EBOLA VACCINE COMMUNICATION, COMMUNITY ENGAGEMENT AND COMPLIANCE MANAGEMENT (3C) GAP ANALYSIS TOOL

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The major evidence base for drafting this Ebola vaccine Communication, Community Engagement and Compliance Management (3C) Gap Analysis Tool were based on the recommendations from expert consultations, which were conducted by World Vision Ireland and London School for Hygiene and Tropical Medicine (LSHTM) as EBODAC consortium members.

The Tool was enriched by the invaluable experiences, opinions, thoughts and ideas of experts and Project Steering Committees consulted in all the three project countries (Senegal, Sierra Leone and Uganda) and the Democratic Republic of Congo (DRC) that was experiencing the 2018 Ebola outbreak at the time of the Tool development. Please see annex 1-3 for the total list of names of stakeholders who participated in the various stages of the Gap Analysis Tool development process including group expert consultations, individual expert consultations, project steering committees and pilot testing.

Ministry of Health of Senegal established a respectable Project Steering Committee that provided oversight to the project implementation in Senegal. Additionally, the Ministry provided appropriate staff with experience in planning and implementing 3C activities for Ebola preparedness in Senegal during the 2014 West Africa Ebola outbreak to participate in the various stages of the Tool development processes in Senegal.

Ministry of Health of Sierra Leone established a respectable Project Steering Committee to provide oversight of the project implementation process in Sierra Leone. Additionally, provided appropriate staff like those with experience in planning and implementation of 3C activities for Ebola outbreak response in Sierra Leone during the 2014 West African Ebola outbreak that engulfed Sierra Leone to participate in the various stages of the Tool development processes in Sierra Leone.

Ministry of Health Uganda established a respectable Project Steering Committees (PSC) to provide oversight of the EBODAC Gap Analysis project implementation process in Uganda. Additionally, the Ministry provided appropriate staff with experiences in planning and implementation of 3C activities in the previous several small Ebola outbreaks in Uganda and the 2014 West Africa Ebola outbreak. The Ministry also provided staff with experience in planning and implementation of 3C activities for Ebola vaccine deployment from the 2018 Ebola vaccination of health workers in Uganda as a preparedness intervention to prevent 2018 Democratic Republic of Congo (DRC) Ebola outbreak from spilling over to Uganda to participate in the various stages of the Tool development processes in Uganda.

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ACRONYMS

3Cs:	Communication, Community Engagement & Compliance Management
AEFI:	Adverse Events Following Immunisation
CDC:	Centre for Disease Control
DHIS:	District Health Information Systems
EBODAC:	Ebola Vaccine Deployment, Acceptance & Compliance
EPI:	Expanded Programme on Immunisation
EOC:	Emergency Operations Centre (aka Public Health Emergency Operations Centre)
EVD:	Ebola Virus Disease
GEVIT:	Global Ebola Vaccine Implementation Team
HIS:	Health Information System
HMIS:	Health Management Information Systems
HPEC:	Health Promotion, Education and Communication (Health Education)
IEC:	Information, Education, Communication
ICTs:	Information Communication Technologies
IC:	Interpersonal communication
IPC:	Infection, Prevention & Control
KAP:	Knowledge, Attitudes & Practices
LSHTM:	London School of Hygiene & Tropical Medicine
M&E:	Monitoring and Evaluation
MoH:	Ministry of Health / and Sanitation / and Social Action
MOTS:	Mobile Training and Support
MOU:	Memorandum of Understanding
NGO:	Non-Governmental Organisation
RI:	Readiness Item
RRT:	Rapid Response Team
SitRep:	Situation Report
SoP:	Standard Operating Procedure
ToR:	Terms of Reference
UNICEF:	United Nations International Children's Emergency Fund
WHO:	World Health Organization
WV:	World Vision

COMMUNICATION:

Real time exchange of information, opinion and advice between frontline responders and people who are faced with the threat of Ebola to their survival, health, economic or social wellbeing.[1]

COMMUNITIES:

Different groups existing in the area targeted for 3Cs for Ebola vaccine deployment including the area surrounding targeted for vaccine deployment. Communities maybe defined by geographical area, purpose or other social cultural dimensions but for the purpose of this tool, the above is the operational definition of communities for 3Cs for Ebola vaccine deployment.

COMMUNITY ENGAGEMENTS:

Mutual partnership between Ebola response teams and individuals or communities in affected areas, whereby community stakeholders have ownership in controlling the spread of the outbreak.[2]

COMMUNITY ENTRY GATEKEEPERS:

People with formal or informal authority who have to be consulted before or during entry into their communities to conduct any sort of activity. This often includes political office bearers, religious leaders, cultural or traditional leaders.

COMMUNITY SEGMENTS:

Layers of target population with differences in geographical location, socioeconomic status, gender, occupation, power dynamics and thus differential access to channels of communication such as TVs, FM radios, community radios, social media and health facilities.

COMMUNITY STAKEHOLDERS:

Formal and informal institutions/organizations, groups and influential personalities operating within the community who have direct or indirect roles in planning, implementation or evaluation of community-based activities, including health interventions.

COMMUNITY STRUCTURES:

Groups and networks within the community such as women's group, mother's union, father's union, farmers group, market women associations, youth groups, teachers' groups, burial groups, cultural dance groups, religious denominations, saving and credit cooperatives, traditional healer's associations, ethnic and cultural groups.

DEMAND-SIDE PREPAREDNESS:

Behavior and inputs of recipients or intended recipients (individuals, households and communities) to service delivery inputs provided on the basis of formal sectoral planning by technical planners and managers. Furthermore, these are activities that will generate and sustain demand towards the Ebola vaccine.

EMERGENCY OPERATIONS CENTRE (EOC) AND PARTNERS:

This refers to the section of Government of the Ministry of Health that is responsible for leading and coordinating the Ebola preparedness and response. The partners may include the private for profit, private not for profit and traditional health providers, UN agencies, development and global health agencies, international and local non-governmental organizations, and community based organizations who are supporting the Ebola response.

[1]Risk communication and community engagement preparedness and readiness framework: Ebola response in the Democratic Republic of Congo in North Kivu
[2]Risk communication and community engagement preparedness and readiness framework: Ebola response in the Democratic Republic of Congo in North Kivu

ENABLING TECHNOLOGIES:
Equipment, methodology, system, or innovation that have the ability to support and enhance the performance and capabilities of the user. Within the context of 3Cs for EBODAC, enabling technologies can be used to support enhanced performance in: media monitoring; identification of persons, including biometric approaches, such as fingerprinting or iris scanning; tracking persons, such as for the purposes of two-dose vaccine compliance tracking; capturing and managing case management data; training, including Mobile Training Support Tools (MOTS); and coordination.

EXPANDED PROGRAM ON IMMUNISATION:
The section of the Ministry of Health that develops and expands immunisation programs in a country.

GENDER:
Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men.

HEALTH PROMOTION EDUCATION AND COMMUNICATION:
The section of the Ministry of Health that increases community awareness and literacy on disease prevention and promotion; promotes public participation and involvement in health-care delivery, increases demand and utilisation of services provided by the health sector.

HOTLINES:
24/7 telephone number which people can call free of charge to reports of any incidences. Example are 117 hotline in Sierra Leone and 0800100066 hotline in Uganda.

HUMAN RESOURCE:
All people engaged in actions whose primary intent is to enhance the health of populations.

IEC:
Information, Education and Communication: An approach whose aim is to change or reinforce support behaviour in a specific target audience towards a specified problem within a period of time. IEC materials are designed to effectively promote this approach.

MECHANISMS:
Procedures, rules and regulations.

MICRO PLAN:
Field level work plan documents that outlines specific activities, methodology, their schedules, venues, targeted beneficiaries, budget lines and responsible persons/institutions for implementation.

MOBILISATION:
The process of bringing together all community influencers to raise awareness of and create a demand for health-care, assist in the delivery of resources and services and cultivate all-round involvement.

OPERATIONAL PLAN:
Provincial, regional or district level documents that stipulate specific objectives, activities and budget lines that should be implemented to achieve the strategic goals and objectives.

PORTAL:
Physical or digital site or system where people can drop a text message, letter, email or other digital reports. One example is 8080 in Uganda where people can send SMS to the ministry of health.

READINESS ITEMS:
Things, systems or mechanisms that could be put in place or done before vaccine deployment (whether many months before, or immediately before) to mitigate the issues that could arise in relation to Ebola vaccine deployment and acceptance.

RISK COMMUNICATION:
The exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being.

RUMOURS:
Stories or reports that circulate amongst communities of uncertain or doubtful truth.

SENSITISATION:
Provision of experiences and knowledge of a particular issue or situation so that individuals or communities can take notice of this and understand it well.

STRATEGIC PLAN:
National level document that stipulates goal, broad objectives and approaches that would be preferred, prioritized and funded for curbing a disease or health problem in question for a specified period of time, usually 5 years. An example is the Uganda Ebola viral disease preparedness and response strategic plan 2010- 2014.

SYSTEMS:
Technologies and tools

TEAM:
Group of people with joint defined scope of work. This can be a department, unit, or committee. Examples are Rapid Response Team for Ebola, national and district task force for Ebola in Uganda, risk communication and social mobilization committee, etc.

TWO-WAY COMMUNICATION IN COMMUNITY ENGAGEMENTS:
Conversation whereby both parties speak, listen and provide feedback to each other.

VACCINE ACCEPTANCE:
Refers to willingness or hesitancy or refusal of vaccines despite availability of vaccination services.

VACCINE COMPLIANCE MANAGEMENT:
Ensuring the targeted are the ones receiving the vaccination and in case of a two-dose vaccine, those who received the first dose are the ones who receive the second dose at the right time.

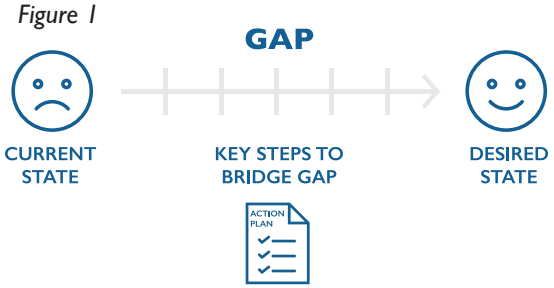
VULNERABLE GROUPS:
Refers to groups of people who may lack access to social-cultural amenities and services compared to general members of the population due to possession of certain characteristics such has being children, pregnant women, elderly people, malnourished people, prisoners, migrants and refugees, people who uses drugs, and people who are ill or immunocompromized, etc.

INTRODUCTION

WHAT IS A GAP ANALYSIS?

A gap analysis is the comparison of current performance state with potential or desired performance state (i.e. where country is versus where the wants to be). The difference between the two is 'the gap' to be analysed and addressed. Gap Analysis are often presented in a gap analysis tool format (see Figure 1).

Figure 1



WHAT IS A GAP ANALYSIS TOOL?

A gap analysis tool is a framework (usually checklist with response options and scoring system) that outlines what the potential or desired performance is, and assists users to measure their current performance against this benchmarks or set performance targets so they can analyse their gaps and look at the steps they'll need to take to reach their goals (often by creating specific action plans to move forward with the steps).

WHAT IS THE EBOLA VACCINE 3C GAP ANALYSIS TOOL?

The Ebola vaccine 3C Gap Analysis tool is a framework that establishes a countries readiness for Ebola vaccine deployment in non-emergency and emergency scenarios in terms of communication, community engagement and vaccine compliance management (3C). It does this by establishing the gap between 3C items the country has in place and what 3C items should be in place for optimal Ebola vaccine deployment, acceptance and compliance.

The Tool poses readiness items and levels of readiness to undertake Ebola vaccine communication, community engagement and compliance management (3C) for both countries and the international community to answer as they are planning or are in the process of deploying Ebola vaccine as a preparedness or outbreak response option. This tool establishes four levels of readiness namely:

LEVEL 3: Where 3C items are fully available and functional/operational

LEVEL 2: Where 3C items are partially available or partially functional/operational

LEVEL 1: Where 3C items are not available or not functional/ non-operational but in process of being developed

LEVEL 0: Where 3C items are not available or not functional/non-operational and there are no plans of developing them

The above level of readiness may be redefined by national authorities on the basis of existing regional and national context.
The Tool is designed to prepare for Ebola vaccine deployment in a variety of different deployment scenarios; regardless of the exact vaccine profile, across Sub-Saharan African countries.


EBOLA ISOLATION CENTRE
MOYAMBA DISTRICT
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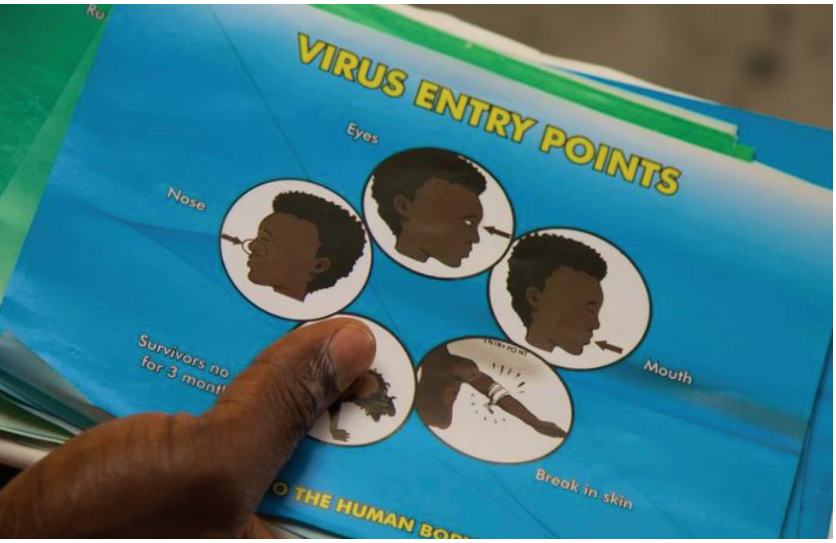
VIRUS ENTRY POINTS
Eyes
Nose
Mouth
Break in skin

WHAT DOES THE EBOLA VACCINE 3C GAP ANALYSIS TOOL COVER?

The Ebola Vaccine 3C Gap Analysis Tool covers 15 aspects of readiness assessment namely:

1. ASSESSMENT OF READINESS TO ENSURE THERE IS A COMPREHENSIVE UNDERSTANDING OF THE TARGET POPULATION(S), CHANNELS FOR COMMUNICATION AND THEIR AUDIENCES – FROM DEMOGRAPHICS TO ATTITUDES – BEFORE AND THROUGHOUT THE VACCINE DEPLOYMENT.

2. ASSESSMENT OF READINESS TO ENSURING THE DEVELOPMENT OF 3C STRATEGIES AND PLANS (INCLUDING WORK-PLANS, M&E PLANS) HAPPEN AT ALL LEVELS (NATIONAL, DISTRICT, COMMUNITY).

3. ASSESSMENT OF READINESS TO ENSURING TIMELY PRODUCTION OF TAILORED COMMUNICATIONS PRODUCTS AND MATERIALS (FAQS, LEAFLETS, POSTERS, VIDEOS, TRAINING MATERIALS ETC) BEFORE AND THROUGHOUT THE VACCINE DEPLOYMENT.

4. ASSESSMENT OF READINESS TO ENSURING FORMAL AND INFORMAL LEGITIMATE AND TRUST COMMUNITY GROUP LEADERS ARE ACTIVELY AND MEANINGFUL ENGAGED THROUGH THE EBOLA VACCINE DEPLOYMENT.

5. ASSESSMENT OF READINESS TO ENSURING TIMELY, CONSISTENT, CREDIBLE PUBLIC AND MASS COMMUNICATION ACTIVITIES ABOUT THE VACCINE.

6. ASSESSMENT OF READINESS TO ENSURING APPROPRIATE, TRUSTED CHANNELS, MESSENGERS AND PARTICIPATORY APPROACHES ARE USED TO REACH, ENGAGE AND DIALOGUE WITH COMMUNITIES AND INDIVIDUALS ABOUT THE EBOLA VACCINATION.

7. ASSESSMENT OF READINESS TO ENSURING EBOLA VACCINE MISINFORMATION, RUMOURS AND AEFIS ARE MONITORED THROUGHOUT THE VACCINE DEPLOYMENT, AND THAT COMMUNICATIONS AND COMMUNITY ENGAGEMENT ACTIVITIES FORM PART OF THE WAY IN WHICH THEY ARE ADDRESSED.

8 ASSESSMENT OF READINESS TO ENSURING VACCINATION COMPLIANCE IS PROMOTED AND TRACKED THROUGHOUT THE VACCINE RESPONSE, AND THAT COMMUNICATIONS AND COMMUNITY ENGAGEMENT ACTIVITIES FORM PART OF THE WAY IN WHICH VACCINATION COMPLIANCE ISSUES ARE ADDRESSED.

9 ASSESSMENT OF READINESS TO ENSURING INTERPERSONAL COMMUNICATION ACTIVITIES ARE USED AS INTEGRAL PART OF COMMUNITY ENGAGEMENT STRATEGY FOR THE EBOLA VACCINE DEPLOYMENT.

10 ASSESSMENT OF READINESS TO ENSURING EBOLA VACCINE COMMUNICATION AND COMMUNITY ENGAGEMENT ACTIVITIES CONSIDER CROSS BORDER DIMENSIONS.

11 ASSESSMENT OF READINESS TO ENSURING EBOLA VACCINE COMMUNICATION AND COMMUNITY ENGAGEMENT ACTIVITIES ARE RESPONSE TO VULNERABLE GROUPS AND GENDER ROLES IN THE COMMUNITY.

12 ASSESSMENT OF READINESS TO ENSURING ENABLING TECHNOLOGIES ARE USED TO IDENTIFY AND TRACK PEOPLE TO BE VACCINATED AND ALSO EDUCATE REMOTE COMMUNITIES DURING THE EBOLA VACCINE DEPLOYMENT.

13 ASSESSMENT OF READINESS TO ENSURING COMMUNICATION AND COMMUNITY ENGAGEMENT ACTIVITIES ABOUT EBOLA VACCINE ARE INTEGRATED INTO THE BROADER HEALTH SYSTEM.

14 READINESS LEVELS AND SCORING SYSTEM.

15 GAP IDENTIFICATION, PRIORITIZATION AND ACTION PLANNING.


EBOLA KEY MESSA
What is Ebola ?
Signs & Symptoms
How is Ebola Spread?
How to Prevent Ebola
Treatment for Ebola
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WHAT DOESN'T THE EBOLA VACCINE 3C GAP ANALYSIS TOOL COVER?

