Annexes: Key considerations for implementing a Community Care Centre (CCC)

September 2014
Annex 1: A model for the systematic preparation and engagement of communities for the safe and rapid introduction of Community Care Centres

Introduction

The structured and systematic engagement of communities is crucial in establishing and maintaining the safe and controlled setting of a Community Care Centre (CCC). Preparation and agreement with communities before building a CCC is especially important in areas of intense and widespread transmission or where resistance is openly being shown towards health workers or responders. Adequately preparing and empowering communities to be at the heart of the Ebola response will contribute to addressing emotions of fear and anger while building trust and confidence between communities and responders.

The model outlined in this document is designed to assist countries plan for and deliver this approach. The model has been jointly developed by WHO and UNICEF with inputs and review from independent communication specialists and leading anthropologists. Countries should take and adapt the model to the individual contexts of their programmes. Ideally it should be used before a CCC is established but can also be used to ensure adequate community linkages are in place for the duration of the use of the CCC.

The model outlines three simple phases:

1. The Red Phase indicates that community contact and engagement has not yet been established. Personnel other than the community engagement team should not enter or approach the community until this phase has been completed.

2. The Amber Phase indicates that the community and their representatives have agreed to participate and contribute to Ebola prevention and control measures and have agreed for a Community Care Centre to be built in the community.

3. The Green Phase indicates that the community and their representatives have agreed to allow other personnel into or near to the community in order to implement the process of Ebola prevention and control.

Pre-planning

The systematic approach should begin by listing and mapping all communities that may need the support of an CCC to treat persons with suspected Ebola. This should be done at the sub-national level by the relevant social mobilization task team working in support of the county or district authorities. This team should also identify the members of the Community Engagement Team (CET) who should be responsible for meeting a community representative from each selected community. At these meetings the logistics of how the CET will reach each community and how the community engagement activities will be coordinated should be agreed. Skills required by the CET include good inter-personal communication, socio-cultural understanding, local language, group facilitation and simple reporting procedures. Ongoing communication and behaviour change activities need to complement the community engagement model.

The Red Phase

Community preparation

The red phase is crucial to establish trust and to build a working relationship with the community. Until this trust has been established no personnel other than the CET are permitted to enter the community except on an agreed basis with the local leaders. This is essential to protect safety.

The CET first meets with the community chief and/or other appointed leaders (faith and community group representatives etc.) to discuss the purpose of the Ebola prevention and control strategy, the establishment of an CCC and the need to resume basic health care services. It is important that they, and anyone else who subsequently enters the community, closely follows the local cultural protocols. This protocol clearly states the cultural etiquette when meeting, interacting and working with local people and is intended to avoid misunderstandings and disrespect between outside workers and community members.

The 1st point of contact with the community leaders will establish if the next step, an open space community conversation, is feasible. This will depend upon the advice of the local leaders and if it is felt safe to hold a
large, open-air meeting, in the community. The open space meeting will give people in the community the opportunity to voice their feelings, ask questions and to identify what they feel are the most important health issues in their locality, at that time. In communities where some groups, for example women, are excluded from large open air meetings, the CET will take measures to engage with their representatives in a separate space. A fact sheet will provide the most up-to-date information and advice on Ebola in the region so that the CET can give people the best possible information. The open space conversation will also allow misinformation to be dispelled and possibly for anger and fears to be alleviated in a safe setting.

An Ebola Care Group (ECG) will be established with representatives from the community and from the outside services to coordinate the planning and implementation of the CCC. The ECG will act as a “bridge” between the community and health staff and services needed for the CCC and to address any on-going issues that arise during the Ebola prevention and control strategy. It is important that the key issues and concerns that are raised by the community during the community conversation are recorded by the CET. This will provide a point of reference for future negotiations and discussions with the community leaders and community members. Some supplies may be left by the CET during the red phase with the community such as soap, buckets, disinfectant and other cleaning materials for distribution by the leaders. This is as a sign of trust and to build respect.

The Amber Phase

Community planning
The amber phase means that personnel can enter the community with agreement of its leaders. It is important that a register is kept by the leaders to monitor who comes and goes in the community in regard to the CCC and the Ebola prevention and control strategy.

The amber phase allows the ECG and the CET to meet to begin the process of planning, to negotiate resources and services, to identify the location of the CCC, the number of beds, the roles and responsibilities of the community, PPE, training gaps, isolation of and contact tracing of family members and mechanisms for communicating information between the CCC and the community.

The amber phase is also an opportunity for the community members to meet to discuss broader primary health care needs of the community beyond the implementation of the CCC. Some of these needs will have been identified in the red phase but other issues may arise when the community development group meets. Members of the community development group should be identified through the ECG or may be given as an extra task of the ECG.

