**CDC’s Behavioral Investigation and Support for Outbreak Response**

This document provides a step-by-step process of how to conduct a behavioral outbreak investigation. Topics included are:

1. Overview
   1. Outbreak Response Structure
   2. Response Roles and Responsibilities
   3. CDC Collaboration and Reporting
   4. Infection Prevention and Control in the Field
2. Behavioral Science Methods during Outbreak Response
   1. Behavioral interviews
   2. Genealogy of family members of interest
   3. Quarantine safety plan and facilitator guide
3. Language and Cultural Facilitators
   1. Contact information
   2. Languages spoken
   3. Experience
4. **Overview**

Behavioral science is a key component of the overall effort of the CDC response team. Health Promotion team members working with Language and Cultural Facilitators (LCF) gather information during the time preceding, during and after quarantine to assess social and cultural considerations as they pertain to outbreak response activities as well as quarantine requirements.

* 1. Outbreak Response Structure: In the District where the outbreak occurrs, the CDC response team works directly with Response leadership.
  2. Responder Roles and Responsibilities: The District Coordinator (DC) and/or District Medical Officer (DMO) provides oversight of the local outbreak response and works closely with representatives from the Department for International Development (DFID) (United Kingdom) and the Republic of Sierra Leone Armed Forces (RSLAF) on logistics issues and the District Health Medical Team (DHMT) on public health and medical issues. The World Health Organization (WHO) is the lead international medical agency in the field and works in collaboration with the CDC and other NGOs to provide medical and public health technical assistance (e.g. GOAL UK/Ireland, Doctors without Borders, etc.). UNICEF and other UN agencies (e.g. World Food Programme) provide water, food, sanitation supplies and other support in the quarantined community. UNICEF is also the lead of the Social Mobilization Pillar in most Districts and works closely with the NGOs assigned to each District (e.g. Red Cross, Oxfam, Restless Development, etc.). The SocMob Pillar works directly in the quarantined community. SocMob team members talk with community members to keep them abreast of quarantine related information, identify individual and community needs and concerns, and find human/material resources to fill those needs. CDC staff from the Health Promotion team provide technical assistance to the SocMob Pillar by conducting behavioral assessments to identify and resolve community needs/concerns.
  3. CDC Collaboration and Reporting: The CDC response team includes membership from the following teams: epidemiology, infection prevention and control (IPC), health promotion (HP) and when required border health. There may also be vaccine team presence depending on the situation. The CDC response team works collaboratively with each other and through the existing response structure (operational logistics and pillar structure) to carry out their assigned tasks.

While HP staff work with and through the social mobilization pillar, they also work directly with the CDC response team. HP staff should report first to the CDC Response Team Lead and then to other pillar leads and/or organizations as needed. Dissemination of information is handled first by the CDC response team and at the discretion of the CDC Response Team Lead. Given the urgency of activities in the response setting, accurate and timely communication of critical information according to established lines of reporting keeps all parties informed, avoids duplication of effort, and allows team leads to set priorities as to the most urgent activities needed given the current response activities.

Responders working directly in the affected community are required to attend morning and afternoon debriefing sessions held at the field location. The CDC Response Team Lead will report on CDC activities and assign CDC staff to address response needs during and after each meeting.

* 1. Infection Prevention and Control in the Field: HP staff must follow all infection prevention and control (IPC) policies and procedures. Some of these IPC measures include: hand washing stations entering/exiting the quarantine community, wearing closed-toe shoes or boots at all times, staying 3 meters away from all quarantined individuals, not sitting down or laying personal items on surfaces inside the quarantined area, and immediate reporting of any symptoms. Failure to comply with these or other measures will result in immediate removal from the field location and/or possibly being sent home. HP staff should immediately inform the CDC Response Team Lead about any and all symptoms.

1. **Behavioral Science Methods during Outbreak Response**

The role of HP staff is to assist CDC Response Team members in collecting behavioral information regarding EVD cases. HP staff use behavioral science methods to identify potential topics for data collection which enhance and enrich outbreak and quarantine response activities. Surveillance and contact tracing activities especially identifying potential new cases can be challenging in outbreak communities. Fieldwork methods which emphasize rapport building and open-ended questions can provide important supplemental and/or corroborative information not only initially but throughout the entire quarantine period. These methods can also be used after quarantine to conduct debriefing interviews with response team and community members. HP staff are expected to work closely with the Language Cultural Facilitator (LCF) assigned to the District *(see contact information later in document).* The LCFs are not only skilled translators but also experienced interviewers in their own right. They can also provide valuable insights on previous local quarantine experiences as well as historical perspectives on outbreak response efforts in Sierra Leone as a whole.

**HP staff activities should include but are not limited to:**

* + **Behavioral interviews** to better understand critical decision-making prior to identification of the case (e.g. the story/narrative of how the index case became sick and what he/she did in the weeks and days leading up to the illness/death)
  + **Genealogy** of family members of interest (high-risk contacts, missing contacts, etc.) to understand possible transmission chains
  + Training of social mobilizers to create a **quarantine safety plan** for each household in the quarantined community (a plan of action for quarantined community members to know how to deal with potentially ill family members in order to prevent transmission)

