Community Engagement and Education, Recruitment and Retention of People Recovered from Ebola as Potential Donors for Convalescent Whole Blood and Plasma

Interim guidance for National Health Authorities, Blood Transfusion Services and Researchers

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Terms and abbreviations used in the text

BTS    Blood transfusion service
CBO    Community-based organizations
CCC    Community care centre
CET    Community engagement teams
COMBI Communication for behaviour impact
CP     Convalescent plasma
CWB    Convalescent whole blood
EVD    Ebola virus disease
ETU    Ebola treatment unit
FBO    Faith-based organization
GPP    Good participatory practice
HIC DARM  Hear about a behaviour, be Informed about it, become Convincing that it is worthwhile, Decide something about the conviction, Act on the new behaviour, Reinforce the action by feeling satisfied and participating, and Maintain behaviour
MEURI Monitored emergency use of unregistered interventions
MoU    Memorandum of Understanding
NGO    Non-governmental organization
NBTS   National blood transfusion service
SOP    Standard operating procedure
1. Introduction

During the current Ebola virus disease (EVD) outbreak, whole blood and plasma collected from people recovered from EVD has been prioritized for investigation, as one of the treatment modalities to be tested. That this treatment could be efficacious is biologically plausible, as blood donations from recovered individuals could quite likely contain protective antibodies against the virus and these could enhance the immunity of EVD patients when transfused. Anecdotal experience and animal studies suggest that passive antibody therapy can ameliorate the clinical disease. Convalescent or immune plasma (containing antibodies against an infectious agent) has already been used for the treatment of illnesses caused by a variety of infectious agents.  

2. Purpose of this document

This document provides interim guidance and outlines key considerations to enable national health authorities, programme managers in the ministries of health, blood transfusion services (BTS) and organizations conducting clinical trials, to effectively inform, educate and engage people recovered from Ebola and the communities in which they live, to consider donations of convalescent whole blood (CWB) and convalescent plasma (CP) for use in the treatment of EVD, including for use in clinical trials in the affected countries. Many of the same considerations are also relevant to the acceptability of CWB/CP treatment among patients with EVD. Inappropriate and/or insufficient community awareness, information and engagement can place additional pressure and cause anxiety and distress to these already vulnerable groups.

Well-planned, well-executed and responsive communication strategies will build trust between field operation teams, people recovered from EVD, health service providers, patients with EVD including clinical trial participants and local communities, as well as policy and decision-makers.

This document draws on the WHO global framework for action “Towards 100% voluntary blood donation”, field reports and expert advice, and has adapted the community engagement model developed by WHO and UNICEF for the rapid introduction of Ebola treatment units (ETU) and community care centres (CCC) in the affected countries.

The proposed framework and strategic interventions should serve as generic guidance and be further subject to local adaptation needs.

3. Blood donation from people recovered from EVD

3.1 Principles of voluntary non-remunerated blood donation

All blood and plasma donation should be performed on a voluntary basis, and subject to stringent ethical and medical criteria.

Voluntary non-remunerated blood donation from EVD recovered people should be compatible with the principles of blood donation from special donors, ensuring that the person about to donate has reached a health status allowing this process without harm (for donor or recipient),

1 WHO interim guidelines on use of convalescent whole blood and plasma. Version 1.0 September 2014
4 Burnouf T, Seghatchian J: Ebola virus convalescent blood products: where we are and where we may need to go; Transf and Apher Sci 2014; 51(2):120-125
5 Towards 100% voluntary blood donation’ A global framework for action, WHO 2010
6 A model for the Systematic preparation and Engagement of Communities for the Safe and Rapid Introduction of Ebola Care Units or Community care centres, WHO-UNICEF
that the person is not subject to moral pressure (i.e. survivor’s guilt) or other means of coercion to undertake this gesture, and that there are no monetary benefits to doing it.

An EVD convalescent/recovered status is mandatory for selection and should be verified prior to donor enrolment. The EVD recovered person donating blood should comply with the national blood donor selection criteria, and should undertake the standardised procedure following pre-donation counselling and informed consent.

Donation should be anonymous and donor data covered by confidentiality.

‘A voluntary non-remunerated blood donor gives blood, plasma or cellular components of his or her own free will and receives no payment, either in the form of cash or in kind, which could be considered a substitute for money. This would include time off work, other than that reasonably needed for the donation and travel. Small tokens, refreshments and reimbursement of direct travel costs are, however, considered compatible with voluntary non-remunerated blood donation’. 7

Provision of recovery support packages by a designated agency, and in the context of national or local rehabilitation programmes, does not conflict with the principles of voluntary non-remunerated blood donation.