The Green Phase

Implementation
The green phase means that personnel can enter the community, using the cultural protocols, and liaise with the ECG. The implementation phase involves actions to establish or construct the CCC and to deliver the necessary resources, training for staff and supplies for its effective and safe operation. This process will require constant communication with the community through the ECG. Training gaps will need to be filled and materials developed or distributed to community members. The community development group will continue to be active to address health and other issues beyond the CCC.

A monitoring and evaluation framework will be put in place and this will include a feedback loop to ensure that community members are aware of what is happening in their area and in neighbouring communities and that the strategy is being successful in regard to meeting their needs.
Annex 1: A model for the systematic preparation and engagement of communities for the safe and rapid introduction of Community Care Centres

<table>
<thead>
<tr>
<th>PREPARATION</th>
<th>PLANNING</th>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RED PHASE</strong></td>
<td><strong>AMBER PHASE</strong></td>
<td><strong>GREEN PHASE</strong></td>
</tr>
<tr>
<td>- Team has first contact in the community</td>
<td>- Cultural protocol</td>
<td>- Resources and supplies delivered, CCC built, training completed, materials developed.</td>
</tr>
<tr>
<td>- Open space/community conversation(s) held.</td>
<td>- Facilitated dialogue.</td>
<td>- Parallel community development group operational.</td>
</tr>
<tr>
<td>- Key health issues identified.</td>
<td>- Updated district/county/national situation FAQ and Fact Sheets.</td>
<td>- Monitoring and Evaluation framework established.</td>
</tr>
<tr>
<td>- Ebola Care Group (ECG) members identified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td><strong>Outputs</strong></td>
<td><strong>Outputs</strong></td>
</tr>
<tr>
<td>1. Community leaders and members have agreed to move to the planning phase.</td>
<td>1. Location and operation of ECU/CCC agreed.</td>
<td>1. Trained people in place.</td>
</tr>
<tr>
<td>2. Community representatives for the ECG have been identified.</td>
<td>2. Roles and responsibilities of the ECG identified.</td>
<td>2. Resources and supplies have been delivered.</td>
</tr>
<tr>
<td>3. Broader PHC needs of the community have been identified.</td>
<td>3. Training gaps and needs identified.</td>
<td>3. CCC established.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GREEN PHASE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

**OUTCOMES**
1. Functioning, effective and resourced CCC’s
2. Contribution to reduced transmission in the community.
3. Community resilience to recover and deal with future outbreaks of infectious diseases strengthened
Annex 2: Triage and facility design

Triage at CCCs

What is triage?

Triage is the process in which a staff member rapidly assesses a patient to determine whether Ebola is suspected, and if there is an urgent need for treatment. This process has three aims:

- Patients who have suspected Ebola are isolated from others who do not have Ebola to reduce the risk of transmission.
- Patients with suspected Ebola who need treatment can receive it quickly, to improve their chance of survival.
- Patients who are unwell but likely NOT to have Ebola can be sent home with instructions/medication, or referred for treatment in other healthcare facilities. This reduces their risk of infection in facilities where patients with Ebola are being cared for.

Triage area

- All patients must enter the facility through one common area (triage area) for screening (see Figure 1 of facility lay out).
- Clear signage must direct all patients through this triage point (see Figure 2).
- Only patients should enter the triage area. Their family members or companions should wait outside. Infants/young children requiring adult assistance should be accompanied by only one adult. CCC guard(s)\(^1\) should be assigned to watch the flow of people at the entrance of the triage area. Guards should keep non-patients away from the CCC, unless visitors have approval to enter.

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\(^1\) Guards can be recruited from the community. The guard should not come in close contact with patients or their remains. Guards should be present 24 hours a day, watching for the patients to not go out of ECU/CCC without discharge certificate and for their family and other visitors not to come in without approval. The Guards are not expected to do any physical interventions, but to provide advice and in case of violation, report to the responsible person in the ECU/CCC. Guards should be trained to perform hand hygiene properly.
Figure 1. Facility design and layout

- Staff access
- Patient access
- Latrine
- Shower
- Hand hygiene
- PPE

Annexes: Key considerations for implementing a Community Care Centre (CCC)
The triage area should be open only during fixed hours (for example, 8am to 6pm).

- The triage area should be divided into two zones: a) one for patients and b) one for ECU/CCC staff to conduct screening/the medical evaluation.

- Avoid direct contact with patients as much as possible. In order to help ‘no touch’ and ‘keep 1m distance’ rules, low wooden fences (about 1m high) have been introduced in the triage areas of some ECUs/CCCs to separate patients and staff.

- In the patient zone, there is need for:
  - chairs at least at 1 metre apart

- In the staff zone, there is need for:
  - infrared thermometers
  - patient medical evaluation forms and pens
  - alcohol-based handrub or washing basin with water and soap and disposable towels in an accessible distance
  - disposable gloves
  - 0.5% chlorine solution and disposable towels for table disinfection
  - rubbish bin

**Triage process**

- A trained person should perform triage – **triage staff**.