The Ebola Vaccine 3C Gap Analysis Tool does not cover 6 aspects namely:

1. **EBOLA VACCINOLOGY**
2. **GUIDANCE ON HOW TO SELECT A VACCINATION STRATEGY OR SET-UP A HEALTHCARE WORKER OR FRONTLINE WORKER OR RING VACCINATION WITH EBOLA VACCINE.**
3. **SUPPLY-SIDE ASPECTS OF EBOLA VACCINATION, I.E.:**
   - **A.** VACCINE STOCKPILES;
   - **B.** SUPPLY CHAIN;
   - **C.** COLD-CHAIN MANAGEMENT;
   - **D.** VACCINE STORAGE & HANDLING;
   - **E.** CLINICAL TRAINING OR TRAINING ON ANYTHING OTHER THAN COMMUNICATIONS, COMMUNITY ENGAGEMENT, OR COMPLIANCE-TRACKING;
   - **F.** WASTE MANAGEMENT & DISPOSAL;
   - **G.** MONITORING OR ASSESSMENT AFTER VACCINE DEPLOYMENT.
4. **CLINICAL SCREENING FOR EBOLA VIRAL DISEASE**
5. **EBOLA CASE MANAGEMENT, SURVEILLANCE AND LABORATORY TESTING**
6. **GUIDANCE ON HOW TO SECURE FUNDING OR EXACT FIGURES SHOWING HOW MUCH IS NEEDED FOR DEMAND-SIDE ACTIVITIES.**

WHAT REAL WORLD CHALLENGES PROMPTED THE DEVELOPMENT OF THE 3C GAP ANALYSIS TOOL?

The 2014 Ebola Virus Disease (EVD) outbreak in West Africa was of an unprecedented scale. Between January 2014 and January 2016, a total of 28,616 confirmed, probable, and suspected EVD cases, including 11,310 deaths, were reported in Guinea, Liberia, and Sierra Leone[3]. The outbreak devastated affected populations and caused considerable socioeconomic disruption across the region.

The EBODAC (Ebola Vaccine Deployment, Acceptance and Compliance) Consortium was formed at the height of this West African Ebola outbreak as part of Ebola vaccine development efforts, and in the recognition of the complex social and cultural hurdles which prevent vaccine acceptance by target populations[4] and particular unique challenges that may prevent acceptance and uptake of an Ebola vaccine.

With several Ebola Vaccines in clinical trial stage showing compelling results[5], the world is moving closer to having a licensed Ebola Vaccine. When an Ebola vaccine does receive regulatory approval for use, exceptional levels of demand-side preparedness will be key to ensuring its successful deployment. Vaccine hesitancy and refusal are issues with all vaccines, but an Ebola vaccine is likely to be especially sensitive for several reasons, from the fear Ebola invokes to the unfamiliar way in which an Ebola vaccine may be deployed, or even different levels of safety testing for vaccines deployed in public health emergencies. Effective communication and community engagement to inform, interact, and create a dialogue with target populations could be the difference between high vaccine confidence, uptake and compliance and heightened vaccine concerns, mistrust, low uptake and compliance, and even boycott.

The World Health Organization's Global Ebola Vaccine Implementation Team (GEVIT) Practical Guidance on the Use of Ebola Vaccine in an outbreak response[6] is the only known guidance that exists for the introduction of an Ebola vaccine. While this tool excels in providing guidance on supply-side preparedness for deployment, it doesn't fully cover exploration of demand-side readiness, and, thus, does not enable governments to systematically assess their own readiness to deploy. Therefore, the Ebola vaccine Deployment, Acceptance & Compliance (EBODAC) Consortium developed this Ebola vaccine 3C Gap Analysis tool to complement the guidance provided by the aforementioned GEVIT tool.

[3]WHO Ebola Situation Report, 10th June 2016 http://apps.who.int/iris/bitstream/10665/208883/1/ebolasitrep_10Jun2016_eng.pdf?ua=1
[4]Larson HJ et al. Addressing the Vaccine Confidence Gap. The Lancet. 2011; 378(9790): p526-535. Larson HJ et al. Understanding vaccine hesitancy around vaccines and vaccination from a global perspective: A systematic review of published literature. Vaccine. 2014; 32: p2150–2159.
[5]World Health Organization (2017). Update on Ebola Vaccine Trials. http://www.who.int/immunization/sage/meetings/2017/april/1_Ebola_vaccine_background_document.pdf
[6]World Health Organization (2017). Update on Ebola Vaccine Trials. Global Ebola Vaccine Implementation Team (GEVIT) Practical Guidance on the Use of Ebola Vaccine in an outbreak response. http://www.who.int/csr/resources/publications/ebola/gevit-guide/en/

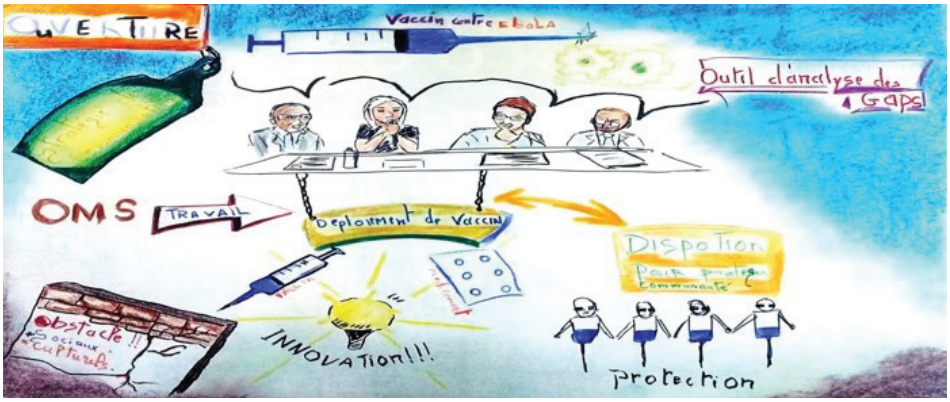
HOW WAS THE 3C GAP ANALYSIS TOOL DEVELOPED?

Figure 2: 3C Gap Analysis Tool - Phases of Development

The EBODAC Consortium's 3C Gap Analysis Team worked in collaboration with the Ministries of Health (MoH) in Sierra Leone, Senegal, and Uganda to develop and pilot the Ebola vaccine 3C Gap Analysis Tool. The team executed four phases of development: (1) rapid review of existing literature on tools; (2) expert consultations; (3) tool prototype development, piloting and refinement into the final Tool; and (4) dissemination (see Figure 2).
The expert consultations were conducted from Uganda, Senegal and Sierra Leone, countries selected because of their unique experiences of Ebola outbreaks and responses and significant expertise and notable achievements in this field.

The expert consultation process provided avenues for obtaining efforts from various national Ministries of Health (MoH), EOC and international institutions including WHO, UNICEF, Red Cross, PATH, MRC, MSF and CDC. Additional inputs into the development process were solicited through meeting with multi-disciplinary Project Steering Committees and joint writing workshops with ministries of health officials in Senegal, Sierra Leone and Uganda. Further development efforts included regional subject expert reviews, comments and pilot testing with future end users in Senegal, Sierra Leone, Uganda and DRC.

The involvement of expert stakeholders in the design of the 3C Gap Analysis Tool ensured that it has been on built on the latest research, best practices and lessons learned from clinical trails and Ebola vaccine deployments.



WHAT IS THE PURPOSE OF THE 3C GAP ANALYSIS TOOL?

The purpose of the 3C Gap Analysis Tool is to generate reliable information on countries' readiness to conduct Ebola vaccine communication, community engagement and vaccine compliance management in non-emergency and emergency scenarios. Specifically, the 3C Gap Analysis Tool is meant to enable governments in sub-Saharan Africa to ensure that communications, community-engagement, and vaccine compliance management (the 3C) strategies, plans and activities are effectively mainstreamed in Ebola vaccine deployment by enabling countries to:

1: Assess their own readiness in terms of communications, community-engagement and vaccine compliance management.

2: Identify the gap between the 3C items they have in place and what needs to be in place for optimal Ebola vaccine deployment.

3: Prioritize 3C gaps to address prior to or during the Ebola vaccine deployment.

4: Undertake action planning to address prioritized 3C gaps

In view of its aforementioned abilities, the 3C Gap Analysis Tool will serve as a resource document for governments and partners to undertake a process of identification and prioritization of gaps; action planning; and subsequent decision making related to preparation for Ebola vaccine deployment.

WHEN TO USE THE 3C GAP ANALYSIS TOOL?

Countries should consider completing the 3C Gap Analysis Tool when a country's Ministry of Health has made the decision to deploy Ebola vaccine whether in non-emergency scenario as part of preparedness intervention package and in emergency scenarios as part of outbreak response intervention package. In non-emergency scenarios, countries can consider completing the Tool as a routine Ebola vaccine 3C readiness baseline or midline or endline status assessments that can be presented to the Ministry of Health Ebola National Taskforce. Whereas in emergency scenario, the Tool should be used to conduct rapid assessment of the status of Ebola vaccine 3C by the Communication and Community Engagement Experts within the National Rapid Response Team (NRRT) within a minimum of one month to Ebola vaccine deployment as part of the outbreak response intervention package. However, it is recommended to plan for sufficient time to address any priority gaps that will emerge between the time of completing the Tool and the vaccine deployment.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WHAT RESOURCES ARE NEEDED TO COMPLETE THE 3C GAP ANALYSIS TOOL?

Country teams should ensure they have access (physically, online or through consultations) to the following information resources before using the Tool:

- National Strategic Plan for Ebola Viral Disease (EVD) Preparedness and Response
- Ebola vaccine communication and community engagement (i.e. risk communication and social mobilization) strategies and plans including human resources and budgets
- Expanded Programme for Immunization (EPI) strategies and plans including human resources and budgets
- Health Promotion, Education and Communication (HPEC) strategies and plans including human resources and budgets
- National policies and guidelines on production, distribution and dissemination of communication products and materials
- National policies and guidelines on vaccine related misinformation, rumours and AEFI management
- National policies and guidelines for routine immunization
- National polices and guidelines for Ebola vaccination
- National policies and guidelines for Health promotion, education and communication
- National gender mainstreaming policies and guidelines
- Cross border coordination mechanisms for Ebola preparedness and response

WHO SHOULD COMPLETE THE 3C GAP ANALYSIS TOOL?

Regardless of the scenario and the version of the Tool, the 3C Gap Analysis Tool should be completed by a multi-disciplinary team comprising of staff and stakeholders from:

- Health Promotion, Education and Communication (HPEC)
- Expanded Program on Immunization (EPI)
- Emergency Operations Centre (EOC)
- Surveillance and Epidemiology
- Epidemic Disease Control

WHO SHOULD TAKE LEADERSHIP IN ORGANIZING COUNTRY TEAMS TO COMPLETE AND ACTION THE PRIORITY GAPS IDENTIFIED BY THE 3C GAP ANALYSIS TOOL?

The Tool should be completed by a multi-disciplinary team of assessors in a meeting format that involves interactive processes such as group discussion, verification of records or quick expert consultative processes (through online emails, phone or social media).

The entire process of forming or enlisting the multi-disciplinary team of assessor(s), filling out the different parts of the Tool and action planning could take between 2-4 meetings. This should be taken into consideration when planning for the assessment.

The Ministry of Health particularly the headships of the departments for Health Promotion, Education and Communication (HPEC) and Expanded Programme for Immunization should take:

- Leadership in forming or enlisting the multi-disciplinary team of assessors to complete the Tool
- Responsibility of presenting the priority gaps and action plans identified through the Tool to relevant higher authorities including potential funders
- Responsibility of following stakeholders including potential funders on the implementation of priority gaps and action plans identified through the Tool

STRUCTURE OF THE GAP ANALYSIS TOOL

The Gap Analysis Tool is divided into four modules:

MODULE 1: STRATEGIC 3C ACTIVITIES

MODULE 2: OPERATIONAL 3C ACTIVITIES

MODULE 3: INTEGRATION OF 3C BEST PRACTICES AND GUIDELINES

MODULE 4: SUPPORTIVE AND ENABLING ENVIRONMENT FOR 3C

Each module is broken down into three parts:

PART 1: GAP IDENTIFICATION AND SCORING

There are a set of headings or topics nested under each module. And under each heading, there are readiness items with a scoring system which is assigned codes using the following schema:

I A.S A.O I

Module Number	Heading Order	Heading Label	Item Order

PART 2: GAP PRIORITIZATION

Part 2 for Gap Prioritization provides a framework for heading-level prioritization and item-level prioritization for the 3C Gap Analysis Tool.

PART 3: ACTION PLANNING

Part 3 for action planning provides a framework for identifying actions or solutions to the priority gaps.

1. COMPLETE THE READINESS ITEM

To complete the readiness item scoring, read each readiness item, reflect and discuss with the team, tick (√) and write one score corresponding to the response option that best reflects the country's current level of readiness regarding the item in question. At the end of the list of readiness items under each heading, you will be prompted to calculate a total score for the heading. Based on the total score for heading, you can calculate summary score for the heading as a percent score.

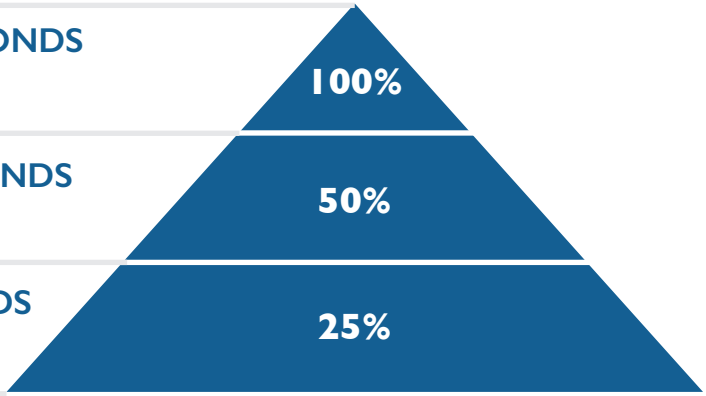
HOW TO INTERPRET THE OVERALL LEVEL OF READINESS SCORE?

Whereas overall level of readiness can range from 0-100%, as shown below, the three (3) critical overall levels of readiness are:

HIGHEST LEVEL OF READINESS CORRESPONDS WITH 324 POINTS (100%).

MODEST LEVEL OF READINESS CORRESPONDS WITH 162 POINTS (50%).

LEAST LEVEL OF READINESS CORRESPONDS WITH 81 POINTS (25%).



AN ILLUSTRATION OF HOW TO FILL IN THE READINESS ITEM SCORING:

HEADING 1A. SITUATIONAL ANALYSIS FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1A.SA.01	Has the EOC incorporated the distribution of 3Cs products and materials for Ebola vaccine deployment into the routine distribution system across the country?	Yes, information sources have been collected and analysed to context ☐	Yes, information has been collected but not yet analysed ☐	No, but plans in place to collect information ☐	No and no plans ☑	0
1A.SA.02	Do the routine healthcare service delivery programmes in public and private health facilities integrate 3Cs for Ebola vaccine deployment?	Yes, information is available and analysed to context ☐	Yes, information is available but not yet analysed ☑	No, but plans in place to collect information ☐	No and no plans ☐	2
1A.SA.03	Has the situational analysis and risk communications planning for the vaccination campaign included the following: 1. Identification and description of information related to known health effects of the vaccine; clinical management of anticipated AEFIs; and planned alert system and management locations/ protocol for AEFIs 2. Cultural meanings for anticipated AEFI symptoms and their management	5 or more ☐	Only 4 or 3 ☐	Only 2 or 1 ☑	None ☐	1
					Total Score for Heading (out of 9 total possible points)	**3/9**
					Percentage (%) score for Heading:	**30%**

2. PRIORITIZE HEADING-LEVEL AND ITEM-LEVEL GAPS

TABLE M1.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
1A.	30%	1ST
1B.	80%	4TH
1C.	60%	3RD
1D.	50%	2ND

TABLE M1.2.1
1ST PRIORITY HEADING CODE 1A.

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED
1A.SA.04	0	Lack of SOP for quick KAP surveys
1A.SA.02	0	Social mob are not part of rapid response team for Ebola
1A.SA.06	0	Insufficient funds for SA for 3Cs
1A.SA.06	0	A few in-country stakeholders trained in SA for 3Cs

3. CREATE AN ACTION PLAN

PRIORITY GAPS	ACTION PLAN	RESPONSIBLE PERSON	TIMELINE	SUPPORT NEEDED
Lack of materials in usable format	Activate standing MoUs	Comm HPEC	1 week	Funds for accessible format translation (etc..)

EBOLA VACCINE COMMUNICATION, COMMUNITY ENGAGEMENT AND COMPLIANCE MANAGEMENT (3C) GAP ANALYSIS TOOL

MODULE 1: STRATEGIC 3C ACTIVITIES

PART 1.1.1: (GAP IDENTIFICATION AND SCORING) This module covers situational analysis, 3C strategy and plans, communication products and materials and 3C messaging to audience. MoH can use the module to determine their own readiness to conduct effective strategic planning in 3C for Ebola vaccine deployment.

HEADING 1A. SITUATIONAL ANALYSIS FOR 3C

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1A.SA.01	Has information been collected on population distribution by age, sex, religion, ethnic group and socio-economics status of the area where the vaccine will be deployed?	Yes, information sources have been collected and analysed to context ☐	Yes, information has been collected but not yet analysed ☐	No, but plans in place to collect information ☐	No ☐	
1A.SA.02	Is there available detailed information on the targeted community's knowledge, attitude, beliefs, behaviours and perceptions on Ebola, Ebola vaccines, global partners, the government and health system?	Yes, information is available and analysed to context ☐	Yes, information is available but not yet analysed ☐	No, but plans in place to collect information ☐	No ☐	
1A.SA.03	Does the situational analysis for Ebola vaccine deployment include the following? 1. Identification and description of information related to known health effects of the vaccine; 2. Clinical management of anticipated AEFIs; 3. Planned alert system and management protocol for AEFIs 4. Cultural meanings for anticipated AEFI symptoms and their management 5. Others	All the 5 ☐	3-4 ☐	1-2 ☐	0 ☐	

HEADING 1A. SITUATIONAL ANALYSIS FOR 3C

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1A.SA.04	Are the 3C strategies and activities[7] for Ebola vaccine deployment informed by the findings of situation analysis?	Yes, all strategies and activities are informed by the situation analysis ☐	Yes, but not all strategies and activities are informed by the situation analysis ☐	No, but plans in place ☐	No ☐	
1A.SA.05	Is there capacity to conduct and utilise situation analysis findings for Ebola vaccine related 3C activities?	Yes, there's full capacity ☐	Yes, but partial capacity ☐	No, but plans in place ☐	No ☐	
1A.SA.06	Are there mechanisms[8] to conduct a rapid situation analysis during an emergency?	Yes, mechanisms are in place and functional ☐	Yes, but not all the mechanisms are functional ☐	No, but plans in place ☐	No ☐	
					Total Score for Heading (out of 18 total possible points)	**/18**
					Percentage (%) score for Heading:	**%**

[7]Strategies/Activities include: Product & materials, Ebola Vaccine messages, Community Engagement, Ebola communication strategy etc.
[8]Mechanisms may include: Rosters, open data toolkits, contingency funds, protocol for rapid situation analysis etc.