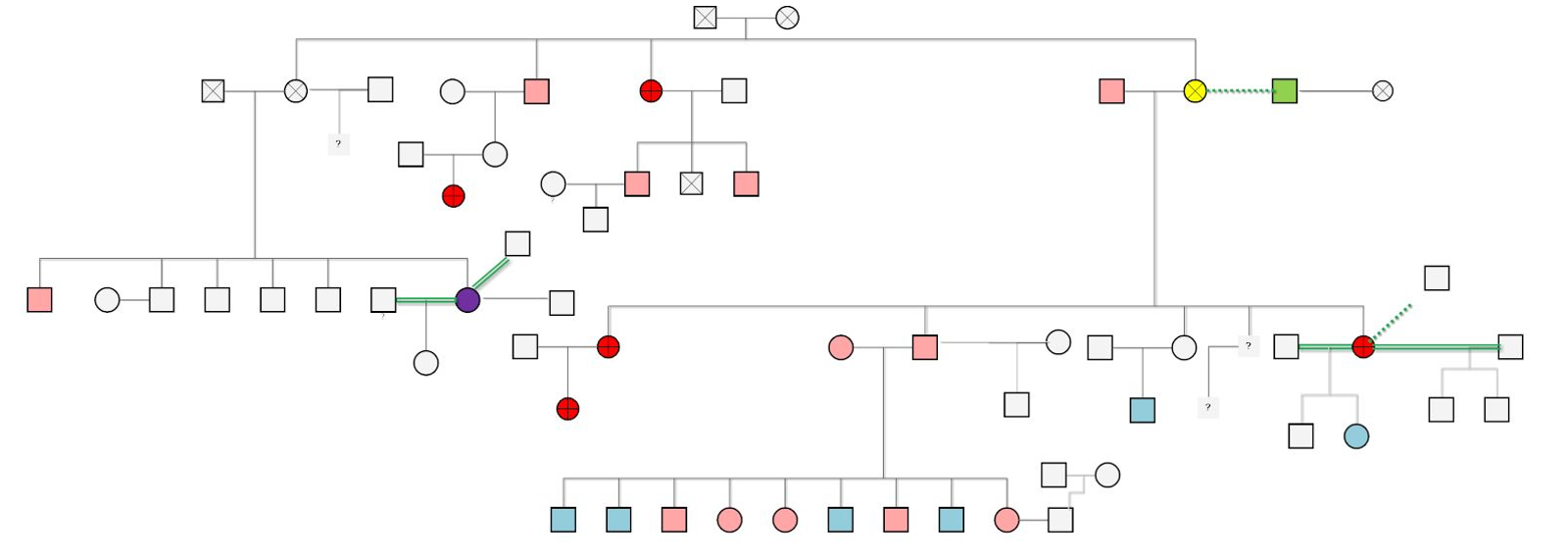
1. ***Behavioral Interviews:*** Behavioral interviews can be conducted to better understand the critical decision-making prior to identification of the case. Below are key questions:
2. **Who?** It is best to interview high-risk contacts and/or those most likely to have been in contact with the index case prior to their diagnosis/death. These individuals are probably the immediate members of the family (relatives) and/or those who live in the same household as the index case. The local chief and members of his household (especially his wife) may provide important clarifications and corroboration to the information and timeline gathered. Close friends (like an age-set member) may also provide additional information and insights.
3. **How?** Use open-ended questions. Since gathering information on potential transmission chains can be challenging given the response environment, it is important that your approach build rapport. During the first 3-4 days after a case is identified, there is a tendency for responders to pepper contacts with lots of specific questions aimed at identifying the who, what, where, and when. Although this information is critically important, similar questions are asked by many different response teams and high-risk contacts tire quickly of answering the same questions repeatedly. By asking questions using an open-ended approach and allowing the respondent to tell their story without interrupting the narrative with a host of detailed-oriented probes, the interview will unfold according to the narrative style of the respondent. Active listening with few interruptions is key. You may want to consider whether your participation in the interview is necessary. Often, translation interrupts narrative flow and your purpose would be better served if the LCF didn’t have to stop and translate for you. If you choose not to participate in the interview, then you need to arrange a note taker to accompany the LCF.
4. **What?** Questions asked during a behavioral investigation are intended to get an in-depth understanding of a variety of topics such as what occurred, who was involved, and how were decisions made by the family before and during illness and, if applicable, at death. It is important to not only understand the event that took place but also why and how the decisions were made. **This is important information to enhance contact tracing as well as to inform social mobilization activities and quarantine safety plans as part of overall efforts to prevent additional transmissions.** As mentioned above, the questions should be asked in a conversational approach and open-ended as much of possible. The questions below are provided to be used as a guide and not intended to be read as a checklist of questions to respondents.
   1. *Event [illness and/or death] questions*
      1. We’re interested in learning about what happened in the days/weeks prior to \_\_\_\_\_ getting sick? I’d like for you to tell me the whole story about how \_\_\_\_\_ got sick and also what he/she did while he/she was sick. You can start from whatever point feels comfortable. If they hesitate or don’t know where to begin, then ask: Maybe you could start by telling me about what was going on around the time before he/she started feeling sick?
      2. How you do you think the family member got sick?
      3. What did you do when you first learned that your family member was sick? Were you one of the caregivers? Who were the caregivers? What roles did each person have? How did people do those roles?
      4. How did you feel when the event occurred?
      5. What did you think was the best way to help your family member who was sick?
      6. What symptoms did your family member have? Had your family member ever had those symptoms before (note: sometimes the first symptoms of Ebola are attributed to an existing chronic conditionand is treated by the family as such)? What type of sickness did you think your family member had? Did you think it may have been Ebola? Why or why not?
      7. How did you get help when you saw that your family member was sick? How long after the symptoms? What type of care was sought (traditional healer, drug peddler, nurse, PHU, 117, etc.).
         1. Was 117 called? Why or why not?
      8. How long was it between when the sick family member first started to feel sick and when help arrived/help was sought? How was that decision made? Who helped make that decision?
      9. What did you do with the items used by the sick family members including clothes, sleeping mats, blankets, towels, etc.
      10. Has anyone been sick, not necessarily from Ebola, in the past month? Maybe from malaria, cholera, or just diarrhea vomiting? Any kind of illness?
   2. *Source of infection*
      1. In the past one month, has the sick family member
         1. Eaten or been around bats or bush meat?
         2. Attended a burial?
         3. Helped with a delivery/childbirth?
         4. Taken care of a sick person? If so, what role did they play? Did they have direct or indirect contact with the sick person’s bodily fluids (saliva, sweat, blood, vomit, diarrhea, semen)?
         5. Had direct or indirect contact with bodily fluids (saliva, sweat, blood, vomit, diarrhea, semen) of a survivor?
         6. Traveled outside of the village? If so, where? Was anyone sick there?
         7. Interacted with someone not from your village who came to your village? If so, where was that person from? Was that person sick?
5. **When?** It is helpful to arrive as early as possible in the outbreak community. Early arrival may mitigate some of the challenges of question-fatigue. You must be mindful, however, of the priority placed on surveillance and contact tracing interviews. It may be difficult to find a time when the high-risk contacts are free long enough to conduct a thorough interview. There are also some distinct downsides to conducting an interview with other responders waiting in the wings or within earshot. Use your best judgement about how to achieve the optimal mix of free time and privacy. The LCF will be a valuable asset to help you negotiate the best potential time for the interview.
6. ***Genealogy of Family Members and Transmission Chains***

