled?

4.
Next, take out the Safe Dignified Medical Burial flyer/video and ask for volunteers to describe what is happening at each step. Do not immediately describe the steps yourself – allow community members to look at the pictures/images and discuss. After they have had some time to discuss among each other, you may answer any questions they have, or clarify any points that were not clear.

5.
Discuss whether these Safe, Dignified Medical Burials are suitable and appropriate for this community. Can people accept these burials? If not, what modifications are needed? How do the burials fit within existing local protocols?

Encourage discussion and debate on these different issues, and do not interrupt if discussion becomes heated. There will likely be very strong feelings about this topic, and it may be particularly sensitive if there have been recent deaths in the community. Allow community members the chance to accept or reject the new Safe, Dignified Medical Burials. If they reject them, find out why and what could be done to make them more acceptable. Take note of the suggestions, these could be useful action points later on.

MODIFYING BURIAL BEHAVIOUR IN EBOLA OUTBREAK

In a recent case, a pregnant Kissi woman died of Ebola, and the community were very clear that the foetus had to be extracted so that the mother and baby could be buried separately. When a pregnant woman dies, the child should be removed and buried separately. Otherwise, there is a 'fault' and the order of things is disrupted. The Ebola Response team considered extracting the foetus to be too dangerous. Without an agreement between the medical teams and the community, the woman could not be buried. Eventually, after discussions with elders, the community and the burial team came to an agreement that the woman could be buried without extracting the foetus, but that a reparation ritual with various offerings and ceremonies would need to be conducted. The Response team agreed to pay for the reparation ritual, and the burial took place. This story demonstrates how communities are willing to work with Ebola Response teams to come up with solutions that can satisfy cultural needs and protect against Ebola transmission.

Source: Fairhead 2014

TIPS

- This is a sensitive topic, particularly in communities that have been affected by Ebola. Be mindful of these sensitivities, and keep eyes and ears open. If the community has had recent Ebola deaths, they may volunteer to share their experience with the burial teams (do not probe, let this come out naturally if they feel comfortable). These experiences may have been positive or negative. Let them discuss what happened, what went well and what could have gone better.
- There may be many rumours and stories emerging about the burial and ambulance teams. Listen to what people say about these teams and ask for different opinions. Do not feel the need to defend these teams.
- Listen for examples of when burials were modified in this community. For example, if someone was buried outside the village because they could not transport the body home. These are good examples of community willingness to alter rituals due to practical circumstances.

Remember

- Death and burial are critical to personal and community security, and are highly significant events in the life of the community.
- The dead can be aggravated if their last words are not heard and honoured; if they are buried out of the village to wander eternally rather than being with their family (or be returned to it as a stone from the tomb); if the correct sacrifices are not made.
- The natural order can be aggravated by the wrong people looking after a dying patient.
- Special rules and protocols for burial can apply for certain groups: pregnant women, uninitiated girls, babies, prominent men.

Personal Protective Equipment (PPE) Demonstration

Objectives	• Show and describe what each piece of PPE is for and why it is important • Community members can touch and feel the suit, get comfortable with it, and discuss ways it could be made less fearful/more approachable
Material	• Sample PPE
Duration	• About 30 minutes
Timing	• Later in the triggering process

Discussion about the burial teams may lead to concerns about their appearance and behaviour. It is very likely that people may voice concerns and suspicions about the strange suits that are worn by these teams and those at treatment centres. This activity aims to dispel some of the myth and mystique surrounding the PPE.

1.
Take out the sample PPE, and spread the pieces of the suit out on a lappa on the ground.

2.
First, invite people to come up and take a look at these items. Encourage them to touch them and pick them up.

3.
You or your partner can then put on the gear, an article at a time – suit, boots, eye protection, a facemask and gloves – as the other explains each item's purpose. Alternatively, consider inviting a volunteer to put the PPE on.

4.
Throughout the demonstration, encourage questions and discussions, for example, about the reasons for the gear, when it should be worn, and how to dispose of it safely.

5.
When the demonstration is finished, encourage community members to offer ideas on how to make the experience of interacting with teams in PPE less fearful, and how these workers could be more approachable.

Remember

- Communities may see the PPE as further proof of sorcery: intruders arriving dressed in suits and masks are associated with sorcery. Use the PPE demonstration to make the PPE more approachable, but be conscious of resistance or suspicion and do not force anyone to touch the suit if they do not want to.
- In some communities the spraying of disinfectant/bleach is very similar to the practice of the leaders of the women's societies who sprinkle decoctions to purify.
- On the other hand, some communities have local customs around purifying the house or room where a death has occurred and replacing furniture, clothing, and other items in that room. This may be comparable with disinfecting houses with chlorine spray after an Ebola death.
- The demonstration is another opportunity to discuss rumours surrounding the activities in Ebola Treatment Units. Allow frank discussion about what people think is happening in these treatment centres and why.

Source: Fairhead 2014

Ebola Survivor Stories

Objectives	• Build a collective realisation that there is hope with early treatment • Analyse and discuss what Ebola Survivors did/did not do that resulted in their survival (e.g. early treatment, self-isolation, etc.) • Discus reasons for delaying or refusing treatment • Discuss stigma and rejection experienced upon a Survivor's return – when, how, and where is stigma most felt • Explore views on Survivors: will people welcome them back? Why/why not?
Material	• Ebola Survivor posters
Duration	• About 30 minutes
Timing	• Later in the triggering process

As community members begin to discuss what happens in treatment centres, it is a good opportunity to open up a conversation about Ebola Survivors. To really be impactful, Ebola Survivor experiences should be shared by Survivors themselves. At the start of the triggering, ask if there are any Survivors in the group. Make a point of hugging and embracing them, and tell people you are not afraid of them. During the triggering process, you or your partner can discreetly ask if the Survivor would be willing to get up and share their story.

1.
Invite the Survivor to stand up and tell their story. If there are no Survivors in this community, ask if anyone knows a Survivor. If so, invite this person to stand up and tell their friend's story.