HEADING 1A. SITUATIONAL ANALYSIS FOR 3C

MANUALS AND GUIDELINES

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 7.
- https://sbccimplementationkits.org/ebola/preparedness-ikit/ chapter-7-situation-analysis/

WHO. Public Health Situation Analysis (PHSA) Standard Operating Procedures.
- https://www.who.int/health-cluster/resources/publications/Public-Health-Situation-Analysis-SOPs.pdf

WHO. Emergency Response Framework 2nd Edition. Chapter 1.
- https://apps.who.int/iris/handle/10665/258604

SADC & FAO. Participatory Rural Communication Appraisal, Starting with the People: A Handbook. Chapter 2 Situation Analysis Framework in PRCA.
- http://www.fao.org/3/y5793e/y5793e00.htm

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 4. Conducting Rapid Assessments for Ebola Communication.
- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

SUCCESS STORIES

"A GOOD SITUATION ANALYSIS, THE KEY TO HANDLE MISINFORMATION AND RUMORS"

28 years' experience against rumors, or rather against negative information currently coming mostly from social networks.

- 1998: rumors against the Polio vaccine. Youssou Ndour (very famous Senegalese musician) helped us a lot with his messages. Journalists from Walfajiri (local TV channel) alerted us to rumors, the Prime Minister immediately set up a crisis committee around the Minister of Health. He has also vaccinated live on television his children against polio, which ended the rumor!

- With regard to measles vaccine, given the measles cases reported among Guineans in Senegal, we visited the ambassador of Guinea who immediately appointed 3 people to accompany the vaccine caravan. A musical tour was organized with these 3 people who supported the measles campaign.

- In the Niayes market gardening area where Peuhl cultivate, we encountered vaccine reluctance ... hence a change in communication by speaking Puular instead of French ... which solved the problem.

- In the case of the cervical cancer vaccine (HPV) among 9-year-old girls, it was the policy that posed a problem. In fact, it is the unresolved HPV issues that constitute blockages. Nevertheless, after the introduction in 2014, a total of 50,000 girls were vaccinated with 100,000 doses without experiencing any serious side effects. In the terminology of the HPV figure the word "uterus" which automatically refers to the idea of birth and therefore baptism, which obviously speaks to imams! Hence the feeling of being concerned by the HPV vaccine. We have worked with imams including a member of LISCA who is funding the treatment (400 000XOF) for the victims; the testimony of the husband of a victim was decisive to bring about the agreement of the imams. This illustrates that we must train these community relays and not focus on the main media!

HEADING 1B. STRATEGIES AND PLANS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1B.SP.01	Are there 3C Strategic and Operational plans for Ebola Vaccine Deployment (whether stand-alone or embedded in other plans)	Yes, both 3C strategic and operational plans exist ☐	Yes, but not both ☐	No but plans in place ☐	No ☐	
1B.SP.02	Does the 3C Strategic Plan for Ebola Vaccine Deployment include all of the relevant 3C activities[9]?	Yes, all relevant 3C activities are included ☐	Yes, but only few of the relevant 3C activities are included ☐	No, but plans in place ☐	No ☐	
1B.SP.03	Does the 3C Strategic Plan for Ebola Vaccine Deployment reflect the principles for: 1. Community feedback 2. Interlinkage with broader Ebola response 3. Interlinkage with the routine health system 4. Close collaboration between supply and demand side teams 5. Others	All the 5 ☐	3-4 ☐	1-2 ☐	0 ☐	
1B.SP.04	Have the key stakeholders[10] that may provide technical, financial and material support to the 3C activities for Ebola vaccine deployment during emergency been identified?	Yes, all of them ☐	Yes, but a few of them ☐	No, but plans in place ☐	No ☐	
					Total Score for Heading (out of 12 total possible points)	**/12**
					Percentage (%) score for Heading:	**%**

[9]3C Activities include: Situational analysis for Ebola vaccine-related communication, community engagement and compliance management, Communication Products and Materials on Ebola vaccine, Messaging to Audience on Ebola vaccine, Public/ mass communication specific on Ebola vaccine, Interpersonal communication specific on Ebola vaccine, Community engagement for Ebola vaccine, Misinformation and rumor management for Ebola vaccine, AEFIs communication management for Ebola vaccine, Compliance management for Ebola vaccine, Collection and use of community level data for Ebola vaccine-related communication, community engagement and compliance management, Coordination with Communication, Community Engagement and Compliance Management Teams for Ebola vaccine, Human resources for Communication, Community Engagement and Compliance management for Ebola vaccine, Equipment and supplies for communication, community engagement and compliance management for Ebola vaccine, Ebola vaccine-related gender considerations, Ebola vaccine-related vulnerable groups considerations, Laws, ethics and human rights in Ebola vaccine, Enabling technologies for Ebola vaccine deployment and compliance management, Cross border management of Ebola vaccine related communications, community engagement and compliance management, M&E for Ebola vaccine related communications, community engagement and compliance management, Capacity building/training on Ebola vaccine related communications, community engagement and compliance management, General health system integration of Ebola vaccine related communications, community engagement and compliance management

[10]Stakeholders include: International technical agencies i.e. WHO. UNICEF, CDC, Vaccine and immunization experts, Ebola outbreak response experts, Ebola vaccination experts, Public / mass communication experts, Community engagement experts, Social media experts, Epidemiologists, Infection prevention and control specialists, Social-anthropologists, ICT and computer specialists, Health educationists , Health workers like nurses, Frontline workers (such as community health workers, borders security agents, etc.), Community group leaders, Religious leaders, Traditional healers, Cultural leaders, Political leaders, Humanitarian response NGOs, Burial groups, Environmental protection, Wildlife, Tourism, Agriculture, Livestock

MANUALS AND GUIDELINES

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix G. Outline for communications strategy document for Ebola vaccine use.

-https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

WHO. Ebola Strategy. Companion tool to GEVIT Practical guidance on the use of Ebola vaccine in an outbreak response. Guidance for establishing AEFI surveillance systems in countries planning to use Ebola vaccines.

- https://www.who.int/csr/resources/publications/ebola/GEVIT_guidance_companion-tool_AEFI.pdf

WHO. Communicating Risk in Public Health Emergencies. A WHO Guideline for Emergency Risk Communication (ERC) policy and practice.

- https://www.who.int/risk-communication/guidance/download/en/

WHO. WHO outbreak communication planning guide.

- https://www.who.int/ihr/publications/outbreak-communication-guide/en/

Communication for behavioural impact (COMBI): a toolkit for behavioural and social communication in outbreak response.

- https://www.who.int/ihr/publications/combi_toolkit_outbreaks/en/

Communication for behavioural impact: field workbook. Field workbook for COMBI planning steps in outbreak response .

- https://www.who.int/ihr/publications/combi_toolkit_fieldwkbk_outbreaks/en/

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 7. Ebola Communication Strategy Guidance.

- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Appendix A. Illustrative Ebola Communication Strategy.

- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

HEADING 1C. PRODUCTS & MATERIALS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1C.MP.01	Is there an Office responsible for the approval of communication products and materials before production?	Yes, it exists at both strategic and operational levels ☐	Yes, but only at one of the levels ☐	No, but plan in place ☐	No ☐	
1C.MP.02	Does a set of guidelines exist for distribution of communication products and materials from points of production to health service delivery points and the communities?	Yes, guide-lines exist and is operational ☐	Yes, but not followed ☐	No, but plans are in place ☐	No ☐	
1C.MP.03	Do existing guidelines have provisions for development, production and distribution of additional communication products and materials at times of emergencies, AEFIs, rumours and misinformation?	Yes, there are several provisions ☐	Yes, but limited provisions ☐	No but in process of review ☐	No ☐	
1C.MP.04	Are there standing Memorandum of Understandings (MoUs) or Open Purchase orders with printing, recording and publishing entities?	Yes, several and are flexible ☐	Yes, but are few or rigid to activate ☐	No, but negotiations are ongoing ☐	No ☐	
1C.MP.05	Are there budget lines for development, production and distribution of communication products and materials?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but lobbying is ongoing ☐	No ☐	
				Total Score for Heading (out of 15 total possible points)		**/15**
				Percentage (%) score for Heading:		**%**

HEADING 1D. 3C MESSAGING FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1D.MA.01	Are there systems[11] for identification of previous Ebola vaccine deployments messages for adaptation and use in emergency scenarios?	Yes, systems exist and are functional ☐	Yes, but not functional ☐	No but system is being developed ☐	No ☐	
1D.MA.02	Does a committee exist with a clear term of reference to develop messages?	Yes, committee exists and is functional ☐	Yes, but non functional ☐	No but the formation process has started ☐	No ☐	
1D.MA.03	Is there a centralized compendium or resource centre where messages are routinely stored and easily retrieved whenever needed?	Yes, a functional centralized compendium or resource centre exists ☐	Yes, but non functional ☐	No but under development ☐	No ☐	

HEADING 1D. 3C MESSAGING FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
1D.MA.04	Are messages on AEFIs, rumours and misinformation incorporated (as appropriate) into materials for: • Training frontline staff • Community engagement • Stakeholder engagement • Interpersonal communication • Public/mass communication • Others	Yes, messages are incorporated and SOPs available ☐	Yes, messages are incorporated but SOPs are not available ☐	No, but plans are in place to incorporate messages or SOPs ☐	No ☐	
1D.MA.05	Are there guidelines for development of messages (from identification of the need for the message up to production)?	Yes, guidelines exist and are operational ☐	Yes, but not operational ☐	No but under development ☐	No ☐	
1D.MA.06	Are there budget lines for development of messages for 3C activities including: • Content drafting • Translation of messages • Message pre-testing • Message piloting • Message review meetings • Others	Yes, sufficient ☐	Yes, but insufficient ☐	Not but being considered ☐	No ☐	
					Total Score for Heading (out of 18 total possible points)	**/18**
					Percentage (%) score for Heading:	**%**

[11]Systems may include: Online repositories, resource centers; networks, associations or communities of practise etc.

MANUALS AND GUIDELINES

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.5 Message maps.
- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

WHO. Key messages for social mobilization and community engagement in intense transmission areas.
- https://www.who.int/csr/resources/publications/ebola/social-mobilization-guidance/en/

WHO. Ebola messages for the general public.
- https://www.who.int/csr/disease/ebola/messages/en/

CDC CERC. CERC Message development worksheet.
- https://emergency.cdc.gov/cerc/resources/pdf/message_development_for_communication.pdf

CDC CERC. CERC Anticipated questions.
- https://emergency.cdc.gov/cerc/resources/pdf/anticipatedqa.pdf

National Social Mobilisation Pillar, Sierra Leone. Consolidated Message Guide for Ebola Communication in Sierra Leone.
- https://reliefweb.int/sites/reliefweb.int/files/resources/consolidated_messaging_guide_sl_26_05_2015.pdf

Ministry of Health and Social Welfare, Liberia. Message Guide for Ebola Communication.
- https://www.medbox.org/social-mobilisation/message-guide-for-ebola-communication-social-mobilization-sub-committee/toolboxes/preview?q=

WHO. Risk Communication and Community Engagement Preparedness and Readiness Framework: Ebola Response in the Democratic Republic of Congo in North Kivu.. Annex 8. Message maps.
- https://apps.who.int/iris/bitstream/handle/10665/275389/9789241514828-eng.pdf

PART 2.1.1

GAP PRIORITIZATION

The Gap Prioritization Plan serves to assist in the identification and prioritization of gaps emerging from the completing Part 1 (Gap identification and Scoring). In addition, it is designed to support action planning to address critical gaps in readiness for Ebola vaccine deployment from the 3Cs perspective.

HOW TO CONDUCT GAP PRIORITIZATION?

After completing the Part 1 (Gap Identification and Scoring), Part 2 the Gap Prioritization Framework should be completed, followed by Part 3 (the Action Planning Framework), as they build upon each other. Each framework has instructions embedded.

The Gap Prioritization Framework undertakes two levels of prioritization: heading-level and item-level. Follow the illustrations and steps outlined below to fill in the Heading-level and Item-level Gap Prioritization Tables.

HOW TO FILL IN THE TABLES:

TABLE P2.1.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
1A.	30%	1ST
1B.	80%	4TH
1C.	60%	3RD
1D.	50%	2ND

TABLE P2.1.2
1ST PRIORITY HEADING CODE 1A.

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED
1A.SA.04	0	Lack of SOP for quick KAP surveys
1A.SA.02	0	Social mob are not part of rapid response team for Ebola
1A.SA.06	0	Insufficient funds for SA for 3Cs
1A.SA.06	0	A few in-country stakeholders trained in SA for 3Cs

PART 2.1.1

HEADING-LEVEL PRIORITIZATION

1

For each heading, fill in the total percentage score for the heading.

2

For each heading, indicate the priority rank, based on the total percentage score. Heading/Area level prioritization whereby the headings with the lowest total percentage score will be the 1st priority, followed by the 2nd lowest and 3rd lowest in that order.

Choose priorities 1st – 3rd for the next step of item level prioritization below. Where there is tie in the priority rank, countries will have the discretion to choose one of them.

TABLE P2.1.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
1A.		
1B.		
1C.		
1D.		

ITEM-LEVEL PRIORITIZATION

Item level gaps exist for items with scores of (0), (1), or (2). (See Box 1)

3

LIST ITEMS WITH A (0) SCORE.

Items with a (0) should be prioritized first, as this represents the most critical state that needs immediate attention.

4

LIST ITEMS WITH A (1) SCORE.

Items with a (1) score are the 2nd priority, and items with a (2) score are the 3rd priority.

5

REVIEW YOUR LISTS AND SET CUT OFFS.

Review your results in Tables 1 and 2 for headings and items. These represent your priority gaps.

BOX 1: INTERPRETING ITEM SCORES

(3) A score of 3 indicates readiness.
(2) A score of 2 indicates a situation where most elements are available or in place, but that some remaining aspects can be addressed.
(1) A score of 1 indicates a situation where not everything exists, but some minor aspects are either in place or underway towards readiness.
(0) A score of 0 indicates a state where nothing exists and no plan is in place to address the issue of concern.

6 REVIEW OF PRIORITIZATION

TABLE P2.1.2
1ST PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.1.3
2ND PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.1.4
3RD PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

ACTION PLANNING

Instructions: Based on the identified priority gaps, develop an action plan for addressing the gaps. The first row shows an example.

PRIORITY GAPS	ACTION PLAN	RESPONSIBLE PERSON	TIMELINE	SUPPORT NEEDED
Lack of materials in usable format	Activate standing MoUs	Comm HPEC	1 week	Funds for accessible format translation (braille, etc.)

MODULE 2: OPERATIONAL 3C ACTIVITIES

PART 1.2.1: (GAP IDENTIFICATION AND SCORING) The Operational 3Cs activities module covers community engagement, interpersonal communication, public/mass communication, rumour and misinformation management, AEFIs communication and compliance management for EBODAC. MoH/EOC can use the module to assess their own readiness to implement key activities that form the core of 3Cs operations with specific reference to an Ebola vaccine deployment scenario.

HEADING 2A. COMMUNITY ENGAGEMENT FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2A.CE.01	Have formal[12] and informal[13] community entry gatekeepers[14] been identified in the target and surrounding area for vaccine deployment?	Yes, 4 or more targets ☐	Yes, but just 1 or 2 targets ☐	Plan in place to include the target groups ☐	No and no plan ☐	
2A.CE.02	Have formal and informal legitimate influential community stakeholders[15] been identified?	Yes, two-way communication exists via multiple channel/procedures ☐	Yes, two-way communication exists via single channel/procedures ☐	No, but one-way communication exists ☐	No plan ☐	
2A.CE.03	Have community segments with previous vaccination resistance and low routine vaccine uptake been identified?	Yes, 4 or more Ebola vaccine compliance specific information are being shared ☐	Yes, 2-3 of the Ebola vaccine compliance specific information are being shared ☐	Yes, just 1 of the Ebola vaccine compliance specific information is being shared ☐	No plans ☐	
2A.CE.04	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include the following engagement activities: 1. Training of community stakeholders 2. Sensitization meetings for various community stakeholders 3. Community dialogues 4. Focus Group Discussions 5. Community action planning 6. One on one engagement meetings with community leaders and stakeholders 7. Others	Yes, teams have been established at all operational levels ☐	Yes, but in some operational level ☐	No but plans are in place to establish ☐	No plans ☐	

HEADING 2A. COMMUNITY ENGAGEMENT FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2A.CE.05	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include target groups for engagement, such as: 1. Community stakeholders 2. Community targeted for vaccination and the surrounding 3. Specific low routine vaccine uptake areas 4. Specific high routine vaccine uptake areas 5. Others	Yes, 4 or more targets ☐	Yes, but just 1 or 2 targets ☐	Plan in place to include the target groups ☐	No and no plan ☐	
2A.CE.06	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include platforms[16] to provide two-way communication between the 3C team and the community?	Yes, two-way communication exists via multiple channel/procedures ☐	Yes, two-way communication exists via single channel/procedures ☐	No, but one-way communication exists ☐	No plan ☐	
2A.CE.07	Does the Ebola vaccine compliance information shared with the community include: 1. Eligibility for Ebola vaccination such as: contacts of suspects, contact of contacts, health workers and frontline workers 2. Importance of vaccinating: contacts of suspects, contact of contacts, health workers and frontline workers 3. Vaccine dosage; 4. Duration between dosage (in case of two dose Ebola vaccine); 5. Importance of second dosage (in case of two dose Ebola vaccine) 6. Information on vaccination eligibility: pregnant and lactating mothers, infants, children, adolescents and elderly 7. Others	Yes, 4 or more Ebola vaccine compliance specific information are being shared ☐	Yes, 2-3 of the Ebola vaccine compliance specific information are being shared ☐	Yes, just 1 of the Ebola vaccine compliance specific information is being shared ☐	No plans ☐	
2A.CE.08	Have 3C teams for Ebola vaccine deployment been established at all operational levels in the targeted areas?	Yes, teams have been established at all operational levels ☐	Yes, but in some operational level ☐	No but plans are in place to establish ☐	No plans ☐	
					Total Score for Heading (out of 24 total possible points)	/24
					Percentage (%) score for Heading:	%

[12]Formal community entry gatekeepers may include: local political leaders, religious leaders, cultural/traditional leaders [13]Informal community entry gatekeepers may include: Musicians, Businessmen/women, Community activists, [14]Community entry gatekeepers: People with formal or informal authority who have to be consulted before or during entry into their communities to conduct any sort of activity. This often includes political office bearers, religious leaders, cultural or traditional leaders. [15]Community stakeholders: Formal and informal institutions/organizations, groups and influential personalities operating within the community who have direct or indirect roles in planning, implementation or evaluation of community-based activities, including health interventions. [16]Platforms to provide two-way communication may include: Suggestion boxes, toll-free lines, dialogues, beneficiary feedback surveys, exit interviews, radio/TV talk shows, beneficiary support groups, community based engagement and reporting systems

MANUALS AND GUIDELINES

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.9 Tips for community engagement.
- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

Social Mobilisation Action Consortium (SMAC). SMAC Field Guide.
- https://restlessdevelopment.org/file/smac-clea-field-manual-pdf

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 5. Community Engagement through Social Mobilization in the Ebola Response.
- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

HEADING 2B. INTERPERSONAL COMMUNICATION FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2B.IC.01	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include interpersonal communication (IC) activities[17]?	Yes, at both strategic and operational levels ☐	Yes, but at only one level ☐	No, but plans are in place to include IC activities ☐	No ☐	
2B.IC.02	Does the mapping of stakeholders for interpersonal communication (IC) include? 1. Community entry gatekeepers 2. Formal and informal community leaders and influencers 3. Persons to facilitate consent and assent process for Ebola vaccination 4. Vulnerable, marginal and difficult-to-reach groups 5. Others	4 or more ☐	2-3 ☐	1 ☐	0 ☐	
					Total Score for Heading (out of 6 total possible points)	**/6**
					Percentage (%) score for Heading:	**%**

[17]Interpersonal communication activities may include one-on-one face-to-face meetings, phone calls and emails

HEADING 2B. INTERPERSONAL COMMUNICATION FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.10 How to communicate.

- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

WHO. Risk Communication and Community Engagement Preparedness and Readiness Framework: Ebola Response in the Democratic Republic of Congo in North Kivu. Annexes 1 & 2. Talking Points.

- https://apps.who.int/iris/bitstream/handle/10665/275389/9789241514828-eng.pdf

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 6. Key Considerations for Effective Ebola Communication.

SUCCESS STORIES

"LIFE TESTIMONY BROKE THE RELUCTANCE AGAINST POLIO IMMUNIZATION"

A head of household refused to vaccinate his child routinely and during anti-polio campaigns. The head of the family lives in a village and the mother had moved to another city where one morning he wakes up and loses the use of his legs. The mother tells the head of the family who orders the mother not to go to a health facility and bring the child back to the village. He does all the mystical and traditional processes without success.

The Head Nurse of the health post is informed. After questioning, the nurse sends the information to the health district that sends the epidemiological surveillance focal point to make the samples that will be sent to the Institute Pasteur Dakar. Result: the sample is positive for polio. A team from the National Service of Education and Information for Health (SNEIPS) sends to the medical region a program to trace the story of this child. In a documentary film, the boy's journey is traced and the father of the child expresses his regrets and calls all parents to vaccinate their children.

This documentary film was screened in a city with high vaccine reluctance and the same night all parents decided to vaccinate their children and they were vaccinated. The capitalization and the documentation of the data makes it possible to manage challenges and bring evidences for the future challenges.

HEADING 2C. PUBLIC/MASS COMMUNICATION FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2C.MC.01	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include public/mass communication activities?	Yes at both strategic and operational levels ☐	Yes, but only at one level ☐	No but plans are in place to include them ☐	No ☐	
2C.MC.02	Have the different targeted audiences, channels and appropriate Messengers been mapped?	Yes, all are mapped ☐	Yes, but some ☐	No, but plans are in place to map them ☐	No ☐	
2C.MC.03	Have the mechanisms[18] for measuring the reach of messages to the targeted communities been set up?	Yes, mechanisms exist and are operational ☐	Yes, but are not operational ☐	No, but there are being set up ☐	No ☐	
2C.MC.04	Have standing Memorandum of Understandings (MoUs) with media houses to disseminate messages to targeted audiences during emergencies been established?	Yes, MoUs with several media houses exist and are flexible ☐	Yes, but with a few media houses ☐	No, but MoUs templates have been developed ☐	No ☐	

HEADING 2C. PUBLIC/MASS COMMUNICATION FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2C.MC.05	Have community communication systems[19] been set up to ensure border communities and communities beyond borders receive communication in a timely way?	Yes, system exist and are operational ☐	Yes, but are not operational ☐	No, but systems are being set up ☐	No ☐	
2C.MC.06	Do the team involved in public/mass communication activities have the relevant competencies for mapping: • Targeted audiences in the communities • Communication channels • Appropriate messengers for the targeted audiences	Yes, all the competencies ☐	Yes, but some ☐	No, but plans are underway for training and/or recruitment ☐	No ☐	
2C.MC.07	Are there budget lines to implement public/mass communication activities for Ebola vaccine deployment?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is underway to include budget lines ☐	No ☐	
2C.MC.08	Has an official spokesperson been designated with a clear Terms of Reference (ToR) for communication about the Ebola vaccine deployment to the public?	Yes, official spokesperson is designated with clear ToR ☐	Yes, but role is ad hoc ☐	No, but plans in place to designate ☐	No ☐	
				Total Score for Heading (out of 24 total possible points)		**/24**
				Percentage (%) score for Heading:		**%**

[18]Mechanisms for measuring the reach of messages to the target audiences may include reports or feedback or testimonies from audience during community meetings, church and surveys,
[19]Community communication systems may include community radios, announcements at churches, mosques, markets, burials and funerals, cultural and marriage events

MANUALS AND GUIDELINES

WHO Effective Media Communication during Public Health Emergencies: WHO Handbook.
- https://apps.who.int/iris/handle/10665/43511

WHO Effective Media Communication during Public Health Emergencies: WHO Fieldguide.
- https://apps.who.int/iris/handle/10665/43477

The Health Communication Capacity Collaborative HC3. A theory-based framework for media selection in demand generation programs.
- http://www.sbccimplementationkits.org/demandrmnch/wp-content/uploads/2014/07/Media-Selection-in-Demand-Generation-Programs-FINAL.pdf

HEADING 2D. MANAGEMENT OF MISINFORMATION & RUMOURS RELATED TO EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2D.RM.01	Have the existing sources, triggers and spreaders of rumours about routine vaccines been mapped?	Yes, comprehensive mapping is available ☐	Yes, but partial mapping ☐	No, but mapping is ongoing ☐	No ☐	
2D.RM.02	Have physical and digital systems been established for Ebola vaccination related misinformation and rumour monitoring and alerting such as: • Social anthropologists or community health workers in community spaces[20] • Software with configurations for social media monitoring and alerting	Yes, systems are in place and functional ☐	Yes, but not functional ☐	No, but under development ☐	No ☐	
2D.RM.03	Have channels and messengers been identified for dispelling misinformation and rumour?	Yes, both have been identified ☐	Yes, but only one of them ☐	No, but identification is ongoing ☐	No ☐	
2D.RM.04	Has a team been designated (with clear TORs) to rapidly investigate and manage rumours and misinformation about vaccines?	Yes, have clear TORs and can be used for Ebola vaccine ☐	Yes, but team is adhoc ☐	No, but designation process ongoing ☐	No ☐	

HEADING 2D. MANAGEMENT OF MISINFORMATION & RUMOURS RELATED TO EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2D.RM.05	Is there a multidisciplinary team to oversee rumour management[21]?	Yes, and functional ☐	Yes, but not functional ☐	No, formation is ongoing ☐	No ☐	
2D.RM.06	Have the teams involved in vaccine related rumours and misinformation management been trained on Ebola vaccine issues?	Yes, all the teams ☐	Yes, but a few of the teams ☐	No, but there are plans for training ☐	No ☐	
2D.RM.07	Are there budget lines for Ebola vaccine rumour and misinformation? • Monitoring systems • Alerting systems • Investigations • Management	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy for budget lines is ongoing ☐	No ☐	
					Total Score for Heading (out of 21 total possible points)	**/21**
					Percentage (%) score for Heading:	**%**

[20]Community spaces may include: bars, taxi stages, markets, worship, healthcare facilities, political, schools and scientific communities etc

[21]Rumor management includes making decisions on the following questions: at what point should rumors be considered too serious/at what point do you decide to monitor them more closely, or consider them 'normal' and 'acceptable' in the context? Should these levels of rumors be pre-determined or considered on a case-by-case basis?

HEADING 2D. MANAGEMENT OF MISINFORMATION & RUMOURS RELATED TO EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.8 Managing misinformation and rumours.

- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Annex III. Rumour tracking tool.

- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

SUCCESS STORIES

"OVERCOMING STIGMA IN VACCINE TRIAL"

There were many difficulties in recruiting for vaccine trials. This obstacle was unexpected given the many awareness and information activities carried out among the different actors involved in the operation of the site. Emphasis was placed on parents' associations and student associations (concerning the HPV trial) but also in different health structures, associations and neighborhood groups (concerning Ebola trials). Surveys of students who did not participate in the study showed that the main reasons for refusing to participate in the project were: misinformation sometimes led by professors working in the structure (notion of experimentation, use as guinea pigs, sterilization ...), the refusal of the responsible person (parent, guardian ...) and the taking of blood samples. These problems have been noted in clinical trials or vaccinations in developing countries that have clarified that informed consent is influenced by several factors including the social context: the phenomenon of mimicry, the order of the husband or the legal representative for minors played an important role.

In general, low adhesion during a trial presages the occurrence of possible vaccine acceptance problems, when it is placed on the market or inserted into a national program. National vaccination programs have suffered from this type of stigma, with a significant negative impact on the results achieved. This problem is further exacerbated when the vaccination targets a specific group and in particular young subjects of childbearing age as it was in our case with HPV. The idea of a strategy to reduce fertility is very quickly advanced by the people. This can be the same with Ebola vaccine as Ebola Virus Disease (EVD) is a source of fear and stigma.

The causes of withdrawals and lost to follow-up that we have listed, were dominated by the change of opinion of participants due to misinformation, the occurrence of an unforeseen situation (pregnancy, marriage, moving ...) and the change of mind of a parent.

The numerous refusals and withdrawals of subjects during clinical trials are most often due to three major causes: the demonization of medical research, the victimization of populations, that is to say the confused notion of experimentation, and finally the blood samples.

In the case of a vaccination trial, or in case of vaccination against a disease such as EVD which is unknown, the rumor that the populations are guinea pigs can be disseminated in the intellectual circles and through specific articles of the press. This justifies the need to inform as much as possible with target potential participants, their entourage, the press if possible and anyone interested in the study (or vaccination in the case of EBODAC). The information should be precise with maximum transparency. Moreover, in order not to be confronted with many withdrawals or lost to follow-up, the level of education of the participants should be taken into account. Indeed, it was realized for this study that most of the withdrawals and lost to follow-up were made in the group of girls who did not have a high level of education and in particular those recruited outside high school. These girls are a vulnerable population, because they are easily influenced. They are quick to adhere to a clinical or vaccine trial like any other, but can withdraw just as quickly when false rumors occur.

HEADING 2E. COMMUNICATIONS AROUND THE ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2E.AE.01	Is there a data-system[22] that collates Ebola vaccine AEFIs information[23] to guide 3C activities?	Yes, and fully functional ☐	Yes, but partially functional ☐	No, but under develop-ment ☐	No ☐	
2E.AE.02	Are there mechanisms for messages about Ebola vaccine AEFIs[24] related to: 1. Producing messages 2. Identifying appropriate channels 3. Identifying appropriate audience	3 ☐	2 ☐	1 ☐	0 ☐	
2E.AE.03	Have staff and stakeholders been trained in Ebola vaccine AEFIs?	Yes, all staff and stake-holders ☐	Yes, but only a few ☐	No, but trainings are being planned ☐	No ☐	
2E.AE.04	Are there budget lines for 3C activities[25] to address Ebola vaccine AEFIs?	Yes, sufficient ☐	Yes, but insufficient ☐	No but advocacy is underway ☐	No ☐	
				Total Score for Heading (out of 12 total possible points)		**/12**
				Percentage (%) score for Heading:		**%**

[22]Data-systems include: Technologies, equipment and tools for collection, analysis and reporting of data

[23]AEFI information to inform 3C activities may include information or data on: beliefs/rumours, behaviours/practices antagonist to public guidance/by-laws, -feedback on performance of /acceptability of AEFI rapid response team, -feedback on acceptability of multidisciplinary AEFI treatment and resource centres (see above) other community concerns related to AEFIs, their investigation, management or follow up

[24]This may include information known/potential AEFIs (if relevant); Cultural beliefs/practices relating to AEFI symptoms; AEFI treatment and resource centres network; Any implications for contact tracing and case management/observation, detainment/quarantine for reporting AEFIs; Emergent concerns/rumours related to AEFI and their management; Emergent information relating to the above

[25]3C activities to address Ebola vaccine AEFIs may include: incorporation of AEFI information and messaging into trainings; accessing network of permanent and mobile health clinics that serve as a multi-disciplinary AEFI treatment and resource centres (for the clinical management of AEFI symptoms, psychological support related to AEFIs, and risk communications on the Ebola vaccine); establishing a mobile and multi-disciplinary AEFI investigation, response and follow up team (for clinical/case management, surveillance/epidemiology, social science research, risk communication, community engagement).

HEADING 2E. COMMUNICATIONS AROUND THE ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI) FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Ebola Strategy. Companion tool to GEVIT Practical guidance on the use of Ebola vaccine in an outbreak response. Guidance for establishing AEFI surveillance systems in countries planning to use Ebola vaccines.

- https://www.who.int/csr/resources/publications/ebola/GEVIT_guidance_companion-tool_AEFI.pdf

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix Q. Standard Practical Steps.

- https://www.who.int/csr/resources/publications/ebola/AppendixP-StandardPracticalSteps.pdf

SUCCESS STORIES

"USING THE MTRAC PLATFORM TO BRIDGE INFORMATION FLOW BETWEEN COMMUNITIES AND HEALTH CARE PROVIDERS FOR IMPROVED HEALTH SERVICE DELIVERY IN UGANDA"

In Uganda, for ease of community and health management information flow and timely improvement by the healthcare sector, the mTrac (mobile tracking) system was designed for real time entry, submission and receiving of information between communities and healthcare sector and even within the healthcare sector. mTrac is a government of Uganda led initiative that was designed to digitize, simplify and quicken the transfer of information from the community to the health sector or within the healthcare sector via mobile phones. It has a computer application (app) or dashboard that does transmission of messages based on RapidSMS; a free and open source framework for dynamic data collection, coordination and communication, leveraging basic short message service (sms) mobile phone technology (Ministry of Health Uganda and mTrac).

The drive behind the development of the mTrac platform was to enable transfer of weekly health management information system (HMIS) including surveillance reports (covering diseases and outbreaks), provide a platform for community members to give feedback on health service delivery and empower health professionals and the district health teams to improve by providing them with timely information. Messages sent into the mTrac system can be received on the mobile phones of all stakeholders registered into the system, including facility health workers, district health teams, local health development partners, Ministry of Health (MoH) headquarter staffs, resource centre, epidemiology surveillance division, and national health development partners.

HEADING 2F. COMPLIANCE MANAGEMENT[26] FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2F.VC.01	Do the guidelines for Ebola vaccine compliance management include clear specifications on: 1. Responsibilities of teams[27] involved in compliance management 2. Role of security sector 3. Role of local political leaders 4. Procedures related to sharing of confidential health information of persons line listed for vaccination 5. Others	4 or more ☐	2-3 ☐	1 ☐	0 ☐	
2F.VC.02	Are there systems[28] for line listing people to be vaccinated and for maintaining database of those already vaccinated?	Yes, and adapted for Ebola vaccination ☐	Yes, but not yet adapted ☐	No, but it's being set up ☐	No ☐	
2F.VC.03	Are there identification systems[29] for people line listed for vaccination?	More than 1 including biometric ☐	More than 1 but not including biometric ☐	No, but a system is under develop-ment ☐	No ☐	

HEADING 2F. COMPLIANCE MANAGEMENT[26] FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
2F.VC.04	Are there reminder system[30] for recipients of two dose vaccines?	Yes, and adapted for Ebola vaccination ☐	Yes, but not yet adapted for Ebola vaccination ☐	No, but it's being set up ☐	No ☐	
2F.VC.05	Does the Ebola response team have members[31] with specialisation in appropriate technologies?	Yes, team covers all required expertise for selected technologies ☐	Yes, but team doesn't cover all required expertise ☐	No, but hiring in progress ☐	No ☐	
					Total Score for Heading (out of 15 total possible points)	**/15**
					Percentage (%) score for Heading:	**%**

[26] Compliance management is related to ensuring the correct target beneficiaries are vaccinated at prime and boost dose (if applicable).
[27] The teams involved in compliance management may include: community health care workers, frontline Ebola response workers, health care workers, etc.
[28] System for line listing people to be vaccinated may include paper-based register, mobile data collection platform or other electronic register
[29] Identification system may include and not limited to: National IDs, Vaccination Cards, Physical address, Phone numbers of patients or family members or local authorities, Photo systems, Iris scans, Biometric fingerprints etc.
[30] Reminder systems can be pre-recorded voice reminder, a SMS, Community Health Worker physical home-visits etc.
[31] Technology teams may include: ICT Specialists, Biomedical Engineers, HMIS experts, Information Specialists/Scientists etc

PART 2.2.1

GAP PRIORITIZATION

The Gap Prioritization Plan serves to assist in the identification and prioritization of gaps emerging from the completing Part 1 (Gap identification and Scoring). In addition, it is designed to support action planning to address critical gaps in readiness for Ebola vaccine deployment from the 3Cs perspective.

HOW TO CONDUCT GAP PRIORITIZATION?

After completing the Part 1 (Gap Identification and Scoring), Part 2 the Gap Prioritization Framework should be completed, followed by Part 3 (the Action Planning Framework), as they build upon each other. Each framework has instructions embedded.

The Gap Prioritization Framework undertakes two levels of prioritization: heading-level and item-level. Follow the illustrations and steps outlined below to fill in the Heading-level and Item-level Gap Prioritization Tables.

