

COMBI

Communication for Behavioural Impact

TOOLKIT

Field workbook
for COMBI
planning steps in
outbreak response



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Overview of COMBI Planning Steps

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The COMBI planning cycle for outbreak response consists of seven steps. This workbook contains tools, templates and checklists which can be used during the seven-step COMBI planning cycle.

Each step has accompanying tools which are not in any particular order. Before using the tools, it is important to understand their purpose and choose those that are most relevant to the requirement and context. In an event, you will have to set priorities and decide which combination of tools are applicable to achieve the desired results.

This document supports the implementation of the COMBI planning steps and tools contained in the main toolkit. This is your field workbook, a handheld guide for “doing” COMBI in the field. Refer to section 3 of the main COMBI document for detailed explanation and guidance on how to use the tools.

The tools outlined on the next page (See Table 1, page 4). will help you gather data relevant to outbreaks rapidly.

- Tools 1–7 will help you assess what already exists
- Tools 8–10 will help you collect information during a rapid situational market analysis
- Tools 11–17 will help you to organize, analyse and use the collected information.

Step	Tool	Outcome
Programme, management and administrative response structure	Tool 1: Reflective questions for assessing the organizational context of outbreak management and response	
	Tool 2: Identifying stakeholders	
	Tool 3: Mapping existing expertise and capacity	
	Tool 4: Frequently asked questions about monitoring and evaluation	
COMBI planning step		
Step 1. Identify the preliminary behavioural objectives	Tool 5: Preliminary behavioural objectives	Preliminary behavioural objectives
	Tool 6: Risk factors in the sociocultural context	
	Tool 7: Environmental scanning	
Step 2. Conduct a rapid situational market analysis	Tool 8: Tips for interviewing	Barriers and facilitating factors for adopting prevention and control measures; what communication can and cannot do
	Tool 9: Checklist for conducting a situational market analysis	
	Tool 10: Semi-structured interviews	
Step 3. Refine the behavioural objectives, state your communication objectives	Tool 11: HIC-DARM Tool 12: Template for channels and settings Tool 13: Communication and non-communication issues	Behavioural and communication objectives
Step 4. Design an overall strategy	Tool 14a: Restated behavioural objectives Tool 14b: Restated communication objectives	A strategy
Step 5. Prepare implementation plans and budgets	Tool 15: Detailed implementation plan Tool 16: Monitoring table Tool 17: Monitoring implementation plan	Detailed implementation plans for the strategy and for monitoring and evaluation
Step 6. Implement and monitor the strategy, identify trends and adapt if necessary	Apply tools 15 - 17	Feedback and adjustments to the strategy
Step 7. Evaluate once the outbreak is over	Tool 4: Frequently asked questions about monitoring and evaluation Tool 10: Semi-structured interviews Tool 16: Monitoring table Tool 17: Monitoring implementation plan	Impact, lessons learnt and good practice



Tools for Understanding Organizational Context

Tool 2. Mapping stakeholders

Instructions: Describe and categorize stakeholders.

'Primary' stakeholders (people who are ultimately affected by the outbreak, such as the beneficiaries and affected communities)

'Secondary' stakeholders (people involved in planning and delivering outbreak response interventions, including technical experts, outbreak managers, government sectors and departments, public and private agencies, health-care workers and hospital managers, nongovernmental organizations and social mobilization and communication partners e.g. community leaders, teachers, religious leaders, women's groups, business owners, older children).

Tool 4: Frequently asked questions about monitoring and evaluation

Q1 When should I plan for monitoring and evaluation?

A1 Monitoring and evaluation planning is an integral part of COMBI and should start immediately, with formative research, definition of an adequate budget, human resources and processes for the further monitoring and evaluation components and phases.

Q2 What if I do not have baseline data?

A2 Start collecting data as soon as possible. As change may take some time, you may be able to compare your findings with data collected after the intervention has begun. Ask partners, local authorities and other agencies for relevant information that was collected in similar situations or for similar populations. Remember, some evaluation is better than none.