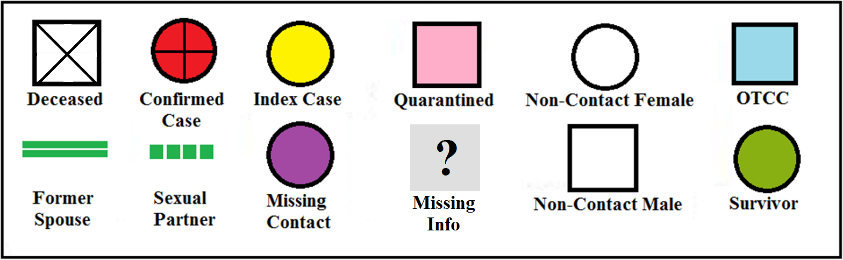
A way to understand the familial relationships and interactions within the homes of high- and low-risk contacts to the index case is to create a family pedigree or family genealogy of the high and low-risk contacts. For each home, identify a family-appointed spokesperson to describe each person living in the home, immediate family members not residing in the home, and household members who have died from Ebola. Data collected should include name, age, gender, relationship to the index care, survivorship status, whether living/deceased, and residence location/name of village.

It may be helpful to identify any fictive kin (non-blood relatives, namesakes, age-set members) living in the community but not in the household. It is not necessary to collect birth/death dates for response purposes.

The most efficient way to collect genealogy information is to get it from more than one source (at least three) in the family of the index case. Start with the immediate members of the family and then work your way further out, collecting information on brothers and sisters of the index case and spouse of the index case to cousins, nieces, nephews, etc. Once you have the preliminary data collected, triangulate it to create a draft family pedigree. Identify any inconsistencies and then re-interview your contacts being sure to address inconsistencies and to collect more information about the extended family. Once you are certain you have identified all those within walking distance of the index case (or in close enough proximity to have had potential contact with the index case during wet symptoms or after death) you can finalize the genealogy. You may wish to present a card-stock or laminated version of the genealogy to the family as a thank-you for their assistance.

Genealogy Example





[Kathy insert description and graph of transmission work here]

1. ***Quarantine Safety Plan***

Quarantined community members will have many questions and concerns about quarantine and about the potential danger they may face having lived in the same community with the index case. The quarantine safety plan (QSP) helps educate community members about quarantine processes and procedures but also includes a behavioral component. That component requires each household to create action plan or QSP which includes identifying one individual who will take responsibility for notifying authorities and caring for a potential EVD case, training on the guidelines and steps for notifying authorities and for dealing with that family member until help arrives (see next section *Quarantine Safety Plan* *and Facilitator Guide* for more detailed information). The recommended approach is to train the social mobilization outreach workers on how to implement the QSP and to have them establish a QSP in each household in the community. HP staff should talk with the Soc Mob Team lead about training the outreach workers.

**Quarantine Safety Plan Facilitator Guide**

This document is designed to be used in conjunction with the Quarantine Safety Plan (QSP) and associated facilitator guide. Quarantined homes should be put in charge of creating their own plan for minimizing the transmission of infection within a quarantine home. For quarantine to be successful, the people quarantined must be empowered and believe that the positive actions they take can make a difference in their health outcomes. This guide uses a motivational interviewing (MI) approach. MI aims to make people more aware of potential problems caused, consequences experienced, and risks faced as the result of a specific behavior. . Task helpful household members figure out on their own

**MATERIALS NEEDED**

* QSP Motivational Interviewing PowerPoint presentation *(for training purposes)*
* Quarantine Safety Plan (QSP)—enough copies for each HH in quarantine
* Quarantine Safety Plan (QSP) Facilitator Guide—enough copies for each social mobilizer
* Education materials: What to expect when you’ve been quarantined flipbook, Get Early Treatment for Ebola, Allow for a Safe Burial when Someone Dies at Home, Know the Early Symptoms of Ebola
  + In general, laminated copies should stay with social mobilizers, non-lamented copies can be left with the homes
* Blackberry or PTL to record geocode information *(if needed)*