HOW TO FILL IN THE TABLES:

TABLE P2.1.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
2A.	10%	1ST
2B.	20%	4TH
2C.	10%	3RD
2D.	20%	2ND
2E.	20%	5TH
2F.	20%	6TH

TABLE P2.2.2
1ST PRIORITY HEADING CODE 2A.

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED
2A.CE.01	0	Lack of SOP for quick KAP surveys
2A.CE.02	0	Social mob are not part of rapid response team for Ebola
2A.CE.03	0	Insufficient funds for SA for 3Cs
2A.CE.04	0	A few in-country stakeholders trained in SA for 3Cs

PART 2.2.1

HEADING-LEVEL PRIORITIZATION

1

For each heading, fill in the total percentage score for the heading.

2

For each heading, indicate the priority rank, based on the total percentage score. Heading/Area level prioritization whereby the headings with the lowest total percentage score will be the 1st priority, followed by the 2nd lowest and 3rd lowest in that order.

Choose priorities 1st – 3rd for the next step of item level prioritization below. Where there is tie in the priority rank, countries will have the discretion to choose one of them.

TABLE P2.2.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
2A.		
2B.		
2C.		
2D.		
2E.		
2F.		

ITEM-LEVEL PRIORITIZATION

Item level gaps exist for items with scores of (0), (1), or (2). (See Box 1)

3

LIST ITEMS WITH A (0) SCORE.

Items with a (0) should be prioritized first, as this represents the most critical state that needs immediate attention.

4

LIST ITEMS WITH A (1) SCORE.

Items with a (1) score are the 2nd priority, and items with a (2) score are the 3rd priority.

5

REVIEW YOUR LISTS AND SET CUT OFFS.

Review your results in Tables 1 and 2 for headings and items. These represent your priority gaps.

BOX 1: INTERPRETING ITEM SCORES

(3) A score of 3 indicates readiness.
(2) A score of 2 indicates a situation where most elements are available or in place, but that some remaining aspects can be addressed.
(1) A score of 1 indicates a situation where not everything exists, but some minor aspects are either in place or underway towards readiness.
(0) A score of 0 indicates a state where nothing exists and no plan is in place to address the issue of concern.

PART 2.2.1

6 REVIEW OF PRIORITIZATION

TABLE P2.2.2
1ST PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.2.3
2ND PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.2.4
3RD PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

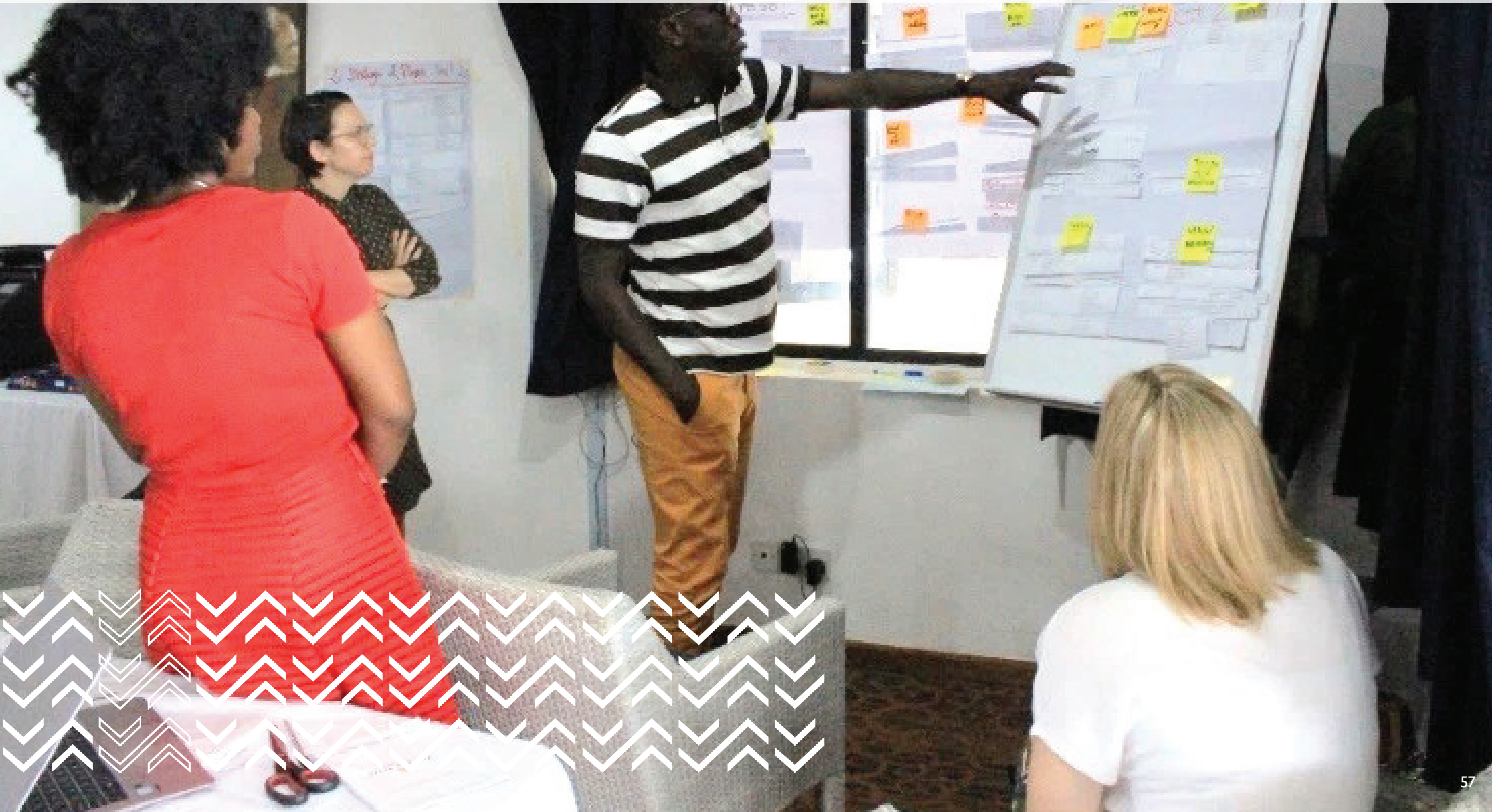
ACTION PLANNING

Instructions: Based on the identified priority gaps, develop an action plan for addressing the gaps. The first row shows an example.

PRIORITY GAPS	ACTION PLAN	RESPONSIBLE PERSON	TIMELINE	SUPPORT NEEDED
Lack of materials in usable format	Activate standing MoUs	Comm HPEC	1 week	Funds for accessible format translation (braille, etc.)

MODULE 3: INTEGRATION OF 3C BEST PRACTICES AND GUIDELINES

PART 1.3.1: (GAP IDENTIFICATION AND SCORING) The Integration of Best Practices and Guidelines module covers capitalization on experiences in 3Cs, gender considerations in 3Cs, vulnerable groups' considerations in 3Cs, ethics and human rights considerations in 3Cs, integration of 3Cs across broader healthcare systems and cross border considerations in 3Cs for EBODAC. Countries can use the module to assess their own readiness or preparedness consider past experiences, gender, vulnerable groups, ethics, human rights, broader health system and cross border best practices and principles in their 3Cs for EBODAC in emergency and non-emergency settings.



HEADING 3A. CAPITALIZATION ON PAST EXPERIENCES FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3A.PE.01	Are there efforts to identify relevant best practices for 3C for Ebola vaccine deployment in emergency or non-emergency situations, specifically for? (can be rephrase better): 1. Communication 2. Community engagement 3. Compliance management	For all 3 ☐	2 ☐	1 ☐	0 ☐	
3A.PE.02	Do mechanisms[32] exist to allow for the integration of best practices, lessons learnt and recommendations into 3C activities for Ebola vaccine deployment?	Yes, mechanisms exist and best practices are being adapted to the local context ☐	Yes, mechanisms exist but best practices not adapted ☐	No, but plans are in place to establish mechanisms ☐	No ☐	
3A.PE.03	Are there budget lines for conducting review of 3C for Ebola vaccination plans, strategies and activities based on lessons learnt, experiences and recommendations?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
3A.PE.04	Do the team involved in Ebola vaccine deployment have competencies to: • Review and adapt 3C for Ebola vaccination plans, strategies and activities based on lessons learnt, experiences and recommendations • Develop and keep a repository of knowledge products[33] from experiences, lessons learnt and recommendations	Yes, 3Cs team has all those skills ☐	Yes, but just one of those skills ☐	No, but plan is in place for capacity building ☐	No ☐	
					Total Score for Heading (out of 12 total possible points)	**/12**
					Percentage (%) score for Heading:	**%**

[32]Mechanisms for integration of best practices may include: Access to successfully used IEC materials in past outbreak responses, capacity building using experienced personnel from past outbreak responses, field trips to successful outbreak response models, etc.
[33]Knowledge products may include: Reports, publications, briefs, etc.

HEADING 3A. CAPITALIZATION ON PAST EXPERIENCES FOR 3C FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

BBC Media Action. Using Media and Communication to Respond to Public Health Emergencies: Lessons Learned from Ebola.
- https://www.bbc.co.uk/mediaaction/publications-and-resources/policy/practice-briefings/ebola

Toppenberg-Pejcic et al. 2018. Emergency Risk Communication: Lessons Learned from a Rapid Review of Recent Gray Literature on Ebola, Zika, and Yellow Fever.
- https://doi.org/10.1080/10410236.2017.1405488

Bedson et al. 2019. Community Engagement during outbreak response: standards, approaches, and lessons from the 2014-2016 Ebola outbreak in Sierra Leone.
- https://doi.org/10.1101/661959

Bastide. 2018. Crisis Communication During the Ebola Outbreak in West Africa: The Paradoxes of Decontextualized Contextualization.
- https://doi.org/10.1007/978-3-319-74098-0_7

Ebola Gbalo Research Group. Responding to the Ebola virus disease outbreak in DR Congo: when will we learn from Sierra Leone?
- http://dx.doi.org/10.1016/S0140-6736(19)31211-5

HEADING 3B. GENDER AND VULNERABLE GROUPS CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3B.VG.01	Have gender issues[34] and vulnerable groups[35] been considered[36] in the Communication and Community Engagement Strategy for Ebola Vaccine Deployment during the following activities: 1. Situational analysis 2. Communications audience mapping 3. Communications channel mapping 4. Communication messenger mapping 5. Communications and Community engagement stakeholder mapping 6. Others	5 or more ☐	3-4 ☐	1-2 ☐	0 ☐	
3B.VG.02	Are data management[37] systems (from data collection tools, databases, analysis, visualisation and reporting) for Ebola vaccine deployment disaggregated by sex and vulnerable groups?	Yes, fully disaggregated with supporting SOPs ☐	Yes, but partial disaggregation ☐	No, but disaggregation integration ongoing ☐	No ☐	
3B.VG.03	Are there inbuilt procedures[38] for reflecting on gender and vulnerable group social norms and Ebola vaccination decision making and health-care seeking behaviour?	Yes, procedures are inbuilt at both strategic and operational levels ☐	Yes, but partially inbuilt ☐	No, but advocacy to consider gender and vulnerable groups is ongoing ☐	No ☐	
3B.VG.04	Have gender and vulnerable group differences in Ebola vaccine acceptance, AEFI reporting and compliance been considered in the Communication and Community Engagement Strategy for Ebola Vaccine Deployment?	Yes, and there are specific SOPs ☐	Yes, but no specific SOPs ☐	No, but SOPs are being developed ☐	No ☐	

HEADING 3B. GENDER AND VULNERABLE GROUPS CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3B.VG.05	Are gender and family dynamics in decision making and caregiving responsibilities incorporated into SOPs[39] for consenting and tracing of people targeted for Ebola vaccination?	Yes, fully incorporated in the SOPs ☐	Yes, but partially incorporated ☐	No, but plans to incorporate in progress ☐	No ☐	
3B.VG.06	Have staff and stakeholders involved in Communication and Community Engagement activities for Ebola vaccine deployment been trained in gender and vulnerable group mainstreaming?	Yes, all staff and stakeholders have been trained ☐	Yes, but not all have been trained ☐	No, but plans are in place to train ☐	No ☐	
3B.VG.07	Are there budget lines for gender and vulnerable group mainstreaming in Communication and Community Engagement activities for Ebola vaccine deployment?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
					Total Score for Heading (out of 21 total possible points)	**/21**
					Percentage (%) score for Heading:	**%**

[34] Gender issues may include: gender norms, gender roles, power dynamics, etc. [35] Vulnerable groups may include: Persons living in conflict zones, nomadic populations, people living in remote areas, refugee populations, etc. [36] Considerations may include: Being a beneficiary or belonging to the beneficiary's family, community-based responders and as decision makers [37] Data management include: data processing, storing and organizing
[38] Inbuilt procedures for reflecting on gender and vulnerable groups may include: coordination meeting agenda point, action plan trigger, training on action plan trigger
[39] SOPs details may include: Tracing strategy for beneficiaries, guide on how to approach more than one family contacts, guide on contact selection processes that are responsive to social norms, consent procedure guidelines that are responsive to community, family and individual decision making.

HEADING 3B. GENDER AND VULNERABLE GROUPS CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

Inter-Agency Standing Committee (IASC). IASC Operational Guidelines on Protection of Persons in Situations of Natural Disasters.
- https://interagencystandingcommittee.org/meeting-humanitaran-challenges-urban-areas/documents-public/iasc-operational-guidelines-protection

Inter-Agency Standing Committee (IASC). IASC Policy on Protection in Humanitarian Action.
- https://interagencystandingcommittee.org/protection-priority-global-protection-cluster/documents/iasc-policy-protection-humanitarian-action

CDC CERC. CERC Special populations assessment.
- https://emergency.cdc.gov/cerc/resources/pdf/specialpopulationsassessment.pdf

HEADING 3C. HEALTH SYSTEM INTEGRATION OF 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3C.HS.01	Has the distribution of communication and community engagement products and materials for Ebola vaccine deployment been integrated into the routine distribution system?	Yes, integrated and fully functional ☐	Yes, but not functional ☐	No, but advocacy is ongoing ☐	No ☐	
3C.HS.02	Are there guidelines for leveraging the existing communication and community engagement structures and programs[40] within the routine healthcare service delivery systems for Ebola vaccine deployment?	Yes, guidelines exist and are operational ☐	Yes, but not operational ☐	No, but guidelines are being developed ☐	No ☐	
3C.HS.03	Are Ebola vaccine messages integrated into the routine health communication products, materials and messaging to audiences?	Yes, fully integrated ☐	Yes, but partially integrated ☐	No, but integration ongoing ☐	No ☐	
					Total Score for Heading (out of 9 total possible points)	**/9**
					Percentage (%) score for Heading:	**%**

[40] 3C structures and programs may include all health facility-based and community-based routine health services in the country

HEADING 3D. ETHICS AND HUMAN RIGHTS CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3D.HR.01	Have best practices for ethical[41] conduct and human rights been integrated into the Ebola vaccination campaign-related materials including: 1. Training materials for front-line workers[42], health workers and stakeholders (including the security sector) 2. Codes of conduct for front-line workers, health workers and stakeholders (including the security sector) 3. Messaging content 4. Others	3 or more ☐	2 ☐	1 ☐	0 ☐	
3D.HR.02	Have staff and stakeholders involved in 3C activities for Ebola vaccine deployment been trained in codes of conduct, ethics and human rights?	Yes, all staff and stakeholders have been trained ☐	Yes, but some have been trained ☐	No, but plans are in place to train ☐	No ☐	
3D.HR.03	Are there budget lines to cover: • Inclusion of social science expertise in ethical decision making; • Integration of ethical issues into training materials, • Conduct of training on codes of conduct, ethics and human rights?	Yes, sufficient ☐	Yes but insufficient ☐	No but advocacy is ongoing ☐	No ☐	
					Total Score for Heading (out of 9 total possible points)	**/9**
					Percentage (%) score for Heading:	**%**

[41]Ethical issues relating to: Standards of care and clinical management of AEFIs related to an Ebola vaccine; confidentiality, privacy, and information disclosure for those vaccinated, community stakeholders engaged in 3C activities, Individual autonomy vs. common good in relation (such as personal movement restrictions/detainment) to contact tracing, clinical management, vaccine 2nddosage compliance; Research conduct and oversight (including rapid review mechanism), including for research related to 3C; data security, stewardship and sharing, including for 3C related data; protection of community members and staff, including for those engaged in 3C-related activities

[42]Frontline workers may include: Community Health Workers, Health-facility gatemen, cleaners, security officers, porters, burial teams, surveillance officers, social mobilization teams, check-point officers, immigration staff, ambulance drivers etc

MANUALS AND GUIDELINES

Schopper et al. 2017. Research Ethics Governance in Times of Ebola. .
- https://doi.org/10.1093/phe/phw039

Vaccine Confidence Project. Vaccine Confidence Handbook. Chapter 2. Ethical Challenges.
- https://www.vaccineconfidence.org/ebohandbook-ethics/

Saxena et al. 2019. Ethics preparedness: facilitating ethics review during outbreaks – recommendations from an expert panel.
- https://doi.org/10.1186/s12910-019-0366-x

WHO. WHO guidelines on ethical issues in public health surveillance.
- https://www.who.int/ethics/publications/public-health-surveillance/en/

WHO. Guidance for Managing Ethical Issues in Infectious Disease Outbreaks.
- https://www.who.int/ethics/publications/infectious-disease-outbreaks/en/

WHO. Ethics in epidemics, emergencies and disasters: Research, surveillance and patient care. WHO Training Manual.
- https://www.who.int/ethics/publications/epidemics-emergencies-research/en/

Global Health Training Centre. Course: Ethics in epidemics, emergencies and disasters: Research, surveillance and patient care Course.
- https://globalhealthtrainingcentre.tghn.org/research-ethics-epidemics-pandemics-and-disaster-situations/

HEADING 3E. CROSS-BORDER CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3E.CB.01	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment incorporate the management of 3C special cross border considerations[43]?	Yes, several special cross border considerations ☐	Yes, but a few ☐	No, but being considered ☐	No ☐	
3E.CB.02	Have coordination mechanisms[44] been established with cross-border stakeholders?	Yes, established and fully harmonised ☐	Yes, but partially harmonised ☐	No, but contact has been made between cross-border stakeholders ☐	No ☐	
3E.CB.03	Are there budget lines to cover cross-border coordination activities and other special 3C cross border considerations?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
				Total Score for Heading (out of 9 total possible points)		**/9**
				Percentage (%) score for Heading:		**%**

[43]Special cross border considerations may include border language, culture, behavior, attitudes, beliefs, mass media channels, migrant communities, internet connectivity, telephone networks etc.
[44]Coordination mechanisms (could be via WHO, UNHCR, immigration) and may include: cross-border coordination protocols approved at United Nations (UN) and ministry level; cross-border coordination meetings to facilitate bi-lateral meeting of health teams, security, immigration etc

HEADING 3E. CROSS-BORDER CONSIDERATIONS FOR 3C FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Technical note for Ebola preparedness planning for entry screening at airports, ports and land crossings.
- https://www.who.int/csr/resources/publications/ebola/entry-screening-poe/en/

WHO. Interim guidance for Ebola event management at points of entry.
- https://www.who.int/csr/resources/publications/ebola/event-management-poe/en/

WHO. Travel and transport risk assessment: Travel guidance for health authorities and the transport sector.
- https://www.who.int/csr/resources/publications/ebola/travel-guidance/en/

SUCCESS STORIES

"HARMONIZED CROSS-BORDER IDENTIFICATION INFORMATION CAPTURE, COMMUNICATION AND COORDINATION HELPS TO DELAY SPILLOVER OF EBOLA OUTBREAK FROM DRC INTO UGANDA"

As the Ebola Viral Disease (EVD) outbreak spirals in the Democratic Republic of Congo (DRC) from its onset in August 2018, the major worry was the spillover of the outbreak into Uganda as there are mass population movements in either direction of the border. Despite having no confirmed case of EVD during early months of the DRC outbreak, as a preparedness activity, the Uganda Ministry of Health and Emergency Operation Centre (EOC) convened the National Taskforce (NTF) for Ebola preparedness and response.