2.
If the volunteer is stuck, you can help by asking questions about what happened: how do they think they caught Ebola? How did they feel? What did they do when they started to feel symptoms? Why did they go to the treatment centre? What happened at the treatment centre? What happened when they returned home? Use probing questions, and encourage others in the group to ask questions as well.

3.
When the story is finished, ask for a volunteer to describe what the Survivor did or did not do that may have contributed to their survival. What are the key lessons for the group? What would you do if that happened to you? How do you think you would feel?

4.
If there are no Survivors or friends/relatives of Survivors, you can use the Survivor posters. Only use the Survivor posters as a last resort, if there is no one who can speak from experience. In this case, show people the posters first and ask what they think is being shown. If someone in the group can read, ask them to read the back and then share the story to the rest of the community members. If at all possible, the Community Mobiliser should not tell the story.

5.
This story can open up further discussion on what is happening in treatment centres. Ask: What concerns do community members have about the isolation units and treatment centres? What is it like to be a patient? What food and drink do they receive? What happens when they die? Can they have visitors? How can last wishes of the dying be conveyed from inside the treatment centres?

6.
This story should also raise up issues about stigma: Ask: would you buy food from a Survivor? Would you share a meal with a Survivor? How do you think they feel?

Ebola Survivor experiences should be shared by Survivors themselves.

TIPS

- If using the Ebola Survivor posters, do not ‘teach’ or ‘tell’ the Survivor story. **The stories should come from the people, never from you the Community Mobiliser.** As an alternative, do not use the real story, but rather ask people to make a story up based on the picture.
- Emphasize questions that try to get people to empathize with Survivors – can they imagine if that was them or their families? If done well, and in a participatory style, this can be a powerful moment of self-reflection and emotion. Allow this to happen, and don’t shy away from high emotion if people do feel ready to talk about this pain and suffering.
- Be sure to ask about different roles within the family, particularly around caretaking for different types of people and groups. Not everyone is able to care for the sick, and there may be a designated person in the family to do this, depending on who the sick person is.
- In discussions about care, be sure to discuss who in the family would make decisions about treatment. This can often be a group decision.
- This is the opportunity to explore whether people would choose to go to the treatment centre if they suspected Ebola. Ask about the distance to the nearest treatment centre, what kind of reputation it has, and whether people would consider going there voluntarily. What are the main barriers to going for treatment, and what are the main motivators?
- If community members did decide to go to the treatment centre, how difficult or easy would it be for them to get there? What are the steps that people would need to take, and how long do they think it would take to get to the treatment centre?
- If the opportunity arises, you may want to ask participants if they know how Ebola is spreading in other countries like America. Ask them what they know about how Ebola is affecting other countries and people from other backgrounds.

Ebola Spread Exercise

Objectives	• Build a collective realisation of the terrible consequences if no community action is taken
Material	• N/A
Duration	• About 20 minutes
Timing	• Earlier or later in the triggering process

When you are sure that the momentum has built to the stage where people are growing confident that Ebola is a disease of contact,ask a group of 8-10 participants to volunteer to tell a story.

1.
Ask them to stand in a cluster and imagine they are all different family members and neighbours.

2.
Imagine one member gets sick with a bad fever. What does the husband/wife do? What do the children do? What does the teacher/pastor/imam do when he sees that this person is not in school/church/the mosque and learns that s/he is sick? Who cooks for the sick person? Who takes care of the children? Let them act out the real interactions between the community/family members.

3.
At the end of the story, ask the volunteers to sit down if they have had ‘contact’ with the sick person. Most of the group will likely be sitting down by the end. Say ‘It is clear this is a real community where everybody helps each other, but now imagine if this person had Ebola, what would have happened to all the people sitting down?Allow people to discuss among themselves. What could have happened? Have they heard of other communities where a large number of members have died? Has this happened in their community already?

Ignition Moment

Be very alert for the ignition moment. It is the moment of collective realisation that due to community practices (of good and caring people) community members are currently at serious risk of catching Ebola. When this happens there is no need to continue with other activities. At this stage the spirit may go high and violent arguments may begin as to how to protect the community. Don't interrupt or advise. Quietly listen to the discussion.

Remember to tell community members throughout this process that they are free to choose anything, including continuing their current practices. You are not promoting anything, and they are free to do whatever they wish. Consistently remind people that you are there to learn. After a few exercises, say 'We have learned a lot…' and summarise the learning – community burial practices, dangers, etc. on a large flip chart in front of the gathering. Best if these are written by a member of the community and read out to all. Ask, whose analysis and findings were these?

There are basically four possible outcomes of the triggering session:

1.
Matchbox in a Gas Station - ready for action: Where the entire community is fully ignited and all are prepared to start local action immediately to prevent Ebola. In this case, you can begin to facilitate an action plan with clear activities and dates, identify a Community Champion, encourage the formation of a Community Board (especially in rural communities where this is more possible), and make a follow-up visit plan.

2.
Promising Flames - almost ready: Where the majority agree, but some people are still unconvinced or undecided. Thank them for the detailed discussion. Ask the group to raise their hands if they want their community to be Ebola-free. Ask them to raise their hands again if they are ready to take local action. If someone from the community agrees to initiate local action, bring this person up front and encourage them to share their thoughts. If enough others are also interested, facilitate action planning and make a plan to follow-up soon.

3.
Scattered Sparks - not quite ready: Where the majority of the people are not decided on collective action, there are many people unsure, and only a few have started thinking about going ahead. Thank them for the detailed analysis and tell them not to misunderstand you as a health promoter. Tell them they are free to stand by and continue their practices. If one or two from the community are ready to take action, call them to the front and applaud them. Make a date to return to the community.

4.
Damp Matchbox - not ready: Where the entire community is not at all interested in initiating their own action to stop Ebola. In this case, thank them all and leave. Do not pressurise. Tell them that you are surprised to know that they are willing to sit and wait while this epidemic continues. Remind them that you are not far away, and ask if they would be interested for you to make another visit soon.