- Triage staff should remain 1–2 metres (3–6 feet) away from patients and not touch them or their remains as much as possible.

- All triage staff should wear PPE: a goggle or face shield to protect their eyes, mask to protect their nose and mouth, disposable apron, gloves and waterproof boots (or closed-toe slip-on shoes without shoelaces and shoe covers).
Greet the patient upon arrival. Inform the patient about what happens in triage area and what information is needed from him/her (history of contact and attendance at funerals, symptoms); explain why his/her answers are so important for the process.

Explain that early treatment can maximise the chance of recovery and reduce the risk of disease for the family.

**Triage staff** should not touch the patient while conducting the interview.

Screening/medical evaluation of the patient includes:

- Interviewing and writing down the findings in the patient evaluation form:
  - **Description of symptoms and their date of onset**: high fever (≥38°C), headache, extreme tiredness, loss of appetite, nausea, stomach pain, sore throat, muscle and joint pain, red eyes, rash, hiccups, diarrhoea, vomiting and bleeding (in vomit, stool, urine, gums, nose, etc.), pregnancy loss (e.g., miscarriage), difficulty breathing, drowsiness.
  - History of contact with an Ebola patient.2
- Take patient temperature with infrared thermometer and write down the result.

Complete the Checklist and Patient Record (Annex 2).

Now you are ready to make a decision about the patient. We will discuss how to do this in the next section.

**Making decisions about patients**

A patient can present with any combination of signs and symptoms described in the table below. Follow the actions described for each scenario in Table 1. A triage algorithm is provided in Figure 3.

All patients with fever should be provided malaria treatment and should complete the treatment.

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**Table 1. What to do for patients presenting with following symptoms**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Food and drink</th>
<th>Malaria treatment</th>
<th>ORS</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever ≥38°C and reports history of contact with an Ebola patient (alive or dead)</td>
<td>Consider as suspected Ebola case and admit to ECU/CCC</td>
<td></td>
<td></td>
<td>• ORS if sign of dehydration&lt;br&gt;• Paracetamol as needed</td>
</tr>
<tr>
<td>Fever ≥38°C and three or more symptoms described above, with or without history of contact</td>
<td>Consider as suspected Ebola case and admit to ECU/CCC</td>
<td></td>
<td></td>
<td>• Start ORS immediately for patients with diarrhoea and/or vomiting&lt;br&gt;• ORS if sign of dehydration&lt;br&gt;• Symptomatic treatment</td>
</tr>
<tr>
<td>No fever, but has a history of fever and more than three symptoms and a history of contact</td>
<td>Consider as suspected Ebola case and admit to CCC</td>
<td></td>
<td></td>
<td>• Malaria treatment if fever after admission&lt;br&gt;• Start ORS immediately for patients with diarrhoea and/or vomiting&lt;br&gt;• ORS if sign of dehydration&lt;br&gt;• Symptomatic treatment</td>
</tr>
</tbody>
</table>

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2 This includes a person who had contact with an Ebola patient by providing care, washing their clothes, touching and/or washing their body even after they have died, and touching contaminated objects such as bed linen. It also includes physical contact, sexual contact, attending the funeral of an Ebola patient who died, and touching a sick or dead animal (monkey, bat).
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Action – admission or send home</th>
<th>Food and drink</th>
<th>Malaria treatment</th>
<th>ORS</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and no other symptoms and does not report history of contact with an Ebola patient</td>
<td>• Give anti-malarial medicines and paracetamol (to reduce pain and fever)</td>
<td></td>
<td>*</td>
<td>*</td>
<td>• Food, ORS, vitamins can be included in the home kit</td>
</tr>
<tr>
<td></td>
<td>• Send home for 48 hours of observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide a home kit if available and advice to prevent transmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ask to come back if fever persists beyond 48 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever &gt;48 hours and no other symptoms, does not report history of contact with an Ebola patient and has not responded to antimalarials</td>
<td>• Consider as suspected Ebola case and admit to ECU/CCC</td>
<td>*</td>
<td></td>
<td></td>
<td>• Complete malaria treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• ORS if sign of dehydration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Symptomatic treatment</td>
</tr>
<tr>
<td>No fever and no other symptoms but reports history of contacts</td>
<td>• Send home</td>
<td></td>
<td></td>
<td></td>
<td>• Home kit can be provided for the contacts according to the local strategy and can include ORS</td>
</tr>
<tr>
<td></td>
<td>• Provide a home kit if available, and advice on how to monitor his/her health and to prevent transmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advise to come back to the ECU/CCC if fever appears</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Ebola symptoms</td>
<td>Send home with or without medication as appropriate, or refer to a separate health facility where possible</td>
<td>Me</td>
<td></td>
<td></td>
<td>• Symptomatic treatment as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Home kit can be provided for the contacts according to the local strategy and can include ORS</td>
</tr>
</tbody>
</table>

* Sign of dehydration – patient complains thirst, decreased skin turgor, skin pinch goes back slowly, sunken eyes are typical signs. If patient has obvious sweating, continuing high fever, frequent vomiting or diarrhoea, the patient can be suffering, or soon suffer from dehydration.