To particularly address the risk of spill over, in September 2018 there was an inter-governmental cross-border meeting between health officials from the two countries (DRC and Uganda) held at an immigrations office in DRC organized by the World Health Organization (WHO). At the meeting, Uganda and DRC resolved to increase awareness among the population on both sides of the border by intensifying risk communication and community engagement to address the issue of misconceptions, rumors and myths on Ebola in the border area.

The Uganda team also shared experiences about the functionality of the different pillars in the EVD preparedness response. From that, the DRC team particularly appreciated the use of Village Health Teams (VHT) aka Community Health Workers to conduct community level risk communication and community engagement in Uganda. They also welcomed this community-based approach, promising to apply it in the DRC context. Officials from both countries attended the meeting, including health, security, immigration, the World Health Organization (WHO), and the Uganda Red Cross officials.

To also improve cross-border communication and coordination, the officials in the meeting agreed to harmonize the data collection tools to ensure that similar identification information is captured at the security screening points along the Uganda-DRC borders in both countries. The officials also highlighted the need to map out all the points of entry along the border to ensure that no border entry point lacks a security screening point. The medical screening is managed by healthcare workers, however the security screening and crowd control is being implemented by security officers on either side of the border.

The harmonized data collection tools in particular, ensured similar identification information captured on the DRC side of the border are relayed to Uganda side of the border and eventually to the health workers and NTF for medical decision making. This similar identification capture and relay system made it possible to identify several alert cases trying to cross from DRC into Uganda as described below:

There was a case of a man a connected to a suspected Ebola case who was trying to cross from DRC into Uganda. The Ugandan Security Officers operating on the Ugandan side of the border were relayed his identification information by the Officers from the DRC side of the border. With the identification information available, the Security Officers on the Uganda side were able to identify the contact at the border point and returned him to DRC for possible vaccination.

Another case was a woman that tried to sneak from Beni in DRC into Uganda. She first mingled into mobile pastoral community operating near the DRC side of the border and slowly came close to the Uganda side of the border and tried to cross. However, she fell sick and became weak. The Security Officers on the Ugandan side of the border were able to identify her. She was denied entry into Uganda purely for health reasons and was returned to DRC for clinical care.

Important to note is that in the repatriation process, the security officers are trained not to violate human rights. The harmonized cross-border identification information capture and relay system is being implemented in a private and confidential manner without disclosing it to the community to avoid stigma and eliciting of dehumanizing feeling that comes with receiving instructions from security officers. If the suspect or contact is detained, it is mandatory that they are fed and well taken care of. If the decision is for the detained person to be transported to another location such as health facility for clinical care, the security officers provide the transportation at no cost to the person.

HEADING 3F. HUMAN RESOURCES FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
3G.HR.01	Are there guidelines[45] for emergency recruitment and deployment of human resources (HR) for 3C activities for Ebola vaccine deployment in emergency scenario?	Yes, guidelines exist and are operational ☐	Yes, but not operational ☐	No, but being developed ☐	No ☐	
3G.HR.02	Is there a national or sub-national roster or database of the trained and or experienced HR[46] required for 3C activities for Ebola vaccine deployment?	Yes, accessible and updated ☐	Yes, but not accessible or not updated ☐	No, but being developed ☐	No ☐	
3G.HR.03	Are there budget lines for emergency HR recruitment, deployment, remuneration and tooling for 3C for Ebola vaccine deployment?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
					Total Score for Heading (out of 9 total possible points)	**/9**
					Percentage (%) score for Heading:	**%**

[45]Emergency recruitment and deployment guidelines should cater for whether to advertise the vacancies or handpick from roster, integrity issues like preference for citizen before foreigners, gender, culture, language, equity, database or roster of experts, remunerations, risk allowance, capacity building, equipment, support supervision, code of conduct and psychological support system considerations in the recruitment.

[46]HR required 3C activities for Ebola vaccine deployment may include health workers, community health workers, socio-anthropologists, journalists, security officials, community leaders, community stakeholders, government spokespersons etc.

HEADING 3F. HUMAN RESOURCES FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.12 Role of social scientists.

- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

CDC CERC. CERC staff planning workbook.

- https://emergency.cdc.gov/cerc/resources/pdf/cercstaffing_planning.pdf

PART 2.3.1

GAP PRIORITIZATION

The Gap Prioritization Plan serves to assist in the identification and prioritization of gaps emerging from the completing Part 1 (Gap identification and Scoring). In addition, it is designed to support action planning to address critical gaps in readiness for Ebola vaccine deployment from the 3Cs perspective.

HOW TO CONDUCT GAP PRIORITIZATION?

After completing the Part 1 (Gap Identification and Scoring), Part 2 the Gap Prioritization Framework should be completed, followed by Part 3 (the Action Planning Framework), as they build upon each other. Each framework has instructions embedded.

The Gap Prioritization Framework undertakes two levels of prioritization: heading-level and item-level. Follow the illustrations and steps outlined below to fill in the Heading-level and Item-level Gap Prioritization Tables.

HOW TO FILL IN THE TABLES:

TABLE P2.3.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
3A.	10%	1ST
3B.	20%	4TH
3C.	10%	3RD
3D.	20%	2ND
3E.	20%	5TH
3F.	20%	6TH

TABLE P2.3.2
1ST PRIORITY HEADING CODE 3A.

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED
3A.PE.01	0	Lack of SOP for quick KAP surveys
3A.PE.02	0	Social mob are not part of rapid response team for Ebola
3A.PE.03	0	Insufficient funds for SA for 3Cs
3A.PE.04	0	A few in-country stakeholders trained in SA for 3Cs

PART 2.3.1

HEADING-LEVEL PRIORITIZATION

1

For each heading, fill in the total percentage score for the heading.

2

For each heading, indicate the priority rank, based on the total percentage score. Heading/Area level prioritization whereby the headings with the lowest total percentage score will be the 1st priority, followed by the 2nd lowest and 3rd lowest in that order.

Choose priorities 1st – 3rd for the next step of item level prioritization below. Where there is tie in the priority rank, countries will have the discretion to choose one of them.

TABLE P2.3.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
3A.		
3B.		
3C.		
3D.		
3E.		
3F.		

ITEM-LEVEL PRIORITIZATION

Item level gaps exist for items with scores of (0), (1), or (2). (See Box 1)

3

LIST ITEMS WITH A (0) SCORE.

Items with a (0) should be prioritized first, as this represents the most critical state that needs immediate attention.

4

LIST ITEMS WITH A (1) SCORE.

Items with a (1) score are the 2nd priority, and items with a (2) score are the 3rd priority.

5

REVIEW YOUR LISTS AND SET CUT OFFS.

Review your results in Tables 1 and 2 for headings and items. These represent your priority gaps.

BOX 1: INTERPRETING ITEM SCORES

(3) A score of 3 indicates readiness.
(2) A score of 2 indicates a situation where most elements are available or in place, but that some remaining aspects can be addressed.
(1) A score of 1 indicates a situation where not everything exists, but some minor aspects are either in place or underway towards readiness.
(0) A score of 0 indicates a state where nothing exists and no plan is in place to address the issue of concern.

6 REVIEW OF PRIORITIZATION

TABLE P2.3.2
1ST PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.3.3
2ND PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.3.4
3RD PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

PART 3.3.1

ACTION PLANNING

Instructions: Based on the identified priority gaps, develop an action plan for addressing the gaps. The first row shows an example.

PRIORITY GAPS	ACTION PLAN	RESPONSIBLE PERSON	TIMELINE	SUPPORT NEEDED
Lack of materials in usable format	Activate standing MoUs	Comm HPEC	1 week	Funds for accessible format translation (braille, etc.)

MODULE 4: SUPPORTIVE AND ENABLING ENVIRONMENT FOR 3C

SECTION A4: (GAP IDENTIFICATION AND SCORING) This Supportive and enabling environment module covers enabling technologies in 3Cs, M&E in 3Cs, capacity building/trainings in 3Cs, fundraising for 3Cs and coordination with 3Cs teams for EBODAC. Countries can use the module to assess their own readiness or preparedness to incorporate and ensure supportive and enabling environment such as enabling technologies, M&E, coordination with communication and community engagement teams and funding for 3Cs for EBODAC in emergency and non-emergency settings.

HEADING 4A. ENABLING TECHNOLOGY FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4A.ET.01	Does the Ebola Preparedness and Response Strategy enlist enabling technologies for: 1. Patient identification[47] 2. Patient tracking[48] 3. Data capture[49] 4. Remote training[50] 5. Reporting or feedback[51] 6. Others	5 or more ☐	3-4 ☐	1-2 ☐	0 ☐	
4A.ET.02	Have feasibility and acceptability assessments[52] on how to incorporate enabling technologies into 3C activities for Ebola vaccine deployment been conducted?	Yes, both ☐	Yes, but just 1 of the 2 ☐	No, but the assessment is ongoing ☐	No ☐	
4A.ET.03	Have community technology engagement and sensitization activities[53] to improve technology awareness, mitigate resistance, alleviate fears and facilitate successful adoption of the technologies in Ebola response (including vaccination) been conducted?	Yes, conducted and report accessible ☐	Yes, but report not accessible ☐	No, engagement and sensitisation is ongoing ☐	No ☐	
4A.ET.04	Have alternatives[54] or ways of improving existing electricity supply in locations where the enabling technologies will be used been identified?	Yes, identified and feasible ☐	Yes, but not feasible ☐	No, but identification is ongoing ☐	No ☐	

HEADING 4A. ENABLING TECHNOLOGY FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4A.ET.05	Have alternatives[55] or ways of improving existing internet connectivity in locations where the enabling technologies will be used been identified?	Yes, identified and feasible ☐	Yes, but not feasible ☐	No but identification is ongoing ☐	No ☐	
4A.ET.06	Have standing Memorandums of Understanding (MoUs) with national and international technology companies and communications firms to leverage existing capacities and infrastructure been established?	Yes, several and flexible ☐	Yes, a few or rigid ☐	No, but MoU negotiations are ongoing ☐	No ☐	
4A.ET.07	Are there teams and policies established to support the set up and use of enabling technologies in Ebola response (including vaccination)?	Yes, both teams and policies are available and operational ☐	Yes, but not operational ☐	No, but the setup of teams and policies is ongoing ☐	No ☐	
					Total Score for Heading (out of 21 total possible points)	**/21**
					Percentage (%) score for Heading:	**%**

[47]Enabling technologies for patient identification may include: biometrics such as finger prints, facial and voice recognition technology and iris scanners, etc. [48] Enabling technologies for patient tracking may include: mobile apps, GPS mapping systems, bar codes, VAXTRAC, etc.
[49]Enabling technologies for data capture may include: Mobile applications such as open data toolkits (ODK), REDCAP, etc. [50] Enabling technologies for remote training may include: MOTECH based applications such as MObile Training and Support Services (MOTS), etc.
[51]Enabling technologies for reporting and feedback may include: mTrac, UReport, mHero, etc. [52] Feasibility and acceptability assessments maybe aimed at determining the existing infrastructure onto which the new technologies would be built and also for determining whether the new technology solutions would be acceptable.
[53]Community technology engagement and sensitization outreach activities may include ccollaboration with governments in particular the Ministries of health, ICTs, science, technology and innovations; meetings with local chiefs, local politicians, religious leaders and community group leaders and members
[54]Alternative of electricity may include use of batteries, solar chargers or petrol-powered generators [55] Alternative of internet connectivity may include: satellite technology, agreements with telephone network providers or configuring the technology to function offline, local area network

HEADING 4A. ENABLING TECHNOLOGY FOR 3C FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Monitoring and Evaluation of Digital Health Interventions: A practical guide to conducting research and assessment.
- https://apps.who.int/iris/handle/10665/252183

WHO. WHO Guideline. Recommendations on digital interventions for health system strengthening.
- https://apps.who.int/iris/handle/10665/311980

Biometric Institute. Ethical Principles for Biometrics.
- http://www.biometricsinstitute.org/wp-content/uploads/Biometrics-Institute-Ethical-Principles-VFinal2019.pdf

SUCCESS STORIES

"IMPROVING VACCINE COMPLIANCE BY USING BIOMETRIC IDENTIFICATION SYSTEM IN EBOVAC SALONE TRIAL SIERRA LEONE"

The issue of participant impersonation (false participants):
The EBOVAC Salone study is conducting a two dose (prime-boost) vaccine regimen such that participants who receive the prime are 'importantly' those who will receive the boost dose else. However, the issue in this incidence was the assurance that people who showed up at the clinic are real participants and what was the extent of their interaction with the study. These are study integrity issues, which requires resolution of accurate assurance that people who show up at the clinic are actual study participants and those who received the prime dose are exactly those who will receive the boost dose of the vaccine.

The Biometric Identification system as a solution:
Biometrics technology is a method of verifying an individual's identity based on measurement of their physical features or repeatable actions that are unique to the individual and are measurable. The technology was employed for the enrolment, identification and verification of all persons who show up at the clinics as a participant. At the initial visit after consenting, the biometrics (Iris and Fingerprint) of the participant are captured and stored as templates within the biometric system then synchronized to other systems that relies on the information to further maintain study integrity. During subsequent visit, the participant goes through the identification and verification process, i.e., in this instance, they first go through the biometric system to be sure that they are actual participants in the study. They will have a recapture of their biometric and the image is compared with existing templates in the system, if the system returns a match it means the participant is positive else, a negative returns shows impersonation.

Achievements from Biometric Identification system:
Since the start of implementation on 30th September 2015, 1,631 participants are accurately enrolled into the biometric system and to this day, the system can trustfully identify each of these participants at any time they show up. With this certainty, eight impersonations (false participants) were identified during the course of the study and the issues were escalated to the site coordinator(s) present. Indeed, the impersonators attested to the fact that they were not participants in the study. This show that the technology has strongly contributed to maintain the integrity of the study. It is a clear solution to the deterrence of impersonation especially in a situation of a two or three dose Extended Program on Immunisation (EPI) campaign.

Best practises for the conduct of Biometric Identification system
Some key considerations for conducting of biometrics:
- Biometric trace(s) are the key identifiers of individuals as such it is very important that the images are perfectly captured during the enrolment process else, identification and verification during subsequent visits can be problematic
- Additional identifiers should be included in participant's records (Photo, Identification numbers etc.) because it is possible for the system to return a false positive (never happened in our case)
- In a close distance setting such as the EBOVAC Salone study, it is important that individual units within the system synchronise data in real-time
- Equipment should be manufactured and designed to match the local context especially in terms of technological interdependencies
- GXP should be continuously revamped during the implementation of the technology

HEADING 4B. MONITORING AND EVALUATION (M&E) FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4B.ME.01	Are there accessible expertise in Monitoring & Evaluation (M&E) and or related specializations to support Ebola vaccine deployment such as: 1. Monitoring and Evaluation (M&E) 2. Behaviour change or risk communication 3. Health management information system 4. Information science 5. Geographic information systems 6. Information Communications and Technology (ICT)[56] 7. Others	6 or more ☐	3-5 ☐	1-2 ☐	0 ☐	
4B.ME.02	Does the Communication and Community Engagement Strategy for Ebola Vaccine Deployment include key M&E components?[57]	Yes, fully inclusive ☐	Yes, but partially inclusive ☐	No, but being developed ☐	No ☐	
4B.ME.03	Have data architecture schema[58] for monitoring data from 3C activities for the Ebola vaccine deployment been developed?	Yes, fully developed ☐	Yes, but partially developed ☐	No, but development is ongoing ☐	No ☐	

HEADING 4B. MONITORING AND EVALUATION (M&E) FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4B.ME.04	Have SOPs[59] for data management, including the ones for 3C activities been developed?	Fully available ☐	Partially available ☐	Being developed ☐	Not available ☐	
4B.ME.05	Are there guidelines and related capacity building at strategic and operational levels for: • Data management • Data analysis • Data visualization • Data dissemination and use	Yes, fully developed and endorsed ☐	Yes, but partially developed or not endorsed ☐	No, but development ongoing ☐	No ☐	
4B.ME.06	Are there budget lines for 3C activity-related data collection, management, analysis, visualization, dissemination and use during Ebola vaccine deployment?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
					Total Score for Heading (out of 18 total possible points)	**/18**
					Percentage (%) score for Heading:	**%**

[56]Expertise in ICT may include: ICT infrastructure/operations; Community Information System/Health information system/HMIS, data management and quality assurance; health, social, and geographic data analysis and visualization.
[57]Key M&E components may include: • Logical framework / theory of change, including explicitly defined theories of behavior change, context and social factors, inputs, process for 3Cs activities, outputs, outcomes (including those related to knowledge, attitude (including trust, fear), and behavior change related to the Ebola vaccine, the vaccine deployment or any of its components). • Indicator/metric list (definition, data source, disaggregation (gender, age, key groups), frequency of data collection) for processes for 3Cs activities (inputs, outputs, fidelity to SOPs) and outcomes (knowledge, attitude, or behavior change, or proxies thereof). • Evaluation plan
[58]Conceptual/semantic data model (including data entities); logic data model (including how data are linked); physical/technology model, outlining processes and functionality (including incorporation of existing technology infrastructure (digital) and/or team networks (paper-based, oral reporting). Models should take into account: integration, where needed, with existing databases (e.g., case management, surveillance, burials/Civil registration and vital statistics, EPI, AEFI, community health); interoperability; anonymization of data at different levels and confidentiality; and data security.
[59]SOPs for data management may include aspects like: Governance and stewardship, security, interoperability, sharing, confidentiality, anonymization, and use of data.