Q3 What kind of budget should I dedicate to evaluation?

A3 The budget depends on the size and scope of your project and the challenges you may face. As a general rule, the monitoring and evaluation budget should be around 5% and not more than 10% of the total project budget.

Q4 What kinds of research, monitoring and evaluation methods should I use to collect information?

A4 These depend on the cultural context and the situation. For example, in some cultures, focus groups may be difficult to form, as people might be too intimidated to express their opinions in the presence of other community members. In this context, multiple in-depth interviews or anonymous questionnaires before and after an event might be more appropriate. Tracking surveys remain the best method for monitoring behavioural results at various intervals, but other methods should also be considered. This manual includes examples of a variety of tools that are already used in COMBI.

Q5 What is the ultimate measure of a successful COMBI intervention?

A5 While we monitor, discuss and evaluate intermediate steps and indicators, these are important only to give a COMBI specialist an idea of progress being made towards behavioural results. The ultimate measure of a successful COMBI intervention is achievement of the behavioural objectives, which contribute to improving public health outcomes of outbreaks. This reflects standard public health communication theories and practice.

NOTES



COMBI

Planning Steps



COMBI Planning Step 1

Defining preliminary behavioural objectives

Tool 5. Defining preliminary behavioural objectives; understanding the context of interventions

What are the epidemiological risk factors for exposure and transmission?	What interventions could reduce and prevent exposure and transmission?

State your top 3 preliminary behavioural objectives:

1
2
3

Tool 6. Risk factors in the sociocultural context

Instructions: Using the tables below (tools 6 and 7), answer the guide questions to be able to identify all risk factors involved in the sociocultural context and conduct an environmental scan of the outbreak situation.

What epidemiological risk factors have you identified?	What are current household practices in relation to the epidemiological risk factors?	What are the beliefs and values behind the practices?	What are the social or community norms related to the practices?

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Tool 9: Checklist for conducting a situational market analysis

Instructions: The following checklist can be used as a guide and adapted as necessary. The goal of the analysis is to ensure that the proposed risk reduction behaviour is feasible and culturally appropriate. You must also identify the ways in which social mobilization and communication can support the public health objectives of outbreak control and the uptake of risk reduction behaviour. Some audiences might require different communication messages and approaches for specific activities.

At-risk groups and populations

- Can particular targets or beneficiaries be segmented or identified? For occupational exposure to the disease, e.g. health workers, traditional healers and abattoir workers; for household or community exposure to the disease, e.g. women who care for sick household members.
- Are there particularly vulnerable or high-risk groups that should be reached?

Knowledge, awareness and perceptions

- What do individuals and communities know about the cause and transmission of the disease?
- What are the local terms or descriptions of the disease?
- What are the individual and community perceptions of the risk posed by the outbreak?
- Have they experienced previous outbreaks, and how have they managed them?
- What are the messages currently circulating within the community?

Information sources, channels and settings

- Where and from whom do people get information and why? Who are the 'trusted' and 'credible' information sources, and what makes them so, e.g. local leaders, religious leaders, health-care staff, influential people (formal and informal)?
- What media or channels of communication are available to promote your messages? Which channels are the most popular and influential? What traditional media are used? What are the current patterns of social communication? What active community networks and structures exist, and how are they perceived by the local population? What other organizations are addressing the issue in the community?
- Which settings are suitable for communication interventions, e.g. clinic, home, village?

Household and community practices

- What are the current health-seeking and health-care practices?
- Do the existing practices amplify the risk, and what beliefs and values support them?
- Are there existing practices that reduce risk, e.g. hand-washing, cooking food thoroughly, chlorination, and what beliefs and values support them?
- How are decisions made about seeking health care in communities and households?