** Paracetamol is also included in ‘symptomatic treatment’ as pain and fever relief.

† Symptomatic treatment. See sections for medicines, page 16.
Flow of suspected EVD patients

Suspected Ebola patients admitted in ECU/CCC are grouped into two categories:
- **Dry cases** (fever plus symptoms other than diarrhoea, vomiting or bleeding).
- **Wet cases** (with diarrhoea, vomiting or bleeding).

Patients not likely to be having EVD

Place things to be given to the patient (home kit, medicines) on the table and give instruction for use, advise on preventing transmission and when to return to the ECU/CCC.
After each patient screening, clean the table with 0.5% chlorine solution, using a moistened towel, remove the gloves, perform hand hygiene and put on a new pair of gloves.

If your apron is soiled, dispose it and put on a clean apron. For more complete information about safe patient care, see SAFE section of this manual.

**Facility design**

There are two separate zones: the green and the red (see Figure 1). The red zone is for caring for patients suspected or confirmed to have EVD and to clean and disinfect the contaminated objects and burn waste generated. The morgue is also in the red zone. The movement of staff and patients is from clean to more contaminated areas. Staff should enter through the PPE donning area and exit through the area for PPE removal.

Hand hygiene stations are to be provided in both these areas. Patients enter and leave through assigned points.

Within patient care areas:
- Beds should be 1 to 2 metres apart.
- Each patient should be provided with a plate, cup, and utensils (spoon, fork). These should not be shared with others.
- Each patient should be provided with a bedpan and a bucket.
- Fresh 0.5% chlorine solution should be provided every day in each patient area to disinfect any spills after cleaning.

The green zone is for all activities that do not pose a risk of infection transmission. This zone has counselling areas, rest areas for staff and patients’ families and supporting services such as data management, administration, stores, pharmacy, kitchen and laundry for staff scrubs and boots.

**Activities in both these zones are mentored, supervised and monitored by designated staff.**
Annex 4: CCC staffing and job descriptions (UNICEF)

Suggested staffing requirements

<table>
<thead>
<tr>
<th>Staff category*</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers</td>
<td>5</td>
</tr>
<tr>
<td>Communication officer</td>
<td>3</td>
</tr>
<tr>
<td>Cleaners / Hygienists</td>
<td>1</td>
</tr>
<tr>
<td>Security guards</td>
<td>3</td>
</tr>
</tbody>
</table>

* For a CCC with 8-10 beds

Job descriptions

Community Health Worker

**Duties**
- Supervise / participate in the triage of patients presenting to the centre
- Patient care (nutrition, symptomatic treatment using oral medication only, assistance with diagnostic procedures) and follow-up of presumed or confirmed Ebola virus disease and other illnesses, under supervision of local health service team
- Maintain strict isolation procedures and infection prevention and control procedures at the CCC
- Provide relevant information to individual patients, family members and other staff
- Liaise with CCC communications officer on disease progress and prevention at community level
- Referral of patients needing a higher level of care; assist arrangement of transport
- Administrative duties, including supply management and liaison with local health service

**Qualifications**
- High school certificate
- Nursing or public health experience or training, according to local standards
- Literacy in the local language and preferably English or French
- Experience with use of mobile phone

**Training**
Training in infection prevention and control and the safe management and care of patients possibly infected with Ebola virus will be provided.

**Remuneration**
A remuneration package will be negotiated with successful candidates according to their qualifications and duties.
# Communications Officer

### Duties
- Provide education on Ebola virus infection prevention and control (IPC) to individual patients and their families
- Provide education on Ebola virus IPC to the local community
- Support other Ebola-related community education, social mobilisation and behaviour change activities, as required
- Participate in case surveillance and follow-up at community level
- Act as a communicator for and/or interpreter on behalf of patients and other CCC staff
- Participate in the triage of patients presenting to the centre
- Support strict infection prevention and control procedures in the CCC, as instructed
- Provide cultural education to people from within or outside the local community, as needed
- Administrative duties and other community liaison, as required

### Qualifications
- High school certificate
- Literacy in the local language and preferably English or French
- Ideally, qualification as a teacher or experience on community panels or groups
- Experience with use of a mobile phone

### Training
Training in infection prevention and control and the safe management of patients possibly infected with Ebola virus will be provided. Training on appropriate messaging and behaviour change communication on Ebola virus, with an emphasis on clear messaging and encouraging appropriate behaviour, will also be provided.

### Remuneration
A remuneration package will be negotiated with successful candidates according to their qualifications and duties.