HEADING 4B. MONITORING AND EVALUATION (M&E) FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix N. Monitoring plan during delivery.
- https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix O. Assessment plan after vaccine delivery.
- https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

WHO. Ebola Strategy. Companion tool to GEVIT Practical guidance on the use of Ebola vaccine in an outbreak response. Guidance for establishing AEFI surveillance systems in countries planning to use Ebola vaccines.

- https://www.who.int/csr/resources/publications/ebola/GEVIT_guidance_companion-tool_AEFI.pdf

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Annex III. Rumour tracking tool.
- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

WHO. Risk Communication and Community Engagement Preparedness and Readiness Framework: Ebola Response in the Democratic Republic of Congo in North Kivu. Annex 7. Theory of Change.
- https://apps.who.int/iris/bitstream/handle/10665/275389/9789241514828-eng.pdf

WHO. Risk Communication and Community Engagement Preparedness and Readiness Framework: Ebola Response in the Democratic Republic of Congo in North Kivu. Annex 4. M&E Framework.
- https://apps.who.int/iris/bitstream/handle/10665/275389/9789241514828-eng.pdf

IASC. IASC Guidelines for Common Operational Datasets in Disaster Preparedness and Response.
- https://interagencystandingcommittee.org/information-management/documents-public/iasc-guidelines-common-operational-datasets-disaster-0

Figueroa et al. 2017. A Theory-Based Socioecological Model of Communication and Behavior for the Containment of the Ebola Epidemic in Liberia.
- https://doi.org/10.1080/10810730.2016.1231725

ECDC. Public Health Preparedness Logic Model.
- https://cdn1.sph.harvard.edu/wpcontent/uploads/sites/1609/2016/11/ECDC-Public-Health-Preparedness-Logic-Model_4-29-16.pdf

Wilkinson et al. 2015 Comment: The FAIR Guiding Principles for scientific data management and stewardship.
- https://doi.org/10.1038/sdata.2016.18

FAIR Principles. - https://www.go-fair.org/fair-principles/

Humanitarian Data Exchange. HDX Tools. - https://data.humdata.org

CDC. Health Behavior Change Theory Picker. - https://www.orau.gov/hsc/theorypicker/index.html

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Appendix D. Ebola Communication Framework..
- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Appendix E. Health Communication Theories.
- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

HEADING 4C. CAPACITY BUILDING FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4C.CB.01	Does the plan for capacity building of staff and stakeholders include 3C for Ebola vaccine deployment?	Yes, and operational ☐	Yes, but not operational ☐	No, but being developed ☐	No ☐	
4C.CB.02	Does the plan for capacity building of staff and stakeholders include specific trainings in 3C for Ebola vaccine deployment for special cadres or groups[60]?	Yes, fully inclusive ☐	Yes, but partially inclusive ☐	No, but being developed ☐	No ☐	
4C.CB.03	Are there training manuals and guidelines[61] for 3C for Ebola vaccine deployment?	Yes, fully accessible ☐	Yes, but not accessible ☐	No, but being developed ☐	No ☐	
4C.CB.04	Are there relevant SOPs such as for AEFIs, rumours, media engagement incorporated into the training manuals and guidelines?	Yes, all are fully incorpo-rated ☐	Yes, but partially incorporated ☐	No but being incorpo-rated ☐	No ☐	
4C.CB.05	Are there budget lines for capacity building of staff and stakeholders including in 3C for Ebola vaccine deployment?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but budgeting is ongoing ☐	No ☐	
				Total Score for Heading (out of 15 total possible points)		**/15**
				Percentage (%) score for Heading:		**%**

[60]Special cadres or groups may include: the media, armed forces, community influencers, traditional healers, burial groups, cross border stakeholders, etc.
[61]Training manuals and guidelines may be for: Ebola vaccine deployment, training, rumor management, Community Engagement, code of conduct, Risk communication during outbreak, development, translation and dissemination of communication of product & materials, financing mechanism, installation of enabling technology equipment, etc.

MANUALS AND GUIDELINES

WHO. Online course: Risk Communication essentials.
- https://openwho.org/courses/risk-communication

WHO. Effective Communications: participant handbook for WHO staff.
- https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

HEADING 4D. COORDINATION FOR 3C FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4D.CO.01	Are there communication and community engagement committees at strategic and operational levels for Ebola vaccine deployment?	Yes, at both levels and mechanisms exist to activate them ☐	Yes, but at one of the levels or there are no mechanisms to activate them ☐	No but being formed ☐	No ☐	
4D.CO.02	Are there clear ToRs[62] for communication and community engagement committees for Ebola vaccine deployment?	Yes, TORs are approved ☐	Yes, but not yet approved ☐	No, but being developed ☐	No ☐	
4D.CO.03	Are there mechanisms[63] for linkages and feedback between communication and community engagement committees and responders at strategic and operational levels?	Yes, and functional ☐	Yes, but not functioning ☐	No, but development ongoing ☐	No ☐	
4D.CO.04	Are there guidelines for integrating community-based stakeholders into communication and community engagement committees at strategic and operational levels?	Yes, and are operational ☐	Yes, but not operational ☐	No, but being developed ☐	No ☐	
4D.CO.05	Are there budget lines to cover 3C coordination activities, equipment and personnel costs at strategic and operational levels?	Yes, sufficient budget ☐	Yes, but insufficient ☐	No but advocacy is ongoing ☐	No ☐	
				Total Score for Heading (out of 15 total possible points)		**/15**
				Percentage (%) score for Heading:		**%**

[62]ToRs may cover: ensuring members from the communication and community engagement committees are part of the rapid response team at the national and sub-national levels, compilation and sharing of Situational Reports (Sitreps), periodic coordination meetings, incident reporting, set up of reporting portals/ hotlines and digital systems to support information flow and coordination across response, developing communication tools/ reference guide and share across the vaccine response, etc.

[63]Mechanisms may include: Hotlines and digital systems to support the information flow and scheduling of meetings (e.g. 117 toll free line in Sierra Leone, mTrack in Uganda), actual meetings, focal persons, etc.

HEADING 4D. COORDINATION FOR 3C FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix D. Proposed composition and subgroups of Ebola Vaccine Programme Committee.

- https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix C. Overview of proposed roles and responsibilities of constituencies involved in Ebola vaccine outbreak activities.

- https://www.who.int/csr/resources/publications/ebola/gevit_guidance_may2016.pdf

WHO. Risk Communication and Community Engagement Considerations: Ebola Response in Democratic Republic of the Congo. Section III.7 Coordinating Partners.

- https://apps.who.int/iris/bitstream/handle/10665/272767/9789241514217-eng.pdf

The Health Communication Capacity Collaborative 3C. Ebola Preparedness Implementation Toolkit. Chapter 3. Coordination Mechanisms for Ebola Communication.

- https://sbccimplementationkits.org/ebola/courses/ebola-preparedness-i-kit/

HEADING 4E. RESOURCE MOBILIZATION FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4E.RM.01	Is there budget for epidemic preparedness and response including Ebola?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
4E.RM.02	Are there specific budget lines for 3C activities within the broader budget for epidemic preparedness and response including Ebola?	Yes, sufficient ☐	Yes, but insufficient ☐	No, but advocacy is ongoing ☐	No ☐	
4E.RM.03	Is there a national emergency rapid response fund with clear guidelines[64] for quick access and accountability?	Yes, and endorsed ☐	Yes, but not yet endorsed ☐	No, but under development ☐	No ☐	

HEADING 4E. RESOURCE MOBILIZATION FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

RI CODE	READINESS ITEM	3	2	1	0	SCORE
4E.RM.04	Is the emergency rapid response funding mechanism responsive to capacity[65] of community-based organizations?	Yes, very flexible ☐	Yes, but rigid ☐	No but advocacy is ongoing ☐	No ☐	
4E.RM.05	Are there funding agreements with partners for allocation of resources towards epidemics, preparedness and response?	Yes, several ☐	Yes, but a few ☐	No, but negotiations are ongoing ☐	No ☐	
4E.RM.06	Are stakeholders[66] involved in advocacy for funds for 3C activities during Ebola vaccine deployment?	Yes, several ☐	Yes, but a few ☐	No, but under development ☐	No ☐	
				Total Score for Heading (out of 18 total possible points)		**/18**
				Percentage (%) score for Heading:		**%**

[64]Guidelines may include: identification external firms for audits and public/mass communication campaigns to transparently share financial information.
[65]Capacity building in financial management and channeling of the resources
[66]Stakeholders may include: public/ mass communication experts; community engagement experts; compliance management experts; NGOs; telecom companies; computer companies; oil, mining and energy companies; religious leaders; local chiefs; community health workers; finance and economists from both national and district/local levels

HEADING 4E. RESOURCE MOBILIZATION FOR 3CS FOR EBOLA VACCINE DEPLOYMENT

MANUALS AND GUIDELINES

WHO. Draft Global Ebola Vaccine Implementation Team (GEVIT) Practical guidance on the use of Ebola vaccine in an outbreak response. Appendix Q. Macro Planning Template.
- https://www.who.int/csr/resources/publications/ebola/GEVIT_guidance_AppendixQ.xlsx

PART 2.4.1

GAP PRIORITIZATION

The Gap Prioritization Plan serves to assist in the identification and prioritization of gaps emerging from the completing Part 1 (Gap identification and Scoring). In addition, it is designed to support action planning to address critical gaps in readiness for Ebola vaccine deployment from the 3Cs perspective.

HOW TO CONDUCT GAP PRIORITIZATION?

After completing the Part 1 (Gap Identification and Scoring), Part 2 the Gap Prioritization Framework should be completed, followed by Part 3 (the Action Planning Framework), as they build upon each other. Each framework has instructions embedded.

The Gap Prioritization Framework undertakes two levels of prioritization: heading-level and item-level. Follow the illustrations and steps outlined below to fill in the Heading-level and Item-level Gap Prioritization Tables.

HOW TO FILL IN THE TABLES:

TABLE P2.4.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
4A.	10%	1ST
4B.	20%	4TH
4C.	40%	3RD
4D.	20%	2ND
4E.	10%	5TH

TABLE P2.4.2
1ST PRIORITY HEADING CODE 4A.

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED
4A.ET.01	0	Lack of SOP for quick KAP surveys
4A.ET.02	0	Social mob are not part of rapid response team for Ebola
4A.ET.03	0	Insufficient funds for SA for 3Cs
4A.ET.04	0	A few in-country stakeholders trained in SA for 3Cs

PART 2.4.1

HEADING-LEVEL PRIORITIZATION

1

For each heading, fill in the total percentage score for the heading.

2

For each heading, indicate the priority rank, based on the total percentage score. Heading/Area level prioritization whereby the headings with the lowest total percentage score will be the 1st priority, followed by the 2nd lowest and 3rd lowest in that order.

Choose priorities 1st – 3rd for the next step of item level prioritization below. Where there is tie in the priority rank, countries will have the discretion to choose one of them.

TABLE P2.4.1

HEADING CODE	TOTAL PERCENTAGE SCORE (%)	PRIORITY RANK
4A.		
4B.		
4C.		
4D.		
4E.		

ITEM-LEVEL PRIORITIZATION

Item level gaps exist for items with scores of (0), (1), or (2). (See Box 1)

3

LIST ITEMS WITH A (0) SCORE.

Items with a (0) should be prioritized first, as this represents the most critical state that needs immediate attention.

4

LIST ITEMS WITH A (1) SCORE.

Items with a (1) score are the 2nd priority, and items with a (2) score are the 3rd priority.

5

REVIEW YOUR LISTS AND SET CUT OFFS.

Review your results in Tables 1 and 2 for headings and items. These represent your priority gaps.

BOX 1: INTERPRETING ITEM SCORES

(3) A score of 3 indicates readiness.
(2) A score of 2 indicates a situation where most elements are available or in place, but that some remaining aspects can be addressed.
(1) A score of 1 indicates a situation where not everything exists, but some minor aspects are either in place or underway towards readiness.
(0) A score of 0 indicates a state where nothing exists and no plan is in place to address the issue of concern.

6 REVIEW OF PRIORITIZATION

TABLE P2.4.2
1ST PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.4.3
2ND PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

TABLE P2.4.4
3RD PRIORITY HEADING CODE

ITEM CODE	SCORE	STATEMENT OF THE GAP IDENTIFIED

ACTION PLANNING

Instructions: Based on the identified priority gaps, develop an action plan for addressing the gaps. The first row shows an example.

PRIORITY GAPS	ACTION PLAN	RESPONSIBLE PERSON	TIMELINE	SUPPORT NEEDED
Lack of materials in usable format	Activate standing MoUs	Comm HPEC	1 week	Funds for accessible format translation (braille, etc.)

ANNEXES

ANNEX I

LIST OF PROJECT STEERING COMMITTEE MEMBERS

SIERRA LEONE PROJECT STEERING COMMITTEE

NAME	TITLE
Ansumana G Foday	Logistician CH/EPI, MoHS
Daniel Carpenter	ITC Engineer, MoHS/DHSE
Dayo Spencer Walters	Independent
Dr A J Moosa	Deputy Director DHSE, MoHS
Dr Dennis Marke	Former EPI Manager, HSS
Dr Francis Samai	PI, Strive Team/ Director of Research & Training, MoHS/COMAHS
Dr Joseph S Kanu	Department Manager, Surveillance, MoHS/DHSE
Dr Mohammed Vandi	Director - Health Security & Emergencies, MoHS
Dr Thompson Igbu	TI-Epi, WHO
Dr Tom Sesay	Epi/Child Health Programme Manager - Directorate Of Reproductive & Child Health, MoHS
Gandi Kallon	HCO MoHS/DHSE
Harold Thomas	Risk Communications - DHSE, MoHS
Ibrahim S Koroma	HED, MoHS
Mohamed Kanu	117 Manager, MoHS/DHSE
Onomie Thomas Abiri	Pharmacovigilance, Adverse Events, MoHS/Pharmacy Board
Patrick Lansana	Communications Officer, DHSE/MoHS
Salieu Jalloh	C4D Officer, UNICEF
Umu Macarthy	Project Coordinator, Ehealth Africa

SENEGAL PROJECT STEERING COMMITTEE

NAME	TITLE
Amadou Cisse	Head of the Network of NGOs, CONGAD/ RESSIP
Baytir Samb	President of the National Network of CHW's, ROCBACS
Bineta Bocoum	Head of Communication, COUS
Boly Niang	Nurse, Fann University Hospital MoHSA
Dr Bailo Diallo	Epidemiologist, WHO
Dr Kemo Diedhiou	Head of the SNEIPS
Dr Khady Seck	Head of Community Health, MoHSA
Dr Koura Coulibaly Diack	Surveillance & Response Program Officer, PATH
Dr Ousseynou Badiane	Head of Immunization, MoHSA

ANNEX I

LIST OF PROJECT STEERING COMMITTEE MEMBERS

UGANDA PROJECT STEERING COMMITTEE	
NAME	**TITLE**
Benjamin Sensasi	Communication Specialist, WHO Uganda
Dr Bernard Opar Replaced by Dr Alfred Driwale	Assistant Commissioner Health Services, Clinical & Curical Services, MoH
Dr Eva Kabwongera	Health Specialist, UNICEF
Dr Flora Banage	Policy & Partnership Advisor, CDC Uganda
Dr Hannah Kibuuka	Executive Director and PI EBOVAC – Makerere University Walter Reed Project
Dr Henry Mwebesa	Director General Health Services MoH – Chair
Dr Issa Makumbi	Manager Public Health Emergency Operations Centre, MoH
Dr Mohammed Vandi Replaced by Dr Annet Kisakye	Team Leader Emergency, WHO Uganda
Dr Miriam Nanyunja	Commissioner Health Services – National Disease Control – Co-Chair
Emmanuel Ainebyoona	Senior Public Relations Officer, MoH
Richard Kabanda	Ag. Commissioner Health Services – Health Promotion, Education & Communication – Co-Chair

ANNEX 2

LIST OF EXPERTS CONSULTED IN THE TOOL DEVELOPMENT PROCESS

NAME	TITLE	COUNTRY	PARTICIPATION		
			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Abass Kamara	CHW/PS MoHS Kambia	Sierra Leone		✓	
Abdul Bangura	Country Director, Traditional Medicine	Sierra Leone		✓	
Abdul K. Bah	National Coordinator, SLAES	Sierra Leone		✓	
Abdul T. Deen	Community Liaison Lead, EBOVAC (LSHTM)	Sierra Leone		✓	
Abdulai Boye Bah	Field Manager, IPA	Sierra Leone		✓	
Adama Tall	Program Manager, Institut Pasteur, Dakar	Senegal		✓	
Agatha Lamin	Community Member, Bo	Sierra Leone		✓	
Agustine Alpha	M&E Officer, DHSE/MoHS	Sierra Leone		✓	
Augustine Fatoma	Section Chief, Bo District	Sierra Leone		✓	
Aissatou Mbaye	National Coordinator of JAMRA NGO	Senegal		✓	
Alassane Cisse	President of AJSPD	Senegal		✓	
Albert Musinguzi	ICT Manager - Makerere University Walter Reed Project	Uganda		✓	
Alexander N. Squire	Community Member, Bo District	Sierra Leone		✓	
Alhaji M Conteh	Freelance Researcher	Sierra Leone	✓		
Alusine Bakarr	Research Consultant, Trio Development	Sierra Leone	✓		
Amadou Cisse	Head of the Network of NGOs, CONGAD/ RESSIP	Senegal	✓		
Amadou Fall	Resonsible for Service Quality, ONG ACDEV	Senegal		✓	
Amadou Godio Diop	Agent in General Directorate of Social Action of MoHSA	Senegal		✓	
Amath Sow	Co-CEO of KARANGUEPproject	Senegal		✓	
Aminata Diagne	Health Educator, SNEIPS	Senegal		✓	
Amjata Bayoh	Freelance Researcher	Sierra Leone	✓		
Ashaba Annet	Administrator - National Disease Control Program, MoH	Uganda	✓		