**PROCEDURE**

1. **Get permission**
   1. Meet with social mobilization lead and explain the QSP activity and ask to train the social mobilizers in the approach.
2. **Hold training**
   1. If possible, review the QSP Motivational Interviewing PowerPoint presentation
   2. Review QSP and QSP Facilitator Guide
   3. Review IEC materials
3. **Staffing**
   1. Determine which staff needs to be present for the QSP and make arrangements with them for the trip to the quarantined houses. Do social mobilizers need a translator?
4. **Access to the quarantine home(s)**
   1. HP typically works with the Social Mobilizer Pillar and response/taskforce leaders for access to the quarantine homes.
   2. At the VQF, talk with the facility head.
   3. Depending on the situation, the Paramount Chief or headsman may need to be consulted.
5. **Visit each household that is quarantined to create a QSP as follows. Engage the HH using motivational interviewing (see PowerPoint presentation – QSP Motivational Interviewing) and develop their QSP.**
   1. Introduce yourself and your team and tell the household why you are there.
      1. My name is \_\_\_\_\_\_\_\_\_\_\_\_, and I am here with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
      2. We want to first say that we are sorry for your loss and hardship. We know this is a difficult time.
      3. I know many people have come out to your home and asked you questions. I’m sure this has been an overwhelming and trying experience. I will do my best not to take up too much of your time.
      4. We want to help you create a plan to keep your family safe from Ebola and minimize your risk if someone does get sick.
      5. I will take notes while we talk on this form and then give you the form.
   2. Household Quarantine Knowledge
      1. What happened when your house was quarantined?
      2. Why do you think the responders wanted to quarantine your home?
      3. Do you think quarantine helps prevent sickness? Why or why not?
   3. Symptoms of Ebola
      1. How can you tell if someone is sick with Ebola? *(Use this question to help you fill in the symptoms of Ebola portion of the QSP.)*
      2. How do you think Ebola is transferred from one person to another?
      3. Can people survive Ebola? If yes, how?
      4. What are some reasons that someone may not want to tell about their sickness or the sickness of someone else?
      5. What would happen if someone in your home becomes sick with Ebola and they aren’t separated from other people?
   4. If someone becomes sick or passes away in the house
      1. If you were feeling sick or knew someone who was feeling sick, what do you think you should do?
      2. Do you think contact tracers/surveillance should be told about all sickness or only Ebola sickness?
      3. What has happened to homes that hide Ebola sickness from community leaders/contact tracers?
      4. What happens to someone when they leave a quarantine home?
   5. Isolating a sick or dead person until help arrives
      1. How can people stay safe from Ebola?
      2. What does isolating a person mean?
      3. Would you feel comfortable isolating a person?
      4. Where should an isolated person sleep?
      5. Can other people touch an isolated person? Sleep near an isolated person?
   6. Taking care of sick person until help arrives
      1. How do you give an isolated person food? Drink? Medicine?
      2. What should happen to the bowl, cup, an spoon that the sick person has used them?
      3. How many people should provide care to a sick person?
   7. If a loved one passes away in the home
      1. Who should the family contact? How will they do that?
      2. Will the family touch the body?
      3. How does a safe burial take place?
      4. How does the family feel about safe burials?
      5. \*Allow for debate on burials. If home finds safe burials unacceptable, probe into why and what can be done to make the burials acceptable.
   8. Review education materials with HH.
   9. Once you have completed the QSP with the quarantined home, take a picture of form with phone.
   10. Go over the QSP form with the HH and give them the form. **(Note: Once they have touched the form, do not take it back, remember to keep yourself safe.)**
6. **Ongoing follow-up each day of quarantine**
   1. Ask to see the form. Don’t touch. Just check that they know where it is. If it is lost or damaged, make a new one with them.
   2. Ask for them to explain each section of their plan to you to check their memory.
   3. Ask if the HH is in agreement of each section.
   4. Ask if there are any questions or concerns.

**Quarantine Safety Plan**

**Today’s Date: \_\_\_\_\_\_ Chiefdom, Village\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ House Number: \_\_\_\_\_\_\_\_\_\_**

**GPS coordinates: \_\_\_\_\_\_ # people in house: \_\_\_\_\_\_ Last day of this quarantine cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INTRODUCE YOURSELF AND YOUR TEAM**