# Cleaner / Hygienist

### Duties
- Clean/sweep and collect and remove all waste in centre
- Disinfect patient care areas as instructed
- Clean and disinfect latrines and bathing facilities as instructed
- Ensure supply and function of designated solid/medical waste disposal site and proper disposal of all rubbish, as instructed
- Support any environmental health personnel to carry out daily activities
- Support burial teams, as required
- Follow instructions on other activities given by the CCC management team

### Qualifications
- Elementary school certificate
- Literacy in the local language and preferably English or French
- Experience in cleaning, especially in health facilities

### Training
Training in infection prevention and control and the safe management of patients possibly infected with Ebola virus will be provided.

### Remuneration
A remuneration package will be negotiated with successful candidates according to their qualifications and duties.
Supervisory teams

The composition of the supervisory teams will vary by context but should include a public health specialist. Daily supervision of each CCC visits is recommended as a minimum.

Each team is expected to visit 5 CCCs per day on average, to provide: technical guidance and support on the quality of care being provided (assistance with decisions on referral), IPC and WASH; social mobilisation; oversight and management of supplies; liaison with higher levels on resource needs; and interactions with CCC personnel to identify and resolve problems on the spot or through follow up.

When a laboratory is available nearby, visits should also include collection of samples for testing, feedback on results and compilation of records.

Ideally the team leader of the supervisory team would be the interface with the local authorities. Higher level supervision will be context specific but may be at a district level or higher.

The table below describes the suggested composition of a supervision team.

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Recommended number*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health specialist **</td>
<td>1</td>
</tr>
<tr>
<td>Environmental health specialist / Logician **</td>
<td>1</td>
</tr>
<tr>
<td>Social mobiliser / Behaviour change specialist</td>
<td>1</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
</tr>
</tbody>
</table>

*Assumes visits to 3 to 5 CCCs each day in a dedicated vehicle
** One of these acts as the Supervision Team Leader and maintains direct and regular contact with District/Prefecture Health Directorate

It is envisaged that the supervisory team be recruited through the UNOPS initiative. Supervisory teams for pilot CCCs may be fast-tracked and recruited from UNICEF staff.
## Annex 5: Indicative CCC supply list

<table>
<thead>
<tr>
<th>Type of supplies</th>
<th>Items</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic general</strong></td>
<td>● Beds (cholera beds if possible)</td>
<td>● Mosquito nets</td>
</tr>
<tr>
<td></td>
<td>● Mattresses (with disposable plastic covers)</td>
<td>● Utensils</td>
</tr>
<tr>
<td></td>
<td>● Linen</td>
<td>● Buckets</td>
</tr>
<tr>
<td></td>
<td>● Beds (cholera beds if possible)</td>
<td>● Body bags</td>
</tr>
<tr>
<td><strong>Basic medical</strong></td>
<td>● Infrared thermometer</td>
<td>● Paracetamol</td>
</tr>
<tr>
<td></td>
<td>● Oral rehydration solution</td>
<td>● Antimalarials (where applicable and according to national recommendations)</td>
</tr>
<tr>
<td></td>
<td>● Broad spectrum oral antibiotics (where applicable)</td>
<td></td>
</tr>
<tr>
<td><strong>IPC equipment</strong></td>
<td><strong>PPE</strong></td>
<td><strong>Hand hygiene supplies</strong></td>
</tr>
<tr>
<td></td>
<td>● Hoods</td>
<td>● Soap &amp; safe water</td>
</tr>
<tr>
<td></td>
<td>● Gloves</td>
<td>● Alcohol based hand rub</td>
</tr>
<tr>
<td></td>
<td>● Face shields</td>
<td>● Chlorine water</td>
</tr>
<tr>
<td></td>
<td>● Masks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Gowns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Boots</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Aprons</td>
<td></td>
</tr>
<tr>
<td><strong>Cleaning and linen</strong></td>
<td>● Heavy duty/rubber gloves</td>
<td>● Cleaning tools</td>
</tr>
<tr>
<td></td>
<td>● Detergent</td>
<td>● Bags for waste disposal</td>
</tr>
<tr>
<td></td>
<td>● 0.5% Chlorine solution</td>
<td>● Rags and paper towels</td>
</tr>
<tr>
<td></td>
<td>● 10% Lime powder</td>
<td></td>
</tr>
</tbody>
</table>

A detailed supply list with specifications can be available upon request at WHO country office.
Annex 6: Infection prevention and control in CCCs