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NAME	TITLE	COUNTRY	PARTICIPATION		
			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Austin Thomas	Deputy Editor, Awoko News	Sierra Leone		✓	
Bagonza Majid	Senior Health Educator - Bundibugyo District	Uganda		✓	
Bailor I Barrie	ICT & General Services Consultant	Sierra Leone	✓		
Barnabas Fornah	Medical Student Rep DMO, Port Loko	Sierra Leone		✓	
Baytir Samb	President of the National Network of Community Health Workers, ROCBACS	Senegal	✓		
Benjamin Sensasi	Communication Specialist, WHO Uganda	Uganda			✓
Bineta Bocoum	Head of Communication, COUS	Senegal	✓		
Birungi Betty	Secretary, Health Promotion & Education Department, MoH	Uganda	✓		
Boly Niang	Nurse, Fann University Hospital MoHSA	Senegal	✓		
Bukenya Henry	Technical Supervisor - Uganda Virus Research Institute	Uganda		✓	
Cecilia Okoth	Journalist / Reporter - New Vision Uganda	Uganda		✓	
Cheptoek Emily	Principal Nursing Officer, MoH	Uganda		✓	
Christian Robert	Hed Officer, HED/MoHS	Sierra Leone		✓	
Christine Nantumbwe	Health Educator - Bundibugyo District	Uganda		✓	
Claudia Marah	Community Liaison Team Lead, EBODAC	Sierra Leone		✓	
Connie Olwit	Lecturer - Nursing Department, Makere University & Central Supervisor - Immunisation Activities, MoH	Ugaanda	✓		
Daraus Bakihire	Communication Specialist, Call Centre, MoH	Uganda		✓	✓
David J. Allieu	Advocate, Health for All Coalition	Sierra Leone		✓	
David Matseketse	Health Officer, UNICEF	Uganda			✓
David Mutegeki	Senior Health Educator - Department of Health Promotion Education & Communication, MoH	Uganda		✓	
Dieng Elizabeth Pauline	CONGAD/RESSIP Member	Uganda		✓	
Dinavence Kebirungi	Public Health Specialist, Uganda Virus Research Institute	Uganda	✓		

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NAME	TITLE	COUNTRY	PARTICIPATION		
			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Dorothy Nabunya	Administrator - Public Health Emergency Operation Center, MoH	Uganda	✓		
Dr Alfred Driwale	Assistant Commissioner Health Services - Clinical & Curative Services, MoH (replaced Dr Bernard Opar in PSC)	Uganda	✓		✓
Dr Allan Murata	Assistant Commissioner National Disease Control, MoH	Uganda		✓	
Dr Bailo Diallo	Epidemiologist, WHO	Senegal		✓	
Dr Betty Mwesigwa	Clinical Research Manager, Makerere University Walter Reed Project	Uganda		✓	
Dr Doudou Diop	Physician, MEASURE EVALUATION	Senegal		✓	
Dr Ian Wurie	Medical Doctor, Ola During Childrens' Hospital, MoHS	Sierra Leone	✓		
Dr Ibrahima Sonko	Head of surveillance department, COUS	Senegal		✓	
Dr Isa Makumbi	Manager Public Health Emergency Operations Centre, MoH	Uganda			✓
Dr Jerlie Roka	Epidemiologist, Manager, CDC	Senegal		✓	
Dr Kemo Diedhiou	Head of the SNEIPS	Senegal		✓	
Dr Khadiatou Dia	Infectious Diseases Physician, Fann University Hospital MoHSA	Senegal			✓
Dr Khady Seck	Head of Community Health, MoHSA	Senegal	✓		✓
Dr Khardiata Diallo	Fann University Hospital, MoHSA	Senegal	✓		
Dr Khoudia Sow	(Anthropologist and Researcher) Head of Social Science Team, IRD	Senegal		✓	✓
Dr Koura Coulibaly Diack	Surveillance & Response Program Officer, PATH	Senegal	✓		✓
Dr Mohamed Bella Jalloh	Medical Doctor, Connaught Hospital, MoHS	Sierra Leone	✓		✓
Dr Mohamed Smith	Medical Doctor, Connaught Hospital, MoHS	Sierra Leone	✓		
Dr Mohammed Vandi	Director - Health Security & Emergencies, MoHS	Sierra Leone			✓
Dr Ousseynou Badiane	Head of Immunization, MoHSA	Senegal			✓
Dr Pierre Ndiaye	Head of Clinical trials Unit, IRESSEF	Senegal	✓		✓
Dr Samba Cor Sarr	Director of Research & Co-ordinator of the Ethics Committee, MoHSA	Senegal		✓	

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			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Dr Seynabou Gaye Faye	Head of the PECADOM, National Malaria Programme	Senegal			✓
Dr Siry Dieye	Clinical Trials Epidemiologist, IRESSEF	Senegal	✓		
Dr Songor Koedoyoma	Medical Doctor, Connaught Hospital, MoHS	Sierra Leone	✓		
Dr T.T. Samba	DCMO - Public Health, MoHS	Sierra Leone			✓
Dr Tom Sesay	EPI/Child Health Programme Manager - Directorate Of Reproductive & Child Health, MoHS	Sierra Leone		✓	✓
Dr. John Mark Bwanika	e-Health Specialist - Infectious Diseases Institute and The Medical Concierge Group	Uganda		✓	
Dr. Josephine Okwera	Director Health - Uganda Red Cross Society	Uganda		✓	
Dr. Kimbugwe Geofrey	Head of Research Compliance and Quality Assurance - Medical Research Council /Uganda Virus Research Institute and LSHTM Uganda Research Unit	Uganda		✓	
Duba Kamara	PHS, HED/MoHS	Sierra Leone		✓	
Edward Metzeger	Intern, DHSE	Sierra Leone		✓	
Elizabeth Dieng	Assistant Coordinator, OAFRESS	Senegal		✓	
Emanuel Margao	Pharmacist, Pharmacy Board/MoHS	Sierra Leone		✓	
Emau John Badram	Records Assistant - Health Promotion Education & Communication, MoH	Uganda		✓	
Emmanuel Ainebyoona	Senior Public Relations Officer, MoH	Uganda		✓	
Engena Robert	Cold Chain Techician - National Medical Stores	Uganda		✓	
Eriko Sam	District Biostatistician and HMIS Focal person, Lira District Health Office, Uganda	Uganda			✓
Evelyne Chevalier	Publishing Consultant	Senegal			
Fr. Joseph Ubemu	Parish Priest, Catholic Faith	Uganda			✓
Geoffrey Babughirana	Health Technical Specialist, EBODAC (WV)	Sierra Leone		✓	
Harold Thomas	Risk Communications - DHSE, MoHS	Sierra Leone			✓
Hawa P. Kargbo	PHS, MoHS	Sierra Leone		✓	
Ibrahim S Koroma	HED, MoHS	Sierra Leone	✓	✓	

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NAME	TITLE	COUNTRY	PARTICIPATION		
			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Ibrahima LO	President of DEFI NGO	Senegal		✓	
Ismail Odubi	Muslim Sheikh, Muslim Supreme Council	Uganda			✓
Janet M Koroma	Community Health Worker, MoHS, Bo	Sierra Leone		✓	
Jenesio Olarker	Cultural Leader, Alur Cultural Institution	Uganda			✓
Jennipher Tambadou	Project Assistant IOM (International Organization for Migration)	Senegal			
Kabuye Ivan	Photo Journalist / Reporter - New Vision Uganda	Uganda		✓	
Kadiatu K. Dumbuya	Chairlady, Kambia District	Sierra Leone		✓	
Kaggwa Ddumba	EPI Technical Officer, MoH	Uganda		✓	
Kalu H. Kamara	Community Member, Kambia	Sierra Leone		✓	
Katunguka Fred	Social Mobiliser, MoH	Uganda		✓	
Kisiriko Vincent	Journalist, Radio One	Uganda		✓	
Komakech Isaac	Statistics Officer - Kampala City Council Authority	Uganda		✓	
Kwabena Owusu-Kyei	Salone Trial Coordinator, EBOVAC (LSHTM)	Sierra Leone		✓	
Kwansiima Dinnah	Senior Health Educator - Department of Health Promotion Education & Communication, MoH	Uganda		✓	
Lansanah Conteh	Principal Medical Officer - Epidemology Surveillance Division, MoH	Uganda	✓		
Mabumba Elly	Principal Medical Officer - Epidemology Surveillance Division, MoH	Uganda		✓	
Madjiguene Ndiaye	Retired Communication Specialist	Senegal		✓	
Mame Diara Diagne	Supervisor, Medical Region, Dakar	Senegal		✓	
Marie Catherine Daba	Master student in political sciences, Gaston Berger University (UGB), St Louis/Senegal	Senegal			
Milton Makobe	Logistics Officer - Public Health Emergency Operation Center, MoH	Uganda	✓		
Mohamed Kanu	117 Manager, MoHS/DHSE	Sierra Leone	✓		
Mohamed Kebe	M&E,MoHS/DPPI	Sierra Leone		✓	

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			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Mohammed Bai-Jalloh	Chief Executive Officer (CEO), FOCUS 1000	Sierra Leone		✓	
Mr Baba Gallé Com	Focal Person - Anti-Smoking/Tabacco, MoHSA	Senegal			✓
Mugamba Stephen	Community Documentation Officer - Makerere University Walter Reed Project	Uganda		✓	
Abass Kamara	CHW/PS MoHS Kambia	Sierra Leone		✓	
Musa Brima	Youth Leader Murray Town Community, Freetown	Sierra Leone		✓	
Mustapha Manneh	Religious Leader, ISLAG	Sierra Leone		✓	
Nakyanzi Prossy	District Technical Officer – Maternal and Child Survival Program (MCSP), John Snow Inc.	Uganda		✓	
Ndeye Mingue Ndiate Ndiaye	Head of the Gender Unit, MoHSA	Senegal			✓
Pa Adikalie Sesay	Section Chief, Kambia	Sierra Leone		✓	
Patrick Lansana	Communications Officer, DHSE/MoHS	Sierra Leone		✓	
Philippe Mutwa	Technical advisor, USAID, Dakar	Senegal		✓	
Prince M. Kanneh	Communications Officer, Christian Aid	Sierra Leone		✓	
Professor Mworozi Edison	Senior Paediatrician, The Uganda Paediatric Association	Uganda		✓	
Rachel Kyeyune	Medical Doctor - National Drug Authority	Uganda		✓	
Rev Alimamy P. Kargbo	Religious Leader, Inter Religious Council	Sierra Leone		✓	
Richard Kabanda	Ag. Commissioner Health Services – Health Promotion, Education & Communication – Co-Chair	Uganda		✓	
Richard Okwir	Senior Health Educator - Department of Health Promotion Education & Communication, MoH	Uganda	✓		
Dr Samba Cor Sarr	Director of Research & Co-ordinator of the Ethics Committee, MoHSA	Senegal	✓		
Sasira Syson	Administrator - National Disease Control Program, MoH	Uganda			
Seye A.M.	Assistant director, AFRIVAC	Senegal		✓	
Shaminah Kauma	Senior Health Educator - Department of Health Promotion Education & Communication, MoH	Uganda		✓	
Sidi Mustapha	Student, MoHS	Sierra Leone		✓	

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NAME	TITLE	COUNTRY	PARTICIPATION		
			CPJ Facilitation Team	CPJ Participant	1:1 Consultation Expert
Souleymane Sow	Sociologist, CRCF	Senegal	✓		
Swalieho Vandi	Media Reporter, AYV-TV	Sierra Leone		✓	
Tamba H. Ngongon	Logistics, DHSE	Sierra Leone		✓	
Tom Mooney	EBOVAC Communications Manager, EBOVAC (LSHTM)	Uganda	✓		
Tony Walter Onera	Officer - Infectious Disease Research Network	Uganda		✓	
Umar T. Sesay	Co-Chair IRCSL, Kambia District	Sierra Leone		✓	
Umu Macarthy	Project Coordinator, Ehealth Africa	Sierra Leone		✓	
Valerie Oriol	Global Medical Affairs Lead, EBODAC (Janssen)	Senegal		✓	
Abass Kamara	CHW/PS MoHS Kambia	Sierra Leone		✓	
Yacine Ndiaye	Nurse & Head of the Health Post Parcelles, Hospital MoHSA	Senegal			✓
Yasin Kertho	Local Council Political Leader, Community Policing	Uganda			✓
Yvette Wibabara	Epidemiologist - Makerere University School of Public Health	Uganda		✓	

ANNEX 3

LIST OF 3C GAP ANALYSIS TOOL PILOT PARTICIPANTS

NAME	TITLE	COUNTRY	ROLE
Jude Okiria	Health Educator, Ministry of Health	Uganda	Participant
Tabuzibwa Michael	Senior Health Educationist, Ministry of Health	Uganda	Participant
Enginyu Sam	Communication Consultant, UNICEF/Ministry of Health	Uganda	Participant
Dr. Kimbugwe Geofrey	Head of Research Compliance and Quality Assurance, MRC/UVRI and LSHTM Uganda	Uganda	Participant
Dr. Musa Sekamatte	Senior Epidemiologist /National One Health Platform Coordinator, Ministry of Health	Uganda	Participant
Emmanuel Ainebyoona	Senior Public Relations Officer, Ministry of Health	Uganda	Participant
Tabley Bakyayita	Assistant Commissioner Health Services, Health Promotion Education and Communication, Ministry of Health	Uganda	Facilitator
Benjamin Sensasi	Communication Specialist, World Health Organization Uganda	Uganda	Facilitator
Nagawa Zainab	Health Educator, Ministry of Health	Uganda	Participant
Katunguka Fred	Social Mobiliser, Ministry of Health	Uganda	Participant
Ronald Kakuru Tibihenda	Community Social Worker, MSF/Epicenter Mbarara Research Base	Uganda	Participant
Mpeirwe Doreen	Head Community Social Workers, MSF/Epicenter Mbarara Research Base	Uganda	Participant
Birungi Betty	Data Officer, Ministry of Health	Uganda	Participant
Nambooze Edrine	Health Economist, Ministry of Health	Uganda	Participant
Richard Okwii	Senior Socialogist, Health Promotion, Education and Communication Department, Ministry of Health	Uganda	Facilitator
Kyasiimire Ruth	Administrator, Ministry of Health	Uganda	Participant
Dr. Nabukenya Immaculate	Senior Project Manager, Ministry of Health - NAPHS Team	Uganda	Participant
Sharmina Kauma	Senior Health Promotion Officer, Ministry of Health	Uganda	Participant
Dr. Nakinsinge Ann	Senior Medical Officer, Ministry of Health	Uganda	Participant
Jauhara Nanyondo	Community Outreach Coordinator, Makerere University Walter Reed Project	Uganda	Participant

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NAME	TITLE	COUNTRY	ROLE
Dr. Eldard Mabumba	Senior Epidemiologist, Ministry of Health	Uganda	Facilitator
Dinnah Kwarisiima	Senior Health Educationist, Ministry of Health	Uganda	Participant
Dorothy Nabunya	Administrator, Public Health Emergency Operations Center	Uganda	Participant
Dr. Luzze Henry	Principal Medical Officer, Ministry of Health	Uganda	Participant
Dr. Joyce Nguna	Senior Epidemiologist, Ministry of Health	Uganda	Participant
Koura Coulibaly	Resource Person	Senegal	Facilitator
Bineta Bocoum	Communications Officer	Senegal	Facilitator
Boly Ameth Niang	Health manager/service supervisor/IDE	Senegal	Facilitator
Khady Seck	Head of Commmunity Health Cell/MOH	Senegal	Facilitator
Ousseynou Badiane	Coordinator of Expanded program of vaccinnation (EPV)	Senegal	Moderator
Barnabe Gning	Technical Adviser - Ministry of Health	Senegal	Moderator
Ibrahima Mamby Keita	Physician (DGS/MSAS)	Senegal	Particpant
Lamine Balde	Programme Manager	Senegal	Particpant
El H Baytir Samba	Participant	Senegal	Participant
Khardiata Diallo Mbaye	Infectologist/Lecturer at Cheikh Anta Diop university	Senegal	Participant
Fatoumata Diene	Physician Epidemologist	Senegal	Participant
Amy Mbacke		Senegal	Participant
Bokary Danfakh	Army Force Health Service	Senegal	Participant
Mohamed B Jalloh	Medical Doctor Connaught Hospital	Sierra Leone	Facilitator
Shegbe Momoh	Logistics Officer	Sierra Leone	Participant

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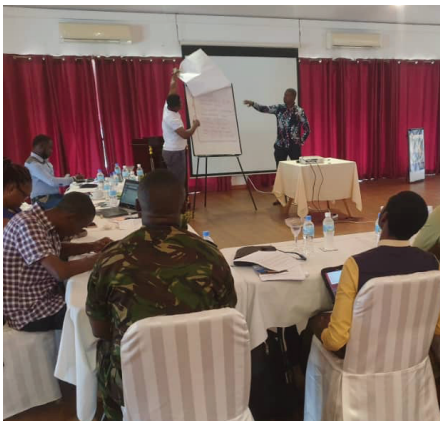
NAME	TITLE	COUNTRY	ROLE
Harold Thomas	Risk Communication	Sierra Leone	Participant
Thomas A Conteh	PV-Clinical practice	Sierra Leone	Participant
Dr. Joseph Kanu	Deputy Program Manager	Sierra Leone	Participant
Sallieu Jalloh	National Surveillance Officer	Sierra Leone	Participant
Major George Gindeh Kiawu	Head of Communication HQ JFC	Sierra Leone	Participant
Chrisitiana Roberts	Health Education	Sierra Leone	Participant
Mukeh K. Fanhbulleh	Public Health Emergency Mgt.	Sierra Leone	Participant
Daniel A.H. Cooper	Deputy Coordinator Point of Entry	Sierra Leone	Moderator
William T. Pesima	CHO	Sierra Leone	Participant
Andrew Charles	CMO Admin	Sierra Leone	Participant
Diana Shehab	Medical Doctor Connaught Hospital	Sierra Leone	Participant
Ian Wurie	Medical Doctor ODCH	Sierra Leone	Facilitator
Bobson D Fofanah	Infection and Prevention Officer	Sierra Leone	Facilitator
Mariama Musa	RN Staff Nurse	Sierra Leone	Facilitator
Bailor Barrie	ICGS	Sierra Leone	Facilitator
Aminata Saccoh	One Health	Sierra Leone	Participant
Umu Macarthy	EMP – Project Coordinator	Sierra Leone	Participant
Alexander Taylor	117	Sierra Leone	Participant
Patrick Lansana	Communications/EOC	Sierra Leone	Participant
Rashid Fofanah	Watch Officer	Sierra Leone	Participant

ANNEX 4

PROJECT ACTIVITY PHOTOS



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