Sociocultural, economic and environmental context

- Are there social and political tensions that would affect adoption of risk reduction practices?
- Do people have access to sufficient resources to implement the risk reduction practice? Do they have access to clean water? Are health services available and accessible? Is it difficult to transport sick people to clinics or hospitals?
- Are there traditional beliefs and social norms that might stop people from implementing risk reduction practices? And are there traditional beliefs and social norms that might favour implementation of risk reduction practices?

Tool 10: Semi-structured interviews

Instructions: Semi-structured interviews are useful for collecting information during a situational market analysis and during monitoring and evaluation. Open-ended questions with probes and prompts are used to elicit a wide variety of detailed responses on topics of interest. Who your informants are depends on the local context, but they might include child caregivers, local health service personnel, traditional healers, community leaders (elected or self-appointed), religious leaders, government officials and members of nongovernmental organizations.

A number of tools can be used for semi-structured interviews.

Free listing

The respondent is asked to say what comes freely to mind in answer to a specific question posed by the interviewer. For example:

- What are the common diseases of poultry in this area? [asked of a poultry farmer or wet-market butcher during an avian influenza outbreak]
- What are the local names for 'mosquito' here? [asked of a child caregiver, traditional healer, nurse or local shop-keeper selling medicines during a yellow fever outbreak].
- What preventive methods do people have to manage yellow fever here? [asked of a child caregiver, traditional healer, nurse, or local shopkeeper selling medicines during a yellow fever outbreak]
- What are your main concerns about [local term for e.g. avian influenza, Ebola haemorrhagic fever, yellow fever]?
- What kind of information do you need or would you like to have?
- Where do you obtain most of your information at present?
- How do you want information to be given to you?
- Do you know whether any particular group of people requires special information?
- Do you know whether another language or dialect is spoken in the community?

Focus group discussion

Focus group discussions can be used during a rapid situational market analysis and during monitoring and evaluation. Groups of 6–12 participants are manageable. Participants are not selected randomly, and you should make sure that the groups are homogeneous. If you visit several places to conduct semistructured interviews, you could organize two focus groups in a few communities (men and women separately if necessary). Spread the focus groups across each of your strategic communication settings.

Representatives of participant groups are usually sufficient for each discussion, such as child caregivers, government officials, local health service personnel, traditional healers, community leaders, religious leaders and members of nongovernmental organizations. Always collect background information on the respondents so that you can characterize the people interviewed, and give these details in your report.

Skilled facilitation of discussions is extremely important. Open-ended questions with probes and prompts are used to elicit detailed responses on topics of interest. For example, a focus group discussion around a given disease outbreak might include questions such as:

- What are the common diseases in this community?
- What is the most important disease?
- What about (the disease that is experiencing an outbreak) [use local terms obtained from earlier free-listing]?
- Who is responsible for looking after children in this community?
- Who usually first detects illness in children?
- Who decides what should be done about the illness? We are interested in knowing everyone involved.

- If a child gets (the disease that is experiencing an outbreak), what treatment is given here? What is the first treatment usually given? Who decides?
- Under what circumstances would you send a child with (the disease that is experiencing an outbreak) to a (name one by one the different treatment options available in the community)?
- How can (the disease that is experiencing an outbreak) be prevented?

Top-of-the-mind analysis

Instructions: A 'top-of-the-mind' analysis allows you to explore people's perceptions of and immediate associations with the outbreak and the outbreak control interventions. It involves simply asking people to say the first thing that comes to their mind when they hear a particular word or phrase (linked to the behaviour or service being explored), then the second thing that comes to mind, then the third. In this way, after a round of questioning, you acquire a sense of what is on the minds of your beneficiary group. This can be done quickly, on the spot, as you are conducting interviews or meeting people. It gives a rapid insight into what people are thinking and feeling about an issue and helps you to define your behavioural and communication objectives.

First, identify the purpose of the tool. You might want to compare the perceptions and associations of different groups on the same topic, for example community members and health workers on 'isolation' or 'cholera'.