Key conditions

- Set up the CCC to allow separation between suspected, dry and wet patients and confirmed EVD cases.
- Equip the CCC with separate latrines for family members and staff, and suspected and confirmed cases, and access to sufficient water supplies along on-site storage, and a dedicated pit latrine for waste. However, patients should be given a bedpan and a bucket that should be preferably used especially if vomiting or diarrhoea.
- Have a fenced area for incinerating health care waste materials. The use of an appropriate incinerator is essential to ensure safe decontamination of the solid infected waste. Different options of burning technologies are available while the safest technologies to decontaminate infectious waste are advanced fuel supported incinerators. For more information refer to Safe Management of Wastes from Health-Care Activities (WHO, 2014).
- Make all necessary PPE to be used by HCWs, cleaners and family members (Table) available at the CCC and have clear plans for continuing inventory and delivery of PPE and materials before opening the CCC.
- Provide basic IPC training to family members and community health workers providing care in the ECU/CCC about essential IPC precautions, performing hand hygiene and using PPEs. Give community health workers the task to always train new family members.
- Organize appropriate cleaning and waste management
- A mobile, IPC-trained supervision team should visit the ECU/CCC regularly (ideally every day) to
  - Collect samples for testing and waste
  - Support safe burials
  - Bring supplies as needed, and
  - To assess safety and IPC

IPC measures for facility infrastructure and equipment

- Organize a triage area where patients are assessed (fever measurement, rapid interview, ideally no touch activities).
- If laboratory confirmation is available, the CCC should have at least 6 areas able to be separated by walls or other physical separation (portable walls, fencing) into (i) triage, (ii) “clean” entry area (to put on PPE), (iii) ‘dry’ suspect EVD patients, (iv) ‘wet’ suspect EVD patients, (v) confirmed patients, and (vi) ‘dirty’ exit area (to remove PPE and disinfection). In addition, a designated sheltered area nearby should be provided for caretaker family members to sleep.
- If laboratory confirmation is not available, the CCC should have at least five areas (i, ii, iii, iv, vi of the above mentioned).
- Allow a 1 metre distance between patients.
- For wet patients, use cholera beds (with hole for bedpan in the middle), if available.
- Provide a bucket and a bedpan to each patient.
- Ensure safe patient flow from ‘clean’ to ‘dirty’. When moving through the CCC, patients, family and workers should enter via the “clean” entry area. They may then move to the suspected cases area (from the dry to the wet patient areas) and then to the confirmed cases area (or from the dry to the wet patient areas if laboratory confirmation unavailable), and finally leave through a “dirty” exit area where equipment removal and disinfection occurs. Circulating with the CCC should only be done if strictly necessary.
- Set up an area for waste management and laundering.
- Organize daily collection of waste by the supervision team to be managed at the associated health-care facility. If possible, set up an incinerator besides the CCC.
Provide hand hygiene facilities according to the Table in the triage area, in the “clean” entry area, in the patient areas and ‘dirty’ exit area.

Provide necessary PPE to be used by HCWs, cleaners and family members according to the table below

Patient care considerations

- No more than one family member may provide care for each patient from the start to the end of their stay in the CCC (unless the family member themselves fall ill, in which case they can be replaced).
- Basic IPC training (wear gloves, don’t touch body fluids, etc.) must be provided to family members providing care in the CCC.
- The family member providing supportive care to the patient must not go back and forth between the CCC and the community; instead, they should sleep in a designated area near but outside the CCC.
- Family members caring for Ebola patients should receive sufficient food and water for the duration of their stay at the facility, to prevent them from community interactions.
- A dedicated toilet or latrine must be available for family members, separate from the toilet facilities for the CCC patients. Family members must be instructed to use only this facility.
- Bodies of dead persons should not be touched by family members and CCC staff. Either the supervision or the burial team should safely prepare all bodies for safe burials.

Perform hand hygiene

- Before donning gloves and wearing PPE on entry to the isolation room/area,
- Before any clean procedures being performed on a patient,
- After any exposure risk or actual exposure with the patient’s blood and body fluids,
- After touching (even potentially) contaminated surfaces/items/equipment in the patient’s surroundings,
- After using the toilet
- After removal of PPE, upon leaving the care area

Waste management

- Waste should be prepared and disposed in a designated area by workers or cleaners using PPE and performing hand hygiene (see table at the end of this section). Health care waste should be separated and disinfected before transport.
  - All solid, non-sharp, infectious waste should be collected using leak-proof waste bags and covered bins.
  - Any sharp objects (e.g. malaria RDTs) that have been in contact with blood or body fluids should be placed inside puncture resistant waste containers.
- Waste should be transported to a secure, fenced area near the incinerator until it can be incinerated. If an incinerator is not available or operating, all waste should be safely buried.
- Each patient should have and individual bedpan and bucket and the contents emptied safely into the designated sewage area/pit latrine. Bedpans and buckets should only be handled by CCC cleaning staff, not family members. Environmental decontamination of the sewage area/ latrine should be continually conducted to minimize contamination. In addition, if possible, lime should be added to excreta from infected patients to minimize risks before handling.
- Waste (both human waste and PPE waste) should be collected daily by the supervision team and burnable waste should be incinerated at the nearest associated healthcare facility. The CCC should be close to an incinerator if possible.
Cleaning