4. ACTION PLANNING

If a community is ready for action, or if most are ready, keep up the momentum and begin to facilitate an action plan. At this stage, it is very important that you do not take control or step in. Allow the community to nominate a note taker and begin discussion around the specific actions they want to work on. Ensure participation from all community members, and ensure the leadership does not dominate the discussion.

Encourage community members to reflect on the previous triggering discussions, and recall if there were any actions or solutions already mentioned during these sessions. If people are struggling, you may want to remind them of a previous discussion, or go back to the map or flip chart to draw out some of the key points. On the day of triggering, the planning process should concentrate on immediate action plans focused on making positive change in communities.

POTENTIAL FOCUS AREA	INDICATIVE ACTIONS
Burials	• Decisions on steps and elements of an acceptable medical burial in the community, that aligns with the Safe, Dignified Medical burial. This could include: - Number of family members attending - Location of community burial site - Identified people to dig the graves - Agreement on the use of coffins or shrouds - Decisions on additional/alternative funerals and memorial ceremonies - Decisions about 'special cases' such as deaths of pregnant women, or death of someone outside the community - Agreement on waiting time for test results to confirm Ebola death • Identification of a community 'Burial Supervisor' to monitor the Burial Team and ensure that they follow all standard operating procedures. • Agreement on community sanctions for those not following agreed procedures.
Reporting new cases and deaths	• Decisions on steps for reporting deaths in the community. • Identification of person responsible for calling the medical burial team. • Decisions on steps for reporting new suspected cases in community. • Identification of roles and responsibilities for reporting new suspected cases. • Decisions on the first point of contact for reporting suspected cases (e.g. CCC, District hotline, treatment centre). • Agreement on community sanctions for those not following agreed procedures.
Home Care	• Decisions on steps for home protection while waiting for health authorities, including: - Agreed isolation areas - Storage of home protection kits - Identification of appropriate caregivers • Agreement on community sanctions for those not following the agreed procedures.
Surveillance/ Child Protection	• Agreement on a community watch system, including a roster of community members who can screen strangers entering the community. • Identification of person responsible for daily check-in on registered Ebola contacts. • Agreement on steps for identifying and referring vulnerable children.
Psychosocial/ Livelihoods support	• Decisions on how community will celebrating Ebola Survivors when they come home; and how they celebrate health workers in the community. • Agreement on steps for identifying hungry households in the community, and on securing food aid support.

TIPS

- Do not give in to the temptation to begin dictating what should go in the action plan. Let community members lead the discussion and remain quietly at the back of the group if possible. If they get stuck or have no ideas, remind community members of the previous triggering activities and how they might be relevant. For example, you can recall the discussion around burials, and ask if there were any solutions that could be included in the plan.
- Encourage action plans that include: who is going to lead, what the activity is, and when it will be completed.
- Do not allow the chief or other leaders to dominate in the action planning session. Action plansshould emerge from the whole community.
- Think beyond by-laws. If enforced, community by-laws can be a powerful tool for community change. However, there are many other ways to encourage households in the community to protect themselves.

4.1
Nurturing Community Champions

It is important to identify Community Champions and encourage them to take charge to ensure that action plans are followed through. Community Champions often emerge during the triggering process, and they may be women, men, youth, school children, elderly people and/or people with special roles such as midwives, headmen, and others. Community Champions are critical to success, because they have the commitment and energy to follow-up with their neighbours and to encourage changes in community norms and implementation of the agreed action plan. Community Champions will be involved in local community watch, early reporting of cases, supervision of burials, and supporting Ebola Survivors. Your recognition and encouragement of Community Champions will be an important part of your work during weekly visits. You may find one or more Community Champions in a community – encourage and support them all. Consider the following when identifying Community Champions:

- Support Women Champions: Although women play key roles in caring for the sick and preparing the bodies of the dead, their role and their voice in the local Ebola responses may be overshadowed by that of men. Actively look for and support Women Champions, and consider reaching out to women's groups as a targeted sub-set of potential Community Champions and leaders of community action.
- Let Community Champions emerge, rather than be appointed: identify Community Champions during the triggering, and facilitate the community to select those with the greatest commitment and enthusiasm. Do not directly ask the chief or councillor to appoint a Community Champion. Rather, support the community to discuss who will be best and consult with the chief/councillor to agree on the right people.
- Consider how to incentivise and recognise Community Champions: although Community Champions do not receive any formal financial incentives (except in cases where they need to travel), they can be supported with phone credit. Champions often take great pride and motivation from this type of more formal recognition.
- Recognise the role of religious leaders: Support religious leaders to use their sermons, kutbas and prayers to accelerate and celebrate local community action. SMAC partner, Focus 1000, will be reaching out to networks of religious leaders, who will be influential leaders in communities, and supporting the delivery of tailored faith-based messages to religious audiences.
- Celebrate Ebola Survivors and Health Workers: these community members are powerful examples of both health-seeking behaviour and the capacity of people to overcome the disease if treatment is sought early.
- Consider the roles of youth and children: young people can play important roles in helping to shift family and community norms. Encourage them to take part in triggering, action planning and follow-up activities, and support the community to consider specific roles for them, for example, in community watch.
- Encourage help for more vulnerable community members: facilitate the identification of people who may be more vulnerable or at risk. Those who have lost a family member to Ebola will often need additional psychosocial and livelihoods support. As a result of triggering, wealthier community members may offer direct support to these people, for example by providing food and other items. Do not directly suggest this to communities, but rather facilitate and encourage these local 'donors' if they emerge.

4.2
Forming a Community Board

During action planning, the community may decide to form a Community Board for supervising the implementation of the action plan. This may include a small group with good representation from different parts of the community, and from different groups (women, youth). Encourage representation from women, Ebola Survivors and vulnerable groups. During action planning, the Community Board can decide on how often they want to meet, and who wants to lead on particular activities. Support them to develop a practical, realistic plan with reasonable time commitment from Community Board members.