Secondly, explain the process, so people understand what you are trying to do. Try a few associations with words not related to the topic you are exploring. What is the first thing that comes to mind when I say 'insert word'? What is the second thing that comes to mind when I say 'insert word'? What is the third thing that comes to mind when I say 'insert word'?

Thirdly, interpret the results. Simple software such as Excel® can be used to generate graphs from the data collected.

Fourthly, use the data. A 'top-of-the-mind' analysis can provide useful information for developing messages and interventions. Look for where there is overwhelming consensus or dissension as this will give you clues about areas that require further investigation or when current perceptions and associations should be changed.

Name and occupation: Location:		
Time of day or segment	Activity	Observations and notes: Opportunities for promoting risk reduction practices, e.g. settings, channels and languages
Morning		
Mid-day		
Afternoon		
Evening		

Tool 12 Template for channels and settings

This tool will help you to identify the most appropriate channels, existing structures, and the most credible voices to carry your messages. It will also help you to identify the most suitable settings for different audiences and will allow you to anticipate where problems may be likely to occur. Use this in combination with other analytical tools.

	Audience		
	Primary audience	Secondary audience	Others
Sources of Information that are trustworthy and credible			
Channels of information dissemination			
Feedback to ensure that strategy is effective			
Settings (locations)			

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Tool 13: Identifying key communication and non-communication issues

Instructions: This tool can be used to identify what should be in place to ensure that behavioural and social interventions can work effectively.

Emerging Issues that can be addressed by communication and social mobilization interventions	Emerging Issues that require non-communication interventions

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COMBI Planning Step 3

Define the behavioural and communication objectives

By analysing the results of the situational market analysis and reviewing the behavioural objectives, you will be able to distinguish what your behavioural and social communication strategy will and will not be able to achieve. You can now start to refine your preliminary behavioural objectives and define your communication objectives.

The 1-3 key behavioural objectives to reduce risks are:

1.

2.

3.

The communication objectives in order to achieve behavioural objectives are:

1

2

3

4

5

COMBI Planning Step 4

Design an overall strategy

Tool 14a : Restate your behavioural objectives

The next stage will help you to define the overall strategy to achieve the behavioural and communication objectives.

An example from a dengue haemorrhagic fever programme.

The three main behavioural objectives for reducing risk are:

- to prompt residents in every household in xxx district to carry out a 30-min inspection of their houses every Sunday, both inside and out, for potential mosquito larval sites over the next xx weeks (x date–x date);
- to prompt every person with fever during the next xx weeks to assume that it is dengue haemorrhagic fever and to go immediately (at least within 24 h) to the nearest health clinic for diagnosis and treatment; and
- to prompt every village, community or block to form a dengue volunteer inspection team to conduct weekly larval site inspections around the community (not within houses) and to take action to rid the area of the breeding sites.

Tool 14b: Restate your communication objectives

In the example above, the communication objectives for achieving the behavioural objectives are to ensure that:

- xx people in (district/village) understand that there is a potential outbreak of dengue haemorrhagic fever in their communities and to raise awareness of the seriousness of the situation and the importance of preventive and control actions;
- xx people in (district/village) and dengue volunteer inspection teams receive clear, accurate information about the signs and symptoms of dengue, where to obtain help and what they should do;

all health-care professionals in public and private clinics serving xx people in (district/village) are able to diagnose rapidly and give appropriate treatment and advice on dengue; and

information on the outbreak, how it is being managed and the measures being taken to provide rapid diagnosis and treatment is communicated in a timely, relevant manner.

- xx people in (district/village) understand that there is a potential outbreak of dengue haemorrhagic fever in their communities and to raise awareness of the seriousness of the situation and the importance of preventive and control actions;
- xx people in (district/village) and dengue volunteer inspection teams receive clear, accurate information about the signs and symptoms of dengue, where to obtain help and what they should do;
- all health-care professionals in public and private clinics serving xx people in (district/village) are able to diagnose rapidly and give appropriate treatment and advice on dengue; and
- information on the outbreak, how it is being managed and the measures being taken to provide rapid diagnosis and treatment is communicated in a timely, relevant manner.