**HOUSEHOLD (HH) QUARANTINE KNOWLEDGE**

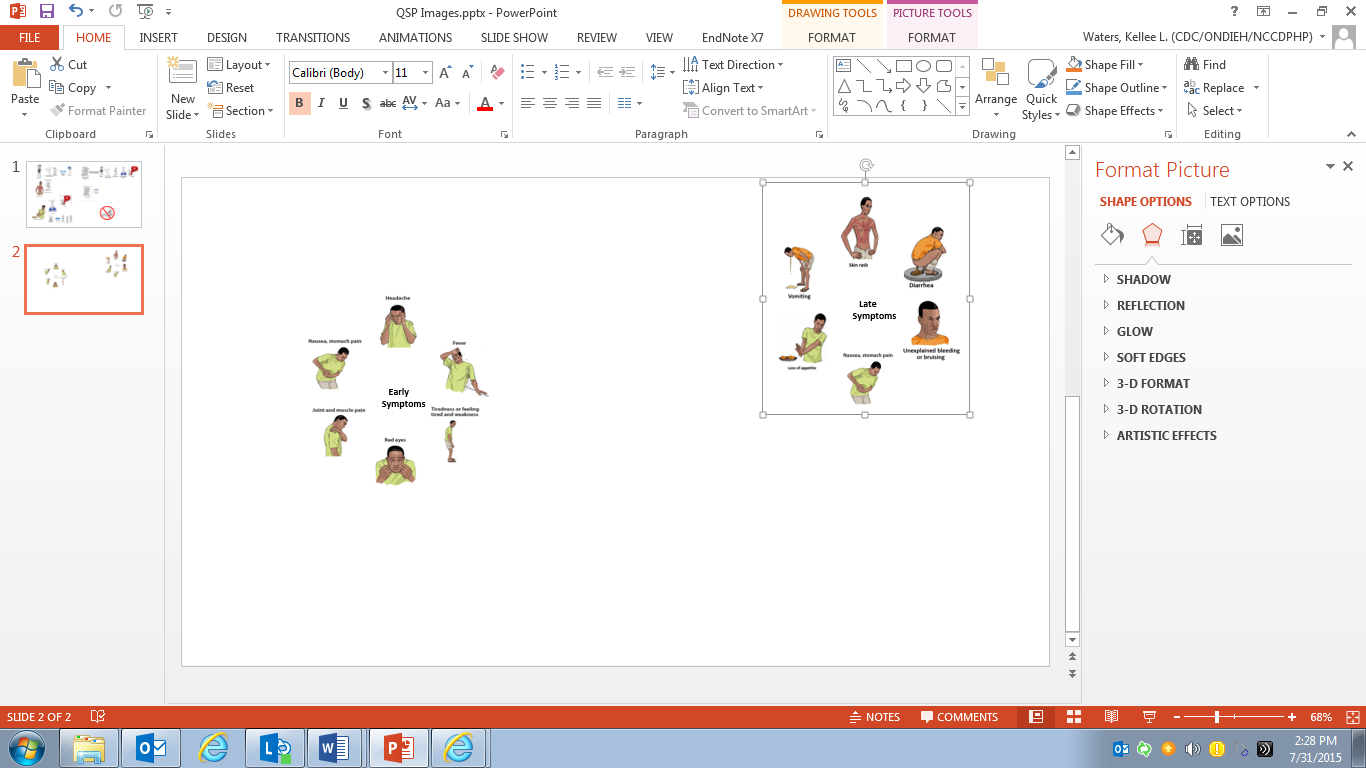
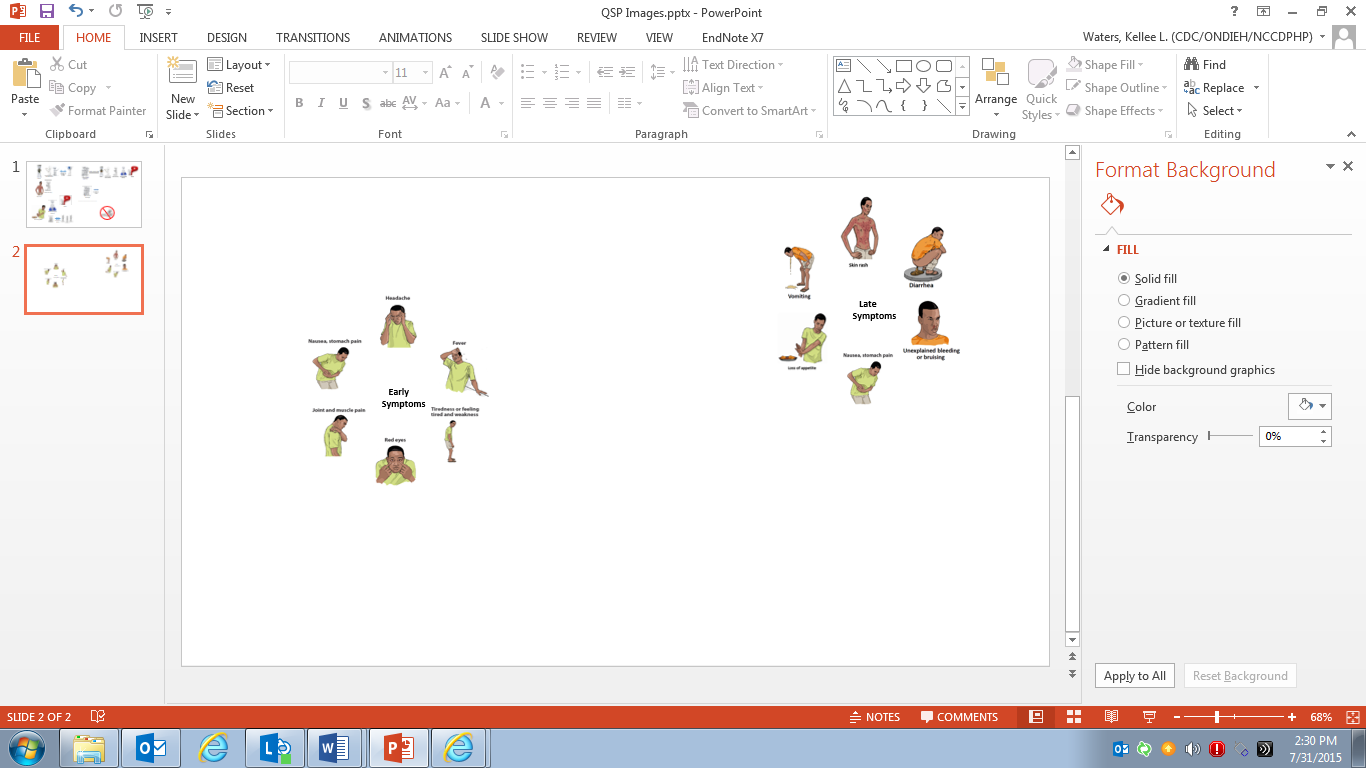
* HH knows number of days left in their quarantine: **Yes No** # of days left: \_\_\_\_\_\_
* HH understands why they are quarantined (breaks cycle of transmission): **Yes No**
* HH understands that infection to onset of symptoms can be up to 21 days: **Yes No**