5. FOLLOW-UP

The triggering point is the stage at which members of a community either decide to act together to stop Ebola, or express doubts, hesitations, reservations or disagreement. Following up after this point is critical, since things can go in many different directions. Follow the plan for revisiting communities in your cluster. Keep up the momentum by offering a positive attitude and enthusiasm in those villages that have already developed an action plan and who have begun to mobilise. Even in less enthusiastic villages, follow-up by phone to check in on how things are going and if there has been any change of heart. Your support and regular follow-up will help to build trust over time. Some key follow-up activities are included below.

5.1 Community Action Follow Up

Regular Phone Calls

You will be responsible for supporting about twelve communities within your community cluster. Although you will be able to visit each community every week, your daily/twice weekly/weekly phone call can help encourage the daily work of Community Champions and community members. During action planning, or before you leave the village, identify who is the best person to call. It may be a Community Champion, or the chief/leader, or perhaps both. During the weekly call, you can:

- Get an update on progress of the community's Ebola action plan, what activities are occurring, who is getting involved, key challenges and issues.
- Collect data and information on new cases and deaths, and understand how these cases were handled in the community. Understand the interaction between the community and health services such as ambulances and burial teams, and whether services met community expectations. This data will be recorded in the weekly monitoring database.
- Provide regular updates to the community on the latest Ebola Response news, including updates from the DHMT, changes to services (such as the opening of new treatment centres), news on food aid coordination, new quarantines, and other relevant information emerging from District authorities. The sharing of timely, credible data on the response will help build trust and will keep the community informed on important changes to the outbreak and to the response.

In addition to the weekly call, it is very likely that community members will begin calling you to support if specific situations arise. You are a resource to the communities, and you may become their first point of contact, often able to provide immediate support. You may need to refer or link communities with relevant services, support conflict resolution, and follow up to ensure that action has been taken. Your will need to deal with each situation on a case-by-case basis, follow the protocols, and maintain regular contact with your Field Officer.

Community and Household Visits

After triggering, you will return to each community in about one week for a follow up, to keep up the momentum and check on progress. After that, you will visit each community once a week (Western Area) or about once every three weeks (other districts). During the community visit, you will spend a full day in the community, conducting activities including:

- Meeting the chiefs/leaders, Community Champions and Community Board (if there is one) to get an update on the Ebola action plan implementation. This includes understanding their daily monitoring mechanisms. You will have time to discuss challenges and help to discuss potential solutions.
- Talking to community members and getting an update on specifics of new cases and deaths.
- Conducting house visits to specific families or groups in particular need to provide psychosocial and other support.
- Attending meetings of different community groups, to speak to different people in the community and learn more about what they are doing to protect themselves from Ebola.
- Offering new information or additional support as new services become available.
- Understanding other challenges such as food shortages, and linking households or communities with necessary support.
- Encouraging the continued use of primary healthcare facilities, e.g. for immunisation and child birth.

Ebola Survivor Welcome-home and On-going support

To overcome discrimination, you should facilitate community discussions and encourage the community to help celebrate Ebola Survivors when they return home following their discharge from the treatment centres. Community members can plan and discuss how they want to celebrate and recognise returning Survivors. If necessary, they may ask you to attend these ceremonies. After the initial return home, you will use the community visits to follow-up on the well-being of Survivors and to provide any additional support.

Psychosocial Support and Child Protection

During the triggering visit and follow-up community visits, you will consult with the community leadership to identify children made vulnerable by Ebola, and vulnerable children more generally. You will refer these children to the Ministry of Social Welfare, Gender and Children's Affairs (MoSWGCA), and continue to follow-up to ensure that appropriate action is taken.

Support Services and Linkages

You will provide additional support through community referrals and follow-ups to ensure that other pillars of the response – ambulances, burial teams, surveillance teams and contact tracers – are meeting community needs and expectations. When needs do not match words – for instance, when ambulances do not arrive or when burial teams treat bodies with disrespect - a community's trust in the messages and services of the response decreases, and they may be less likely to try to use these services in future. As Community Mobilisers, you will bear the brunt of poor service delivery. Your work is to inspire community action. Good behaviours will be seriously undermined if community demand is not met with acceptable, quality services. Through SMAC's role in the District and National Ebola Response Centres, specific community concerns can be shared with medical teams and health authorities. Your job will be to listen to community members and share their insights on how services are working, and how they could improve, in the communities you work in.

5.2 Fostering Pride and Sharing Best Practices

Peer Sharing and Exposure

Sharing lessons and practical experience from one community to another is one of the best ways to spread good ideas, foster community pride and build momentum. Although physical movement within the country is currently restricted due to Ebola quarantines, there are still opportunities for allowing communities to learn from each other.

- Use regular Ebola meetings of chiefs/leaders at section/ward, chiefdom and district level to celebrate community leaders and Community Champions who are implementing creative ideas, or who are particularly strong in executing their action plans. Give these leaders recognition for their work in keeping their communities safe from Ebola. Use these meetings as a chance to update on progress and discuss challenges. This will also help to encourage leaders that are resistant by using positive peer pressure.
- Invite senior officials, religious leaders, politicians, journalists and others working on the national response to visit strong communities and be exposed to positive examples of community action. Encourage them to make public statements about community progress and plans. This will build a sense of pride among community members, and will also help the ideas to spread to other parts of the country.
- Arrange for Community Champions to speak and present their local successes at national Ebola events in Freetown. Support senior officials to recognize and celebrate these local community leaders.

- Work with SMAC partner, BBC Media Action to support inspiring Community Champions and chiefs to share their experiences on radio discussions. Use radio dramas and public service announcements to spread the word about specific actions communities can take, and examples of successful CLEA-triggered communities.
- In your weekly community visits, share photos, stories and experiences from communities that are having success, with other communities, to help inspire them and spread innovation.
- Encourage phone communications between local Community Champions, to allow them to share information and ideas.