Describe your integrated strategy based on the 5 communication action areas below**Try to do the same below:**

- | | |
|----|--|
| 1. | Public advocacy and mobilizing decision-makers and administrative structures |
| 2. | Community mobilization |
| 3. | Personal selling and mobilizing local networks and advocates |
| 4. | Promotional materials and advertising |
| 5. | Point-of-service promotion |
| 6. | Others |

The communication action areas for achieving your objectives

1.

2.

3.

4.

5.

6.

COMBI Planning Step 5

Develop detailed plan of action and a budget

Tool 15

Detailed Implementation Plan : The example of a planning and monitoring table below lists detailed activities for each communication action area. This ensures that the planning team understands who is doing what, when and how, and that progress is followed-up

Example: Detailed plan of action for communication interventions

Strategy	Communication intervention							
		Task	Responsible person	Budget	June (week)			
					1	2	3	4
Mobilizing decision-makers	1.1	Prepare a two-page briefing on mass vaccination to be executed on XX. To be prepared in xx languages.	District medical officer					
	1.2	Share the briefing paper and social mobilization plan with district departments and nongovernmental organizations that will be directly involved in implementation. Share the plan of action and secure commitment to specific actions.	District medical officer					
	1.3	Agree and set up a management and implementation structure to oversee and coordinate the social mobilization plan and organize a schedule of regular meetings.	District medical officer					
	1.4	Prepare and distribute a memo to all health personnel in the district, informing them of the mass vaccination plan, urging their support and explaining what they should do.	District medical officer					

Tool 16: Monitoring Plan

Instructions: The tool below lists examples of questions asked in each form of monitoring, with some examples of indicators and methods of collecting the information.

An example of a monitoring table

Key questions	Indicator	Data collection method
<p>Are activities being implemented as planned?</p> <p>Are outputs being delivered as planned?</p> <p>Are activities within the budget?</p>	<p>On the basis of the implementation schedule, plan of action and budget, for example:</p> <p>number of participants in meetings</p> <p>number of posters produced and distributed</p> <p>number of radio spots aired</p> <p>number of volunteers trained and engaged in social mobilization</p> <p>number of households visited</p> <p>costs within budget</p>	<p>Activity reports</p> <p>Attendance sheets</p> <p>Financial reports</p>
Process	Indicator	Data collection method
<p>Is the message or activity reaching the people for whom it was designed?</p> <p>Is participation good?</p> <p>To what extent are outbreak interventions being adapted to local needs?</p> <p>Is there a recent change or trend that should be considered?</p> <p>Are there any changes in the social, political or policy context that might affect the control measures and the COMBI strategy?</p>	<p>Examples of quantitative indicators:</p> <p>% of target population who have heard or seen messages and activities</p> <p>% of target audience who understand, like or agree with messages</p> <p>% of target audience who know the symptoms of the disease</p> <p>numbers of women and men who have been actively involved in social mobilization and other outbreak control interventions</p> <p>Examples of qualitative indicators:</p> <p>Existence of circulating rumours or messages that promote non-participation</p> <p>Participants feel that their concerns and ideas are taken into account by the local outbreak management committee</p> <p>Interventions are perceived as relevant and responding to the expressed needs of the target population</p> <p>Examples of quantitative indicators</p> <p>% accurate media reporting and coverage</p> <p>Examples of qualitative indicators:</p> <p>Evidence of communication hoaxes that undermine response strategies</p> <p>Evidence of conflicting messages</p>	<p>Rapid surveys, interviews and observation through:</p> <p>central location intercept interview</p> <p>focus group discussions</p> <p>observation at service and delivery points</p> <p>interviews with field personnel involved in outbreak response</p> <p>observation of field staff carrying out interventions in local communities</p> <p>review and analysis of media coverage</p> <p>Informal conversations and meetings with key. grass roots organizations, journalists etc</p>