- Cleaners should wear PPE and perform hand hygiene (see table at end of this section).
- The CCC floors and surfaces should be regularly cleaned using a moistened cloth at least once a day with water and a detergent and then disinfected with a 0.5% chlorine solution (or a solution containing 5,000 ppm available free chlorine).
- Environmental surfaces or objects contaminated (e.g. bedpans) with blood, other body fluids and secretions should be immediately cleaned with water and a detergent and then disinfected with a 0.5% chlorine solution (or a solution containing 5,000 ppm available free chlorine).
- If locally prepared, cleaning and disinfectant solutions should be prepared every day. Change cleaning solutions and refresh equipment frequently while being used during the day.
- Cleaning should always be carried out from “clean” areas to “dirty” areas.
- Occupied and unoccupied clinical areas should not be cleaned with spray disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

Management of linen

- Workers managing soiled linen or clothes should wear PPE (see table at end of this section).
- It is preferable that linen and patient clothes soiled with blood and body fluids are washed in a facility equipped with washing machines.
- If washed elsewhere, soiled linen or clothes should be placed in clearly labelled, leak-proof bags or buckets and the container surfaces should be disinfected with a 0.5% chlorine solution before transport.
- If washed at the CCC by hand, cleaning should occur in the following order:
  1. Treat solid excrement such as faeces or vomit with lime (calcium hydroxide) if available and then scrape off carefully using a flat firm object. Flush excrement down the toilet or sluice, then place linen in the ‘dirty’ container.
  2. Soak (totally cover with water) soiled linen or clothes in a large drum container of hot water and soap. Use a stick to stir and then drain the water. Refill the drum with clean water and add 0.1% chlorine solution (or a solution containing 1,000 ppm available free chlorine) and allow to soak for 10-15 minutes.
  3. Remove the linen and rinse in clean water.
  4. Remove excess water and spread out to dry.

WHO acknowledges the contribution of the Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, United States of America to this guidance.
### CCC Infection Prevention and Control Measures for Health Care Workers, Cleaners and Family

<table>
<thead>
<tr>
<th>Recommended precautions and PPE</th>
<th>Triage (HCWs and Family)</th>
<th>Care of dry patients (HCWs and Family)</th>
<th>Care of wet patients and all confirmed EVD cases (HCWs and Family)</th>
<th>Cleaning, laundering and waste management (Cleaners)</th>
<th>Disposal or reprocessing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (with alcohol based hand rub or soap &amp; water)</td>
<td>∙</td>
<td>∙</td>
<td>∙</td>
<td>∙</td>
<td>NA</td>
</tr>
<tr>
<td>Examination gloves</td>
<td>∙</td>
<td>∙</td>
<td>∙</td>
<td>Double gloves</td>
<td>Disposable. Do not reuse. Change between patients. Possible disinfection with alcohol or chlorine 0.5% of inner pair of gloves and replacement of outer pair between pts.</td>
</tr>
<tr>
<td>Heavy duty gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disinfect whenever soiled with blood or body fluids and when leaving the CCC by cleaning with water and soap and then soaking in chlorine 0.5% for 30 min.</td>
</tr>
<tr>
<td>Goggles*</td>
<td>∙</td>
<td></td>
<td></td>
<td></td>
<td>If reusable, clean with water and soap, then disinfect by soaking in chlorine 0.5% for 30 min and rinse with water before re-use.</td>
</tr>
<tr>
<td>Face masks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disposable. Do not reuse. Change immediately if soiled and dispose when leaving the CCC.</td>
</tr>
<tr>
<td>Face shields</td>
<td>∙</td>
<td></td>
<td></td>
<td></td>
<td>Disposable. Do not reuse. Change immediately if soiled and dispose when leaving the CCC.</td>
</tr>
<tr>
<td>Head cover</td>
<td>∙</td>
<td></td>
<td></td>
<td></td>
<td>Disposable. Do not reuse. Change immediately if soiled and dispose when leaving the CCC.</td>
</tr>
<tr>
<td>Disposable gown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disposable. Do not reuse. Change immediately if soiled and dispose when leaving the CCC.</td>
</tr>
<tr>
<td>Reusable rubber aprons</td>
<td>∙</td>
<td></td>
<td></td>
<td></td>
<td>Change immediately if soiled. Disinfect whenever soiled with blood or body fluids and when leaving the CCC by cleaning with water and soap and then soaking in chlorine 0.5% for 30 min.</td>
</tr>
<tr>
<td>Gum boots</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disinfect whenever soiled with blood or body fluids and when leaving the CCC by cleaning with water and soap and then soaking in chlorine 0.5% for 30 min.</td>
</tr>
</tbody>
</table>

* If unavailable or uncomfortable to use, a face shield can be used.
** Optional. Use hood if preferable, but cap acceptable.
*** If impermeable gown, rubber apron not needed
Annex 7: Procedures for handling and disposing excreta

Protective gear should be worn at all times when following this procedure and great care should be taken to avoid splashing.