**PERSONS IN CHARGE OF THE PLAN** *(needs to be able to read English)*

* Primary person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Secondary person: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SYMPTOMS OF EBOLA**

*(First, ask HH to describe symptoms, circle the ones they mention. Then, go over diagram with them, emphasizing the importance of reporting at the first sign of ANY symptoms)*

**Early symptoms:** Headache, fever, tired, weak, red eyes, muscle/joint pain, nausea/stomach pain

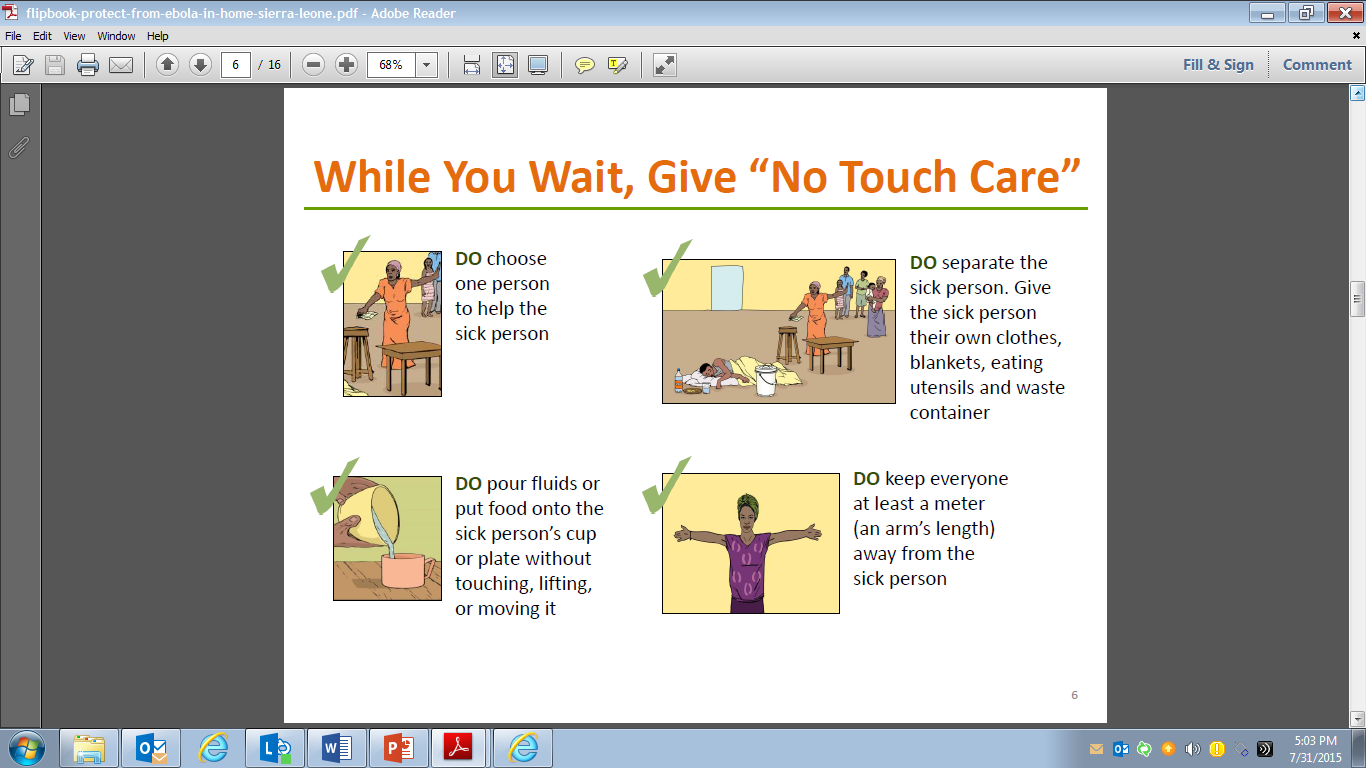
**Late symptoms**: rash, diarrhea, bleeding, loss of appetite, vomiting

* Is HH clear on the early and late symptoms? **Yes No** *(if no, clarify)*
* Does HH understand to contact help at first sign of ANY symptoms? **Yes No** *(if no, clarify)*

**IF SOMEONE BECOMES SICK OR PASSES AWAY IN THE HOUSE**

* Who will be responsible for calling for help/reporting the death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Who is the alternate if the first person is sick? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who will be called/notified that there is a sick person in the house?
  + Option 1 (and number, if applicable): \_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Option 2 (and number, if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* If someone becomes sick or dies at night and responders are not around, who will be notified?
  + Option 1 (and number, if applicable): \_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Option 2 (and number, if applicable): \_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is cell phone charged? **Yes No** *(if no, make a plan to get charged)*
* Does cell phone have credits to make a call? **Yes No** *(if no, make a plan for credits)*
* Does the family agree on this approach? **Yes No** *(if no, find agreement)*