5.3
Learning by Doing

It is hoped that this Field Guide provides you with inspiration and ideas for getting started with a community-led approach to fighting Ebola. As Community Mobilisers, your job is to learn from and support communities. You will develop strong relationships within the communities in your cluster, and this will help you adapt your approaches and strengthen your mobilisation skills over time. At weekly team meetings, you and your SMAC colleagues will share experiences, discuss challenges, and support one another to learn and improve. Your experiences and contributions to weekly action-learning sessions will help to build best practices and ensure continuous improvement. Congratulations for being the first to use the CLEA approach, with your help we will be successful in making Sierra Leone Ebola free.

6.
Annexes

Annex A: SMAC CLEA Training Agenda

TIME	SESSION
DAY 1: Introductions	
8:30 – 10:00	**Session 1:** Icebreaker, Expectations and Objectives
10:00 - 11:00	**Session 2**: Introduction to SMAC
11:00 - 11:15	TEA BREAK
11:15 - 12:15	**Session 3:** Values, Attitudes and Behaviours
12:15-13:15	LUNCH
13:15 - 15:30	**Session 4:** Ebola Action
15:30 - 16.30	**Session 5:** Introduction to CLEA
16:30- 17:15	**Session 6:** Signing-up to be a CLEA Community Mobiliser
17:15 – 17:30	Daily Wrap-Up
DAY 2: Community-Led Ebola Action (CLEA)	
09:00 – 09:30	Recap
9:30 – 10:15	**Session 7:** Understanding Community Perspectives
10.30 – 10.45	TEA BREAK
10:45 – 12.30	**Session 8:** Introduction to Participatory Methods
12:30-13:30	LUNCH
13:30-17.15	**Session 9:** Introduction to CLEA Triggering Tools I
17.15-17.30	Daily Wrap-Up
DAY 3: More CLEA, Action planning, Follow-up, Safety and Security	
9:00-9:15	Recap
9:15-11:00	**Session 10:** Introduction to CLEA Triggering Tools II
11:00-11:15	TEA BREAK
11:15-12:30	**Session 11:** Community Action Planning and Follow-Up
12:30-13:30	LUNCH
13:30-15:30	**Session 12:** SMAC Safety and Security
15:30-16:45	**Session 13:** Planning for Hands-On CLEA Triggering
16:45-17:00	Daily Wrap-Up

TIME	SESSION
DAY 4: Hands-On Triggering Practice in Communities	
7:30-13:00	Hands-on Triggering in Communities
13:00-14:30	Travel/Break
14:30-16:30	Reflection on Triggering Experience
16:30-16:45	Daily Wrap-Up
DAY 5: Monitoring, Psycho-social Support and Child Protection	
09:00-09:30	Recap
09:30-10:30	**Session 14:** SMAC Targets and M&E
10:30-10.45	TEA BREAK
10:45-12:00	**Session 15:** Using the Community Visit Monitoring Forms
12:00-13:00	LUNCH
13:00-14:30	**Session 16:** Psycho-social Support and Child Protection

Annex B: Community Visit Monitoring Forms

Social Mobilization Action Consortium (SMAC) Monitoring Form For Triggering

District: _____ Mobilizer Code: _____

General Information		Day 1	Day 2	Day 3	Day 4	
Date of triggering:						
Chiefdom:						
Section:						
Ward/Zone:						
Name of Community:						
Demographic Information						**Total**
Household Visits		**Day 1**	**Day 2**	**Day 3**	**Day 4**	
# Male 0-18yrs						
# Male 19yrs plus						
# Female 0-18yrs						
# Female 19yrs plus						
Community Discussions						
Chiefs	# Male					
	# Female					
Youth leaders	# Male					
	# Female					
Religious leaders	# Male					
	# Female					
Police	# Male					
	# Female					
Women's leaders	# Male					
	# Female					
Health workers	# Male					
	# Female					
Ordinary citizens	# Male					
	# Female					
Children	# Male					
	# Female					
Others **specify**	# Male					
	# Female					
Health Statistics Indicators		Day 1	Day 2	Day 3	Day 4	Total
How many seriously sick people have you had in the community since our last visit?	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					
	# Female 19yrs plus					
How many of those sick people were referred to a health facility within the first 24 hours?	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					
	# Female 19yrs plus					
How many Ebola survivors are living in the community?	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					

Social Mobilization Action Consortium (SMAC) Monitoring Form For Triggering

	# Female 19yrs plus					
Total number of deaths in the community since October 2014.	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					
	# Female 19yrs plus					
Of these deaths, how many were buried by Ebola Burial Teams		**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Total**
	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					
	# Female 19yrs plus					
Of these deaths, how many were buried by the community?	# Male 0-18yrs					
	# Male 19yrs plus					
	# Female 0-18 yrs.					
	# Female 19yrs plus					

Action Points Day 1

Did the community develop an Action Plan? (Please circle one) YES NO

If an Action Plan was developed, please record all of the Action Points developed in the table below.

1	
2	
3	
4	
5	

Who has ownership of the Action Plan and is responsible for its implementation?
Name:_____ Position:_____ Phone Number:_____
Please have them sign their name here:_____

Did the community decide to set up a community committee or similar structure? YES NO

If you identified a champion to be your contact: Name: Phone #:
Position:

If no champion is identified, who is your primary link in the community? Name:
Position: phone #:

How would you rate the outcome of the session today? **(Please circle one)**
5 – Very High 4 - High 3 - Medium 2 - Low 1 – Very low

What are the most common concerns expressed by members of this community related to Ebola?

What are some of the most commonly asked questions in this community?

What did the community initially assess and rank as key risks for catching Ebola?

Annex B: Community Visit Monitoring Forms

Social Mobilization Action Consortium (SMAC) Monitoring Form For Triggering

What bye-laws have been developed on Ebola in this community before the Triggering? Please any examples of bye-laws implementation.