Assuming a 10-litre covered bucket, add approximately 600 ml (three cups) of a 10% (i.e. 100 g of lime powder in 1 litre of water) slurry (suspension) of hydrated (slaked) lime to the bucket. Then, carefully add the excreta/bodily fluids, leaving sufficient space in the bucket to add safely at least an additional 400 ml (two cups) of lime slurry.

The final material should continue to be treated with caution and carefully disposed of to a latrine meeting the above requirements.

It is not recommended to use chlorine to disinfect excreta as it is ineffective and may inhibit natural biological degradation processes.

The messages are driven by the need to be: empathetic, action oriented (prompting specific preventive behaviours), and focused on the informational and emotional needs of people and communities. They are designed to help people understand Ebola virus disease and make them less likely to become ill, enhance trust throughout the community, promote dialogue and community ownership of the response, and minimize psychosocial distress.

Resources


Annex 8: Management of dead bodies

Burial ceremonies often carry a high risk of Ebola transmission, as a result of the gathering of large numbers of people either during the preparation of the body or during the funeral. It is essential to reduce transmission that may occur during burials through contact with dead bodies.

Management of dead bodies and burials should be performed by a team trained in infection prevention and control measures. The team should have all the necessary material such as personal protective equipment, body bags, disinfectant and transportation.

Other considerations are incineration of bodies and adequate management of waste. The respect of cultural practices and beliefs is essential for the success of this intervention.

Resources

Annex 9: Example of family support kits distributed in Liberia (UNICEF)

<table>
<thead>
<tr>
<th>Item</th>
<th>Unit</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubber gloves (large, heavy duty)</td>
<td>Pair</td>
<td>2</td>
</tr>
<tr>
<td>Measuring cup</td>
<td>No.</td>
<td>1</td>
</tr>
<tr>
<td>Jerry cans (each 20 litres)</td>
<td>No.</td>
<td>2</td>
</tr>
<tr>
<td>All-purpose soap (90 grams)</td>
<td>Pcs</td>
<td>12</td>
</tr>
<tr>
<td>Water guard</td>
<td>Bottles</td>
<td>3</td>
</tr>
<tr>
<td>Plastic bucket (20 litre with lid and faucets)</td>
<td>No.</td>
<td>1</td>
</tr>
<tr>
<td>Plastic bucket (20 litre without faucets)</td>
<td>No.</td>
<td>1</td>
</tr>
<tr>
<td>Leaflet (on Ebola + instructions for use)</td>
<td>No.</td>
<td>1</td>
</tr>
<tr>
<td>Hand washing demonstration flyer</td>
<td>No.</td>
<td>1</td>
</tr>
<tr>
<td>Chlorax</td>
<td>Litre</td>
<td>3</td>
</tr>
<tr>
<td>Kit bag</td>
<td>No.</td>
<td>1</td>
</tr>
</tbody>
</table>
## Annex 10: Indicative list of medicines for Community Care Centres

<table>
<thead>
<tr>
<th>Product</th>
<th>Specifications</th>
<th>Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol-based hand rub</td>
<td>Solution, 100ml bottle; 500ml bottle</td>
<td>Disinfectant</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>Solid oral dosage form: 250mg; 500mg (as trihydrate)</td>
<td>Antibacterial</td>
</tr>
<tr>
<td>Artesunate + Amodiaquine</td>
<td>Tablet: 25mg + 67,5mg; 50mg + 135mg; 100mg + 270mg</td>
<td>Antimalarial (follow national guidelines)</td>
</tr>
<tr>
<td>Arthemether + Lumefantrine</td>
<td>Tablet: 20mg + 120mg (dispensible or not)</td>
<td>Antimalarial (follow national guidelines)</td>
</tr>
<tr>
<td>Ascorbic acid (Vit C)</td>
<td>Tablet: 50mg</td>
<td>Vitamin supplementation</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>Tablet: 250mg (as hydrochloride)</td>
<td>Antibacterials (in septic shocks management)</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Tablet (scored): 2mg; 5mg</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Loperamide</td>
<td>Solid oral dosage form: 2mg</td>
<td>Antidiarrheal medicine for adult</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>Solid oral dosage form: 10, 20, 40 mg</td>
<td>Antiulcer (for stress ulcer) and gastrointestinal upper-bleeding</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>Solid oral dosage form: eq 4mg base; eq 8mg base; eq 24mg base</td>
<td>Antiemetic</td>
</tr>
<tr>
<td>Oral rehydration salts</td>
<td>Powder in sachets for dilution in 200ml, 500ml or 1 litre</td>
<td>Rehydration</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>Tablet: 100mg to 500mg</td>
<td>Fever and analgesic</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>Eye ointment: 1% (hydrochloride)</td>
<td>Anti-infective</td>
</tr>
<tr>
<td>Zinc sulfate</td>
<td>Solid oral dosage form: 20mg</td>
<td>For diarrhoea in children</td>
</tr>
</tbody>
</table>

### References


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Annexes: Key considerations for implementing a Community Care Centre (CCC)