**ISOLATING A SICK OR DEAD PERSON UNTIL HELP ARRIVES**

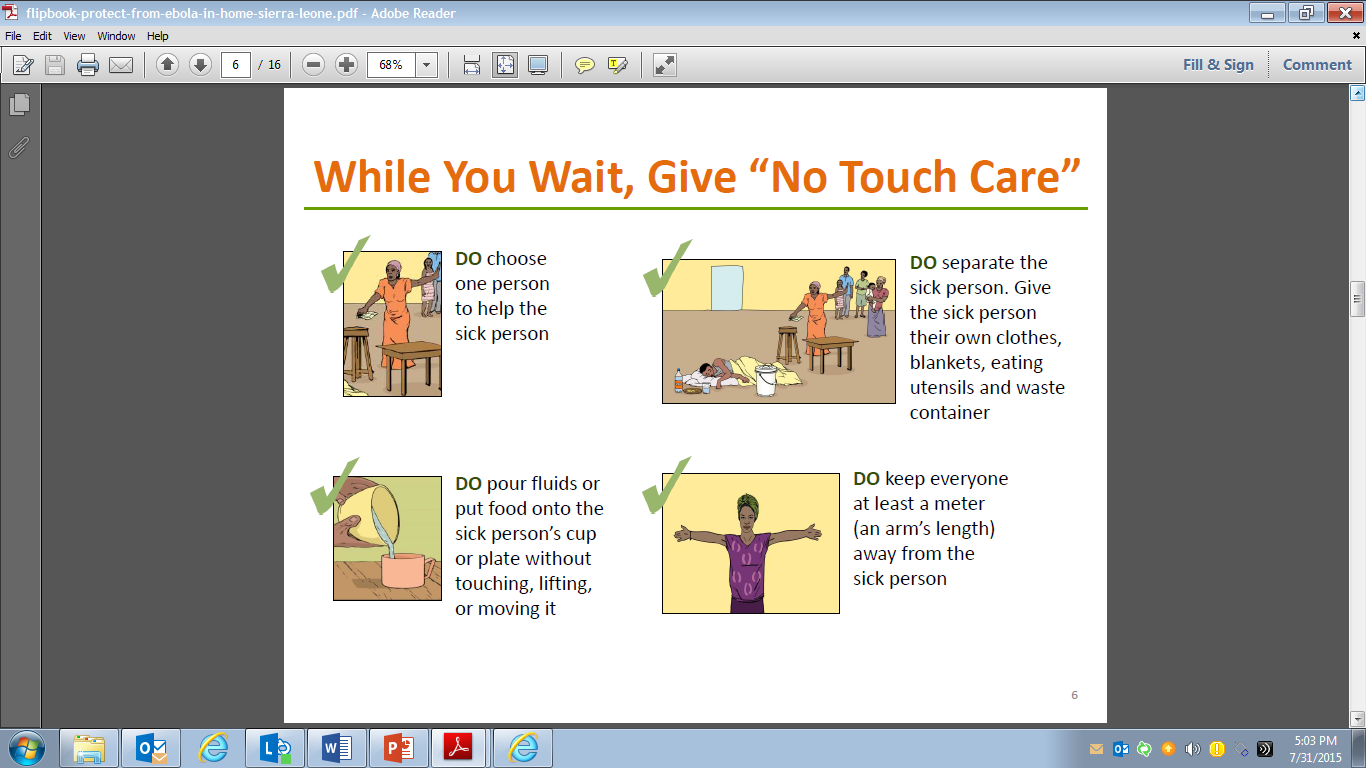


* Where in the house will the sick person be isolated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_
* If the sick person is not able to walk to the isolation area, how will the HH isolate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Who should stay in the room with the sick person? \_\_No one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who should touch the sick/dead person? \_\_\_ No one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who will identify the things that the sick/dead person has touched and make sure that no one touches them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does the family agree on this approach? **Yes No** *(if no, find agreement)*