For this group of special donors, preference should be given for plasma collection where this can be done safely either by separation or by apheresis. Continuing long-term collection of convalescent plasma from these donors would depend on the country needs for convalescent products. It is recommended that the inclusion of EVD recovered people in the general donor pool should be delayed by at least one year after recovery.

3.2 Ethical considerations8 for blood donations for clinical trials and for compassionate use

Since there is an urgent need to generate evidence on the safety and efficacy of CWB and CP, it is ethically relevant that these interventions be provided – to the greatest extent possible – to patients within scientifically robust research studies. These studies should be governed by research ethics guidelines, and recipients and donors who are participants in research should be treated according to the standards established in these guidelines.9 Patients who are otherwise eligible to receive these interventions but do not fulfil the research criteria should be offered these in the context of MEURI10. Informed consent forms the basis of all transfusion, whatever the context.

Potential donors of CWB/CP have recently recovered from a disease with a high case fatality rate and it should be kept in mind that when first approached, they may not be ready for donation either for physical or psychological reasons (or both), but may feel compelled to accept doing so due to societal pressures. Therefore counselling – that is independent of the transfusion services – should be made available to all potential donors to support them in their decision-making. A refusal to donate at a given time does not preclude a donation at a later stage, when the donor is more ready to donate, feeling both physically and psychologically stronger. The stigma of EVD increases donor’s vulnerability and care should be taken not to break confidentiality, or their trust.

Transparency in all aspects, including communicating about the uncertainty in relation to the therapeutic use of CP/CWB will go a long way to maintaining trust. All donations should be

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7 Towards 100% voluntary blood donation’ A global framework for action, WHO 2010
8 For detailed guidance on the ethics of use of convalescent whole blood and plasma during the Ebola epidemic, please refer to the corresponding WHO publication (under development)
10 MEURI, monitored emergency use of unregistered interventions, is a term coined by WHO in the context of the Ebola outbreak, to refer to the exceptional use of experimental interventions for therapeutic purposes, and to reflect the urgent need to collect data on their efficacy and safety. (http://apps.who.int/iris/bitstream/10665/137509/1/WHO_HIS_KER_GHE_14.2_eng.pdf)
preceded by an informed consent, clearly indicating the use of the donation in a research setting. All messages should be conveyed in simple terms, using language that the donor understands. Since research concepts, including the uncertainties of research may not be well understood in many communities, community engagement activities should include messages that explain the concepts of research, the contribution of research to generating knowledge, the availability of counselling services and the oversight provided by research ethics committees.

4. Community engagement to support CWB/CP donation from EVD recovered people

4.1 Principles of community engagement to CWB/CP donation

Community engagement strategies should be informed by the local factors that shape the values, beliefs, attitudes, behaviours and practices around donating blood or plasma and receiving blood products as transfusion.

Lessons learned from interventions against HIV/AIDS\(^\text{11}\) emphasize the importance of addressing the societal response to EVD survivors: engaging with the families and communities where the people recovered from Ebola live, to ensure that these individuals are not subjected to stigma and discrimination, and that myths and false information are dealt with promptly.

A safe environment that addresses the health, psychological and social needs of people recovered from Ebola is crucial to establish their structured and systematic engagement in a donation programme.

Acknowledging a set of shared values among the stakeholders will ensure that community engagement is taken into account in the provision of convalescent blood and plasma for the empirical treatment of EVD or for clinical trials (Annex 1). Good participatory practice principles\(^\text{12}\) are fundamental to sustain the partnership and achieve planned goals. Based on a common understanding between stakeholders over objectives and ways to achieve them, these include:

- **Respect Autonomy** of communities and individuals, observing context, and local values;
- **Protect Rights** of communities and individuals, observing ethical integrity of the process;
- **Fulfill Responsibilities** towards communities and individuals, so that the highest scientific and ethical standards will be adhered to (scientific and ethical integrity), with full transparency and accountability over processes and results.

4.2 Contextual considerations for community engagement of EVD survivors

Early in the epidemic, reports from anthropologists\(^\text{13,14}\) and response staff working in Ebola affected countries described a general sense of fear in seeking early care from the ETU. Many rumours circulated causing distress and deepening distrust in medical services, especially related to Ebola. Because of the high mortality rates, and the initial lack of safe and well-equipped health-care facilities, anxiety was high, preventing successful implementation of interventions. In some places, health workers were afraid of becoming infected.