What else did you hear/observe in the community discussions that you think is important to note?

Do you have any concerns about the community's capacity to carry out the action plan? What might be some of the obstacles?

Action Points Day 2

Did the community develop an Action Plan? (Please circle one) YES NO

If an Action Plan was developed, please record all of the Action Points developed in the table below.

1	
2	
3	
4	
5	

Who has ownership of the Action Plan and is responsible for its implementation?
Name:_____ Position:_____ Phone Number:_____
Please have them sign their name here:_____

Did the community decide to set up a community committee or similar structure? YES NO

If you identified a champion to be your contact: Name: Phone #:
Position:

If no champion is identified, who is your primary link in the community? Name:
Position: phone #:

How would you rate the outcome of the session today? **(please circle one)**
5 – Very High 4 - High 3 - Medium 2 - Low 1 – Very low

What are the most common concerns expressed by members of this community related to Ebola?

What are some of the most commonly asked questions in this community?

What did the community initially assess and rank as key risks for catching Ebola?

Social Mobilization Action Consortium (SMAC) Monitoring Form For Triggering

What bye-laws have been developed on Ebola in this community before the Triggering? Please any examples of bye-laws implementation.

What else did you hear/observe in the community discussions that you think is important to note?

Do you have any concerns about the community's capacity to carry out the action plan? What might be some of the obstacles?

Action Points Day 3

Did the community develop an Action Plan? (Please circle one) YES NO

If an Action Plan was developed, please record all of the Action Points developed in the table below.

1	
2	
3	
4	
5	

Who has ownership of the Action Plan and is responsible for its implementation?
Name:_____ Position:_____ Phone Number:_____
Please have them sign their name here:_____

Did the community decide to set up a community committee or similar structure? YES NO

If you identified a champion to be your contact: Name: Phone #:
Position:

If no champion is identified, who is your primary link in the community? Name:
Position: phone #:

How would you rate the outcome of the session today? **(please circle one)**
5 – Very High 4 - High 3 - Medium 2 - Low 1 – Very low

What are the most common concerns expressed by members of this community related to Ebola?

What are some of the most commonly asked questions in this community?

What did the community initially assess and rank as key risks for catching Ebola?

What bye-laws have been developed on Ebola in this community before the Triggering? Please any examples of bye-laws implementation.

Annex B: Community Visit Monitoring Forms

Social Mobilization Action Consortium (SMAC) Monitoring Form For Triggering

What else did you hear/observe in the community discussions that you think is important to note?

Do you have any concerns about the community's capacity to carry out the action plan? What might be some of the obstacles?

Action Points Day 4

Did the community develop an Action Plan? (Please circle one) YES NO

If an Action Plan was developed, please record all of the Action Points developed in the table below.

Who has ownership of the Action Plan and is responsible for its implementation?
Name:_____ Position:_____ Phone Number:_____
Please have them sign their name here:_____

Did the community decide to set up a community committee or similar structure? YES NO

If you identified a champion to be your contact: Name: Phone #:
Position:

If no champion is identified, who is your primary link in the community? Name:
Position: phone #:

How would you rate the outcome of the session today? **(tick one)**
5 – Very High 4 - High 3 - Medium 2 - Low 1 – Very low

What are the most common concerns expressed by members of this community related to Ebola?

What are some of the most commonly asked questions in this community?

What did the community initially assess and rank as key risks for catching Ebola?

What bye-laws have been developed on Ebola in this community before the Triggering? Please any examples of bye-laws implementation.

What else did you hear/observe in the community discussions that you think is important to note?

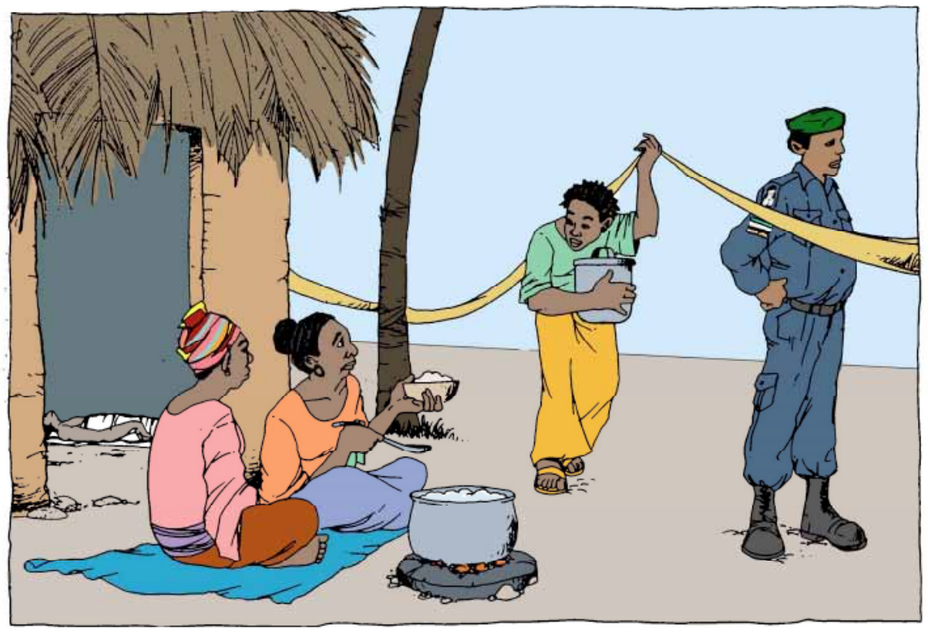
Do you have any concerns about the community's capacity to carry out the action plan? What might be some of the obstacles?

Annex C: Danger Discussion Cards

To be used when facilitating the SMAC CLEA 'Danger Discussion' Tool. These do not represent model behaviours and should not be used for general distribution.

To be used when facilitating the SMAC CLEA 'Danger Discussion' Tool. These do not represent model behaviours and should not be used for general distribution.