Behaviour	Indicator	Data collection method
<p>As a result of the interventions, are target populations adopting the desired behaviour?</p> <p>Objective 1</p> <p>Objective 2</p> <p>Objective 3</p>	<p>Examples of quantitative indicators:</p> <p>% of target population who have adopted the desired behaviour</p> <p>% who can describe risk reduction practices and say they are carrying them out</p> <p>Examples of qualitative indicators:</p> <p>Members of target populations believe that the proposed behaviour is effective in reducing risk</p> <p>Observation of applied risk reduction practices</p>	<p>Local authority report cards</p> <p>Rapid survey</p> <p>Health facility data or investigation forms</p> <p>Focus groups</p> <p>Key informant interviews</p>
<p>Are activities being implemented as planned?</p> <p>Are outputs being delivered as planned?</p> <p>Are activities within the budget?</p>		
<p>Process</p> <p>Is the message or activity reaching the people for whom it was designed?</p> <p>Is participation good?</p> <p>To what extent are outbreak interventions being adapted to local needs?</p> <p>Is there a recent change or trend that should be considered?</p> <p>Are there any changes in the social, political or policy context that might affect the control measures and the COMBI strategy</p>		
<p>Behaviour</p> <p>As a result of the interventions, are target populations adopting the desired behaviour?</p>		

Tool 17. Develop an implementation plan for monitoring

Once you have established indicators for each monitoring and evaluation category (see tool 16), you can use a table like that presented below to summarize the data collected on the first two to three indicators for each category. The outbreak management team should agree on the main indicators and expected changes from baseline. See example table below.

Indicator Description (include quantitative and qualitative parameters)	Activity (for implementation and some categories of process monitoring ONLY)	Baseline	Expected Change/	Data Collection Method	Frequency of data collection	Responsible Organization
Sample implementation indicators: Attendance and quality of participation in local meetings re: outbreak control and response	Community meetings and dialogue Workshop, Health fair or point-of-service	If your meeting is part of a series, or builds upon a previous event, compare with attendance data from previous relevant meetings	Attendance: XX% increase in the participation of community members in local events on outbreak control and response organized within the last XX days/weeks. Quality of participation: New information/facts and suggestions by event participants that are critical to outbreak control interventions or sheds new light on a specific issue	Activity reports (meeting minutes, supervision reports, mission/travel reports etc) Situation updates Attendance sheets	At each event	Staff member of local partner or member of COMBI team or someone else involved in event planning and evaluation (e.g. outside agency or M&E consultant) or previously trained community member(s)

Indicator Description (include quantitative and qualitative parameters)	Activity (for implementation and some categories of process monitoring ONLY)	Baseline	Expected Change/	Data Collection Method	Frequency of data collection	Responsible Organization
Sample process indicator: message exposure and retention	This is not activity-specific since multiple activities of an integrated COMBI plan contribute to changes in this indicator	Percentage of intended populations who may know/remember key facts highlighted by your core messages (prior to your implementation)	% of intended population who have heard/seen messages and activities re: your plan and remember core messages after XX time from launch of your interventions	Rapid surveys, interviews and observation with key audiences and stakeholders through: Central location intercept interview Focus group discussions Observation at service and delivery points Interviews with key field personnel involved in outbreak response Observation of field staff carrying out intervention in communities	At regular intervals after program implementation/launch (days, weeks, month, etc.) depending on outbreak duration and level of urgency on collecting data early on	Staff member of local partner or member of COMBI team or someone else involved in program monitoring and evaluation (e.g. outside agency or M&E consultant) or previously trained community member(s)
Sample behavioural indicator: Adoption of recommended outbreak/emergency behaviour (e.g., sheltering in place, immunization, etc.	This is not activity-specific since multiple activities of an integrated COMBI plan contribute to changes in this indicator	Percentage of intended population who practiced behaviour prior to your implementation	% of intended population who have adopted the desired behavioural practices within XX days/weeks from implementation of intervention	Local authority report cards Rapid survey Health facility data/investigation forms Focus groups Key informant interviews	At regular intervals after program implementation (X days, X weeks, X month, etc.) depending on outbreak duration and level of urgency on early data collection	Staff member of local partner, or member of COMBI team, or someone else involved in program monitoring and evaluation (e.g. outside agency or M&E consultant) or previously trained community member(s)