\(^{12}\) Good participatory practice guidelines for biomedical HIV prevention trials, 2\(^{nd}\) edition, UNAIDS/AVAC, 2011

\(^{13}\) Omidian et al: Medical Anthropology Study of the Ebola Virus Disease (EVD) Outbreak in Liberia/West Africa

\(^{14}\) http://www.ebola-anthropology.net/ accessed 26 November 2014
In addition, people who have recovered from the disease have often then faced rejection, stigmatization, discrimination and prejudice from their community and society at large. Such attitudes have been affecting survivors’ quality of life, their morale, confidence and trust in the people they call their family and community. To mitigate the occurring hardships\textsuperscript{15}, they have organized themselves in groups and networks in the affected countries.

Raising awareness of the special and heroic role these people can play in the community could be an opportunity to enhance social reintegration of the recovered person and to develop and strengthen a local culture of blood donation. Furthermore, a positive blood or plasma donation experience, staff empathy and donor care can foster the retention of these individuals as regular blood donors after the deferral period defined by the national guidelines.

In Ebola-affected countries, the annual supply of donated blood covers only up to 45% of the estimated national transfusion needs\textsuperscript{16} already flagging the low prioritization of blood donation in normal times, and a need for a new impetus given to the NBTS as a whole.

Several important facts need to be taken into account in this context dominated by scarce resources, lack of substantive health-care infrastructure, and low levels of literacy:\textsuperscript{17,18}

- A high level of solidarity foundation has been documented to exist in many African societies by anthropological and sociological research.
- The fear of Ebola and rejection of people recovered from EVD is attributable to a lack of knowledge, limited understanding, and traditional beliefs linked to lethal diseases, survivors and blood.
- The societal disruption created by the disease outbreak has resulted in people recovered from EVD being isolated, to the point of lacking basic living commodities and medical follow-up.
- The scarcity and sometimes the non-acceptance by communities of the ETU and CCC where these have been established, and the underlying disintegrated health-care infrastructure contribute to the lack of capacity for post-disease care.
- The BTS, where activities about blood donor education, selection and retention are undertaken, and collection of blood and plasma take place, in most instances are located in hospital laboratories, and are inadequate, often poorly equipped and staffed.

4.3 Integrated community engagement for multi-stakeholder mobilization

A collaborative model for dialogue and engagement\textsuperscript{19} should foster participatory approaches in making the process of EVD convalescent blood and plasma donation understood by and acceptable to the community (see box: EVD survivors in Firestone district, Liberia, 2014).

\textsuperscript{15}http://ebolasources.Wordpress.com/ accessed 26 November 2014

\textsuperscript{16}WHO Global Database for Blood safety, accessed 26 November 2014

\textsuperscript{17}Study on public knowledge, attitudes and practices relating to Ebola virus disease prevention and medical care in Sierra Leone, Catholic Relief Services, Focus 1000, UNICEF, September 2014


\textsuperscript{19}Communication for behavioural impact (COMBI), a toolkit for behavioural and social communication in outbreak response, section 4: Essential resources, case studies and fact sheets, 67-108, 2012, UNICEF-FAO-WHO
The national emergency response led by the Ministry of Health and the national social mobilization task team for Ebola response (with international partners) provides the political umbrella and an entry point for the planned intervention.

The analysis of stakeholders involved aims to ensure the mapping and alignment of key players who engage directly or indirectly in this process and can influence the perceptions, understanding, and actions of clinical trials’ participants and their local communities. These stakeholders could be largely grouped into policy/decision-makers (including village chiefs, religious leaders and other traditional and administrative authorities); health service providers (that would include formalized care, medical staff, traditional healers and BTS); field operators (including the communication engagement team, district health teams, investigators); and the general public with two broad inclusive categories: the community at large with its various layers, and the people recovered from EVD that currently represent a vulnerable group of the larger community. The NGO sector (including Red Cross, faith-based organizations, support organizations) and the media appear active in all above categories (see box: Communication during Ebola outbreak in Sudan, in 2004).

The information and communication methods targeting each of these groups should be guided by anthropological understanding of local beliefs, values and practices around blood, and supported by robust advocacy (Annex 2).

Knowledge of attitudes towards the benefits perceived regarding the prevalence of donating blood outside the context of EVD will help synergise existing positive patterns of action in the service of this particular circumstance, and facilitate understanding of existing barriers from low donation practice combined with the Ebola-specific challenges.