Annex C: Danger Discussion Cards



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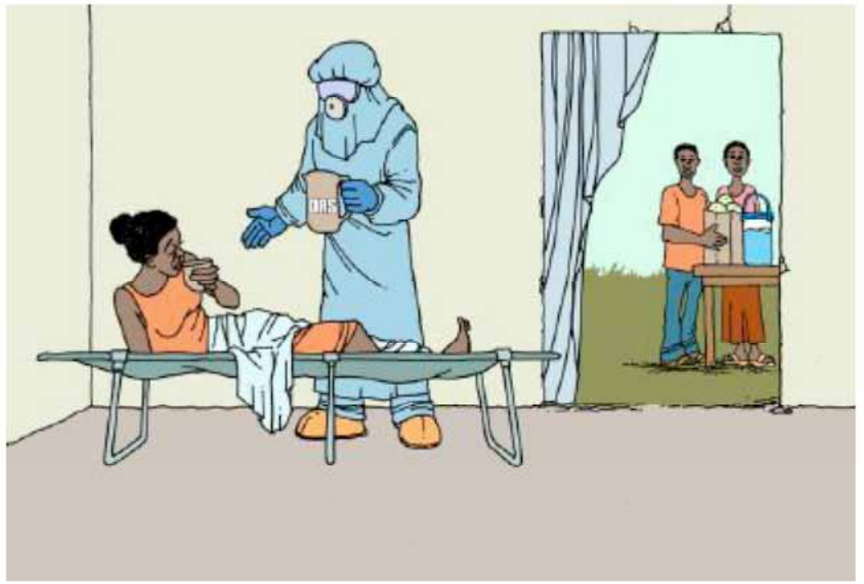

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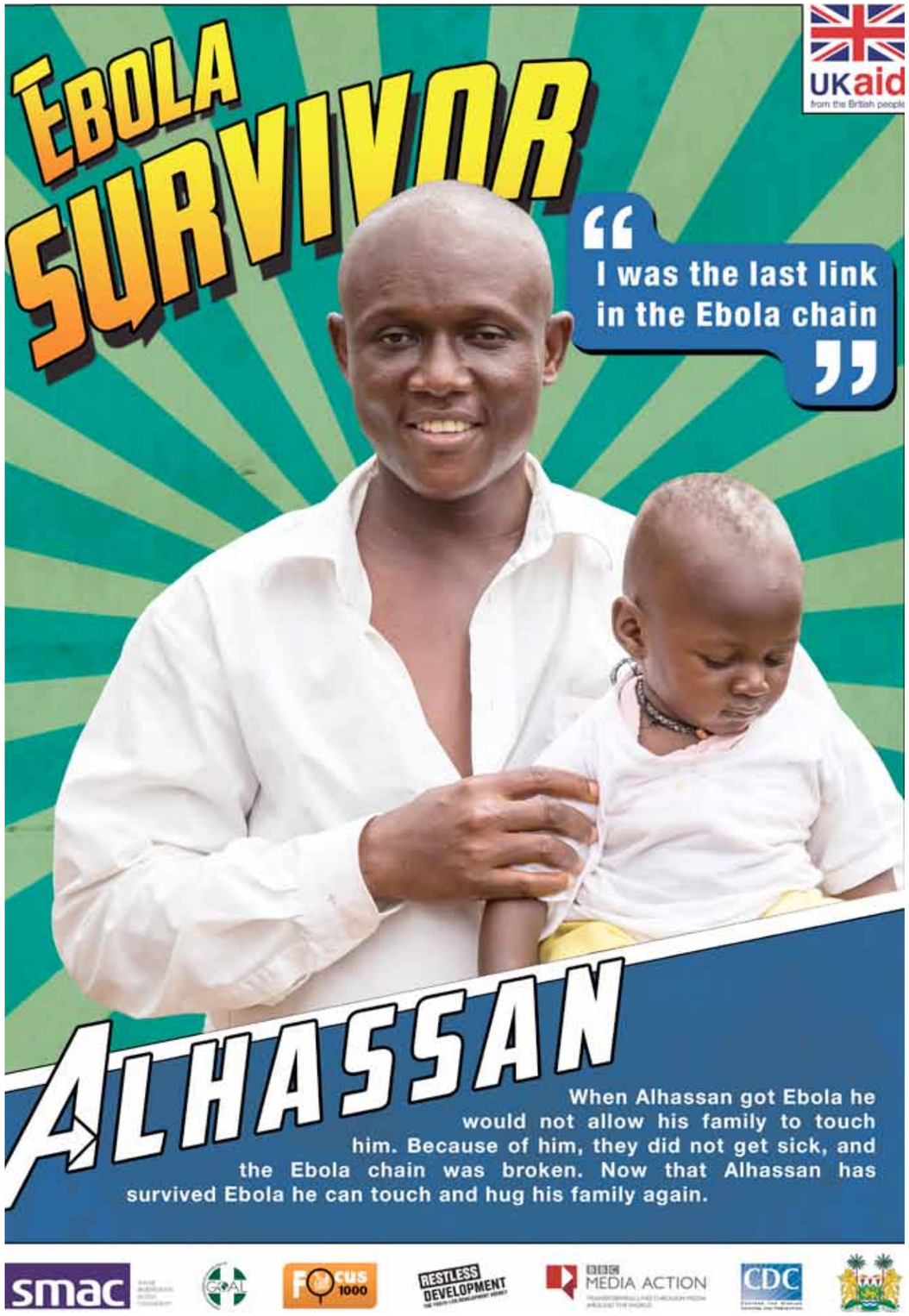
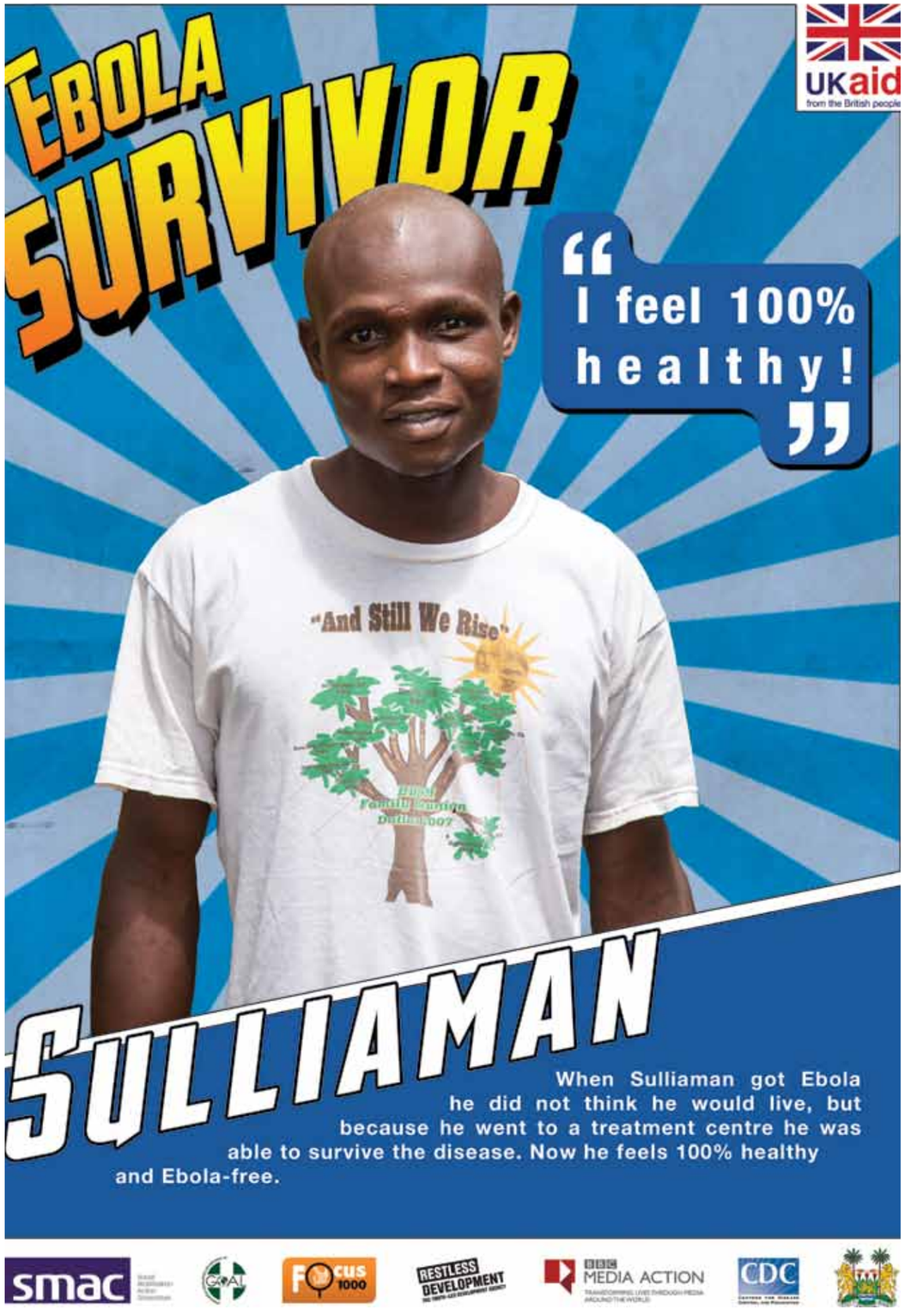
Annex D: Ebola Survivor Posters