**TAKING CARE OF A SICK PERSON UNTIL HELP ARRIVES**



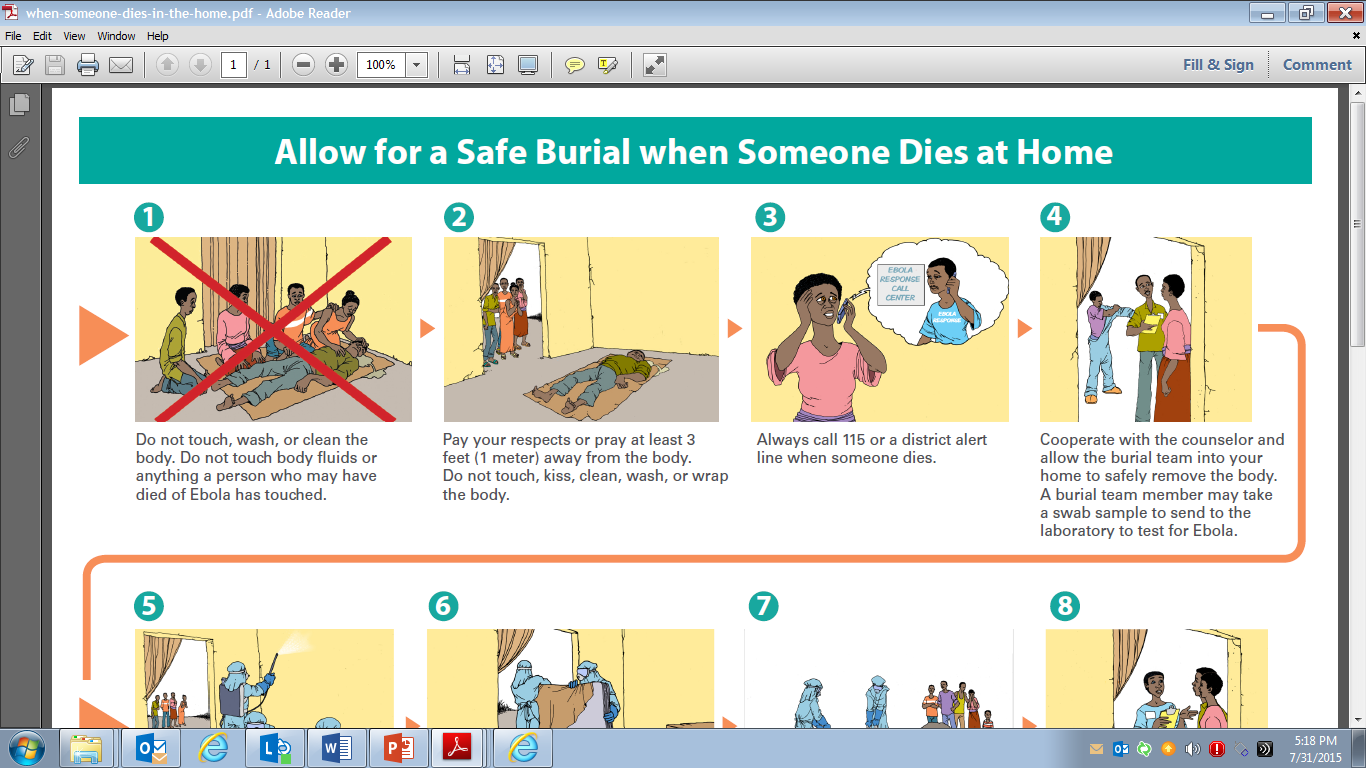
* Who will be the single caregiver? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Who is the alternate if this person is sick? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is there an extra bowl, cup and spoon that can be used ONLY by the sick person? **Yes No** 
  + *If yes, ask the single caregiver to show you the bowl, cup and spoon so the family can mutually agree that is what will be used.*
  + *If no, make a note to ask the Response Leadership for supplies to be brought to the house.*
* Demonstrate to family how to feed and give water without touching using the plastic cups and bowls.
  + Ask the two single caregivers to practice right now and have family help correct process

***House Number: \_\_\_\_\_\_\_\_\_\_***

* Does the family agree on this approach? **Yes No** *(if no, find agreement)*

**IF A LOVED ONE PASSES AWAY**

* Who should touch the dead person? \_\_\_ No one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who will make sure that no one touches the things that the dead person has touched, including their bowl, cup and spoon? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Does the family agree on this approach? **Yes No** *(if no, go back and find agreement)*



**ADDITIONAL IMPORTANT PHONE NUMBERS**

* person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discuss any fears, concerns, or questions about quarantine, PHU, 117, ambulances, ETC.**

**REVIEW EDUCATION MATERIALS WITH EACH HOUSEHOLD**

**NOTES**

***House Number: \_\_\_\_\_\_\_\_\_\_***

**Language and Cultural Facilitators**

**NOTE: Prior to contacting an LCF, discuss with Laura Shelby (**[**lks2@cdc.gov**](mailto:lks2@cdc.gov)**) as LCFs are set up on an at-need day rate funded by e-Health. Laura is the point of contact for the e-Health mechanism. Also, note that the LCFs may be employed and not able to respond to a case. CDC would be asking for their availability to help.**

**Contact Information and Languages**

* Alhaji Amadu Barrie: 088-766-207 / 078-941-038 / 078-327-100
  + Krio, Fullah, Temne
  + *Note: Provided behavioral investigation support to the last case in Sierra Leone (Bombali), also experience in Tonkolilli, Kambia and Western Area, helped developed the genealogy approach , conducted many behavioral assessments, in-depth interviews and focus group discussions (using open-ended questions with probes)*
* Gibrilla Kamara: 088-247-609
  + Krio, Limba and basic Temne
  + *Note: Provided behavioral investigation support to the second to last case in Sierra Leone (Kambia), extensive experience in Kambia including work in quarantined communities, helped developed the genealogy approach, conducted many behavioral assessments, in-depth interviews and focus group discussions (using open-ended questions with probes)*
* Hindolo John Langba: 077-259-536 / 088-766-053
  + Krio, Mende
  + *Note: Extensive experience in Western Area, some experience in Kambia, conducted many behavioral assessments, in-depth interviews and focus group discussions (using open-ended questions with probes)*
* Soriba Suma: 088-766-296 / 077-355-009
  + Krio, Temne, Susu, Bullom
  + *Note: Extensive experience in Port Loko, conducted many behavioral assessments, helped develop the quarantine safety plan, conducted many behavioral assessments, in-depth interviews and focus group discussions (using open-ended questions with probes)*
* Lucian Fahnbulleh: 076-295-171 / 079-252-065 / 088-765-135
  + Krio, Mende
  + *Note: Extensive experience working with CDC’s vaccine trial (STRIVE), some experience in Western, has not worked an outbreak investigation, some experience conducting focus group discussions.*