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Annex 1

Essential facts about major outbreak-prone diseases

Currently known transmission routes of epidemic-prone diseases

Mode of transmission	Disease
Contact	
Direct environmental, e.g. faeces	Highly pathogenic avian influenza
Direct or indirect, bloodborne	Crimean Congo haemorrhagic fever Ebola haemorrhagic fever Hendra virus infection Marburg haemorrhagic fever Nipah virus disease Rift Valley fever West Nile virus infection
Airborne	Influenza Measles Meningococcal meningitis Nipah virus disease
Food and water	Cholera Nipah virus disease Rift Valley fever
Vector-borne Mosquito	Chikungunya fever Dengue haemorrhagic fever Rift Valley fever Yellow fever
Flea	Plague
Tick	Crimean Congo haemorrhagic fever
Perinatal	Crimean Congo haemorrhagic fever Ebola haemorrhagic fever Marburg haemorrhagic fever Nipah virus disease Rift Valley fever West Nile virus infection
Blood transfusion	West Nile virus infection
Organ transplant	West Nile virus infection

Transmission routes and groups potentially at high risk

Mode of transmission	Type of transmission	Potential transmission routes	High-risk groups and individuals
Contact (direct or indirect: bloodborne)	Human–human	Direct or indirect contact with blood, secretions, organs, other body fluids or skin lesions of infected people or recently contaminated objects Burial ceremonies in which people have direct contact with the body Infected semen up to 7 weeks after clinical recovery Unsafe injections	General community, caregivers of infected people, hospital staff, laboratory workers
	Domestic animal–human	Direct or indirect contact with blood, secretions or other body fluids of infected animals During slaughter or butchering, assisting at animal births, conducting veterinary procedures or disposal of carcasses or fetuses Ingesting unpasteurized or uncooked milk of infected animals	People who slaughter and handle animals, such as herders, farmers, slaughterhouse workers, veterinarians and household members People who drink and eat uncooked products from infected animals, e.g. milk, blood, meat
	Wildlife–human	During slaughter or butchering, assisting at animal births, conducting veterinary procedures or disposal of carcasses or fetuses Entry into caves or mines inhabited by bat colonies	Hunters, wildlife staff, miners, soldiers, tourists visiting caves or mines, health-care workers
Airborne (inhalation of contaminated air)	Human–human	Close contact with infected respiratory tract excretions and droplets	People in close, regular contact with infected people People who touch contaminated objects, for instance after an infected person has sneezed, coughed or transferred saliva
Food and water (ingestion of contaminated food or water)	Animals infecting human food or drinking-water	Eating food contaminated by bats	General community in endemic areas
	Human–human	Direct contact with the mouth of an infected person Food and utensils contaminated by infected people who did not wash their hands after defaecating	Caregivers of infected people, health-care workers
Vector-borne	Mosquitoes	Bites from infected mosquitoes	People living in endemic areas

Mode of transmission	Type of transmission	Potential transmission routes	High-risk groups and individuals
	Ticks	Bites from infected ticks	According to season, people living in endemic areas, people who work with livestock in endemic areas, health-care workers
	Fleas	Bites from infected fleas	General community during an outbreak
Perinatal	Human–human	Transplacental transmission	Infants in utero or during labour
Blood transfusions	Direct or indirect	Blood transfusion	People who have blood transfusions
Organ transplants	Direct	Organ transplant	People who have organ transplants

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