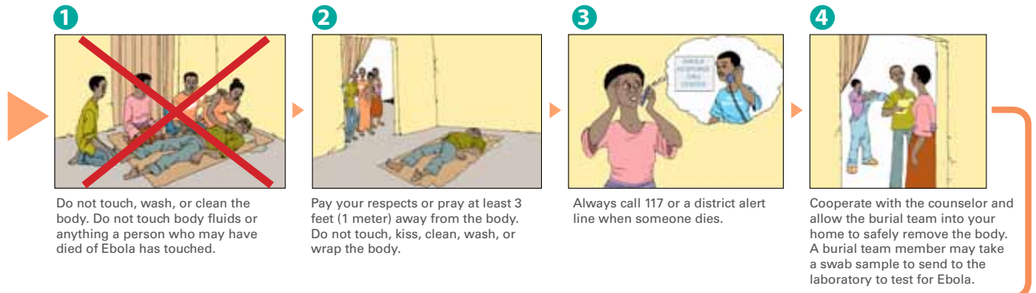


Annex D: Ebola Survivor Posters



Annex E: Safe and Dignified Medical Burial Flyers

Allow for a Safe Burial when Someone Dies at Home



1. Do not touch, wash, or clean the body. Do not touch body fluids or anything a person who may have died of Ebola has touched.
2. Pay your respects or pray at least 3 feet (1 meter) away from the body. Do not touch, kiss, clean, wash, or wrap the body.
3. Always call 117 or a district alert line when someone dies.
4. Cooperate with the counselor and allow the burial team into your home to safely remove the body. A burial team member may take a swab sample to send to the laboratory to test for Ebola.
5. People who die must be buried quickly to protect others from Ebola. The burial team will place the body in a body bag and disinfect the home with a safe chlorine solution.
6. All items that the person who died touched such as a mattress and clothing should be taken from the house and not used by anyone else.
7. The body will be taken by the burial team to a cemetery. Families cannot travel with the burial team to the cemetery. The family and a religious leader may be able to view the burial from at least 15 feet (5 meters) away.
8. If the Ebola test confirms that your loved one died of Ebola, you will have to stay at home for 21 days. This is how long it can take to develop Ebola symptoms. Health workers will visit the house every day to check if anyone becomes sick.

U.S. Centers for Disease Control and Prevention

CS251378