A community engagement plan should be developed and should articulate with other community engagement interventions foreseeing use of already existing operational structures on the ground. A non-exhaustive list of expected outcomes for every stakeholder category is presented in table 1.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Expected outcomes</th>
</tr>
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<tbody>
<tr>
<td>People recovered from Ebola in communities</td>
<td>• People recovered from EVD willing to volunteer and be blood donors</td>
</tr>
<tr>
<td></td>
<td>• Donors confident of being able to understand the rationale of the intervention</td>
</tr>
<tr>
<td></td>
<td>and give informed consent</td>
</tr>
<tr>
<td></td>
<td>• Donors keen to engage in presenting their experience and inviting other recovered people to donate</td>
</tr>
<tr>
<td></td>
<td>• Communities genuinely involved in the development of procedures for information and education materials</td>
</tr>
<tr>
<td></td>
<td>• Communities committed to supporting donations of CWB/CP for</td>
</tr>
<tr>
<td>Field operators, investigators</td>
<td>Field operators understand and are able to clearly explain the purpose and rationale of the interventions and the importance of community engagement</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Investigators respect the rights of blood donors and communities</td>
</tr>
<tr>
<td></td>
<td>Fulfil responsibilities towards communities and individuals</td>
</tr>
<tr>
<td></td>
<td>Work to the highest scientific and ethical standards</td>
</tr>
<tr>
<td></td>
<td>Build mutual understanding, transparency and accountability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health service delivery/providers</th>
<th>Service providers understand and are able to clearly explain the purpose and rationale of the interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service providers able to establish empathetic and trustful relationships with clinical trial participants and their families</td>
</tr>
<tr>
<td></td>
<td>Good working relationship between professional groups, clinical settings and blood services with the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision-makers, policy officials</th>
<th>Supportive and clearly articulated policy developed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy and decision-makers fully informed and regularly briefed</td>
</tr>
<tr>
<td></td>
<td>Endorsement by ‘chiefs’ (communities, corporations, religious groups) to policy actions reducing stigma and motivating donors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General public</th>
<th>General awareness and understanding of purpose and rationale of interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recognition of potential blood donors in their ‘medical benefactor’ role for the community</td>
</tr>
<tr>
<td></td>
<td>Neighbouring communities able to understand/accept the rationale of choice of location/sites for EVD treatment including clinical trials and participants</td>
</tr>
<tr>
<td></td>
<td>Mitigation of fear, anxieties that could lead to compromising the integrity of the empirical treatment with convalescent blood and plasma including clinical trials</td>
</tr>
<tr>
<td></td>
<td>Societal involvement in identifying solutions to problems encountered in relation to EVD recovered people and other aspects of Ebola response</td>
</tr>
</tbody>
</table>

Irrespective of the channels of communication used, information consistency and uniformity should be maintained, constantly keeping in mind the existing cultural norms and practices.

All blood and plasma donation should be voluntary and appropriate ethical considerations should be observed in the process of donation of blood and plasma from people recovered from Ebola and their retention as regular blood donors. Ethical criteria should include: transparency about all aspects of medical selection and care; informed consent; freedom of choice; confidentiality; respect for the person; preservation of their dignity; and involvement of the community.

When planning for clinical trials implementation, the following should be given full consideration:

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21 A code of ethics for blood donation and transfusion, ISBT, adopted 2000, amended 2006
• Pondering the unforeseen termination of clinical trials due to evidence of harm to the donor or the patient, and a plan for mitigating actions, should this occur
• Providing participants with sufficient information related to the trial development and results
• Discussing with stakeholders (before initiating the clinical trial) the plan to disseminate results, including expectations, timelines, key messages, implications of the clinical trials, ownership of data and record keeping.

There is a moral obligation to collect and share all data generated, including from treatments provided for compassionate use and clinical trials once available, to foster transparency and trust of the community.

5. Strategies for the mobilization of people recovered from EVD as potential donors of CWB and CP

The acceptability and willingness of people recovered from EVD to donate blood or plasma need to be understood within the overall context of this outbreak with widespread transmission of EVD, i.e. cultural, organizational, social, political and economic setting. Demystification and upholding each individual’s respect, rights, wellbeing and avoidance of exploitation by market forces will restore the self-esteem and trust of EVD recovered people. It will also motivate them to adopt a new behaviour, and help others by donating blood.

The four Cs of integrated marketing communication illustrate the phases of adopting a new behaviour (see table 2): Consumer focus, Cost as effort and opportunity, Convenience of behaviour and access and Communication that shares the previous three Cs with the consumer. Segmentation of the audience for tailored intervention uses the HIC-DARM acronym detailed below.

Table 2: The HIC-DARM acronym

<table>
<thead>
<tr>
<th>First we</th>
<th>Hear about the behaviour</th>
</tr>
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<tbody>
<tr>
<td>then we are</td>
<td>Informed about it</td>
</tr>
<tr>
<td>and later</td>
<td>Convinced that it is worthwhile</td>
</tr>
<tr>
<td>In time, we</td>
<td>Decide to act on the new behaviour</td>
</tr>
<tr>
<td>and later we</td>
<td>Act on the new behaviour</td>
</tr>
<tr>
<td>We then</td>
<td>Reinforce our action by feeling satisfied about carrying out the behaviour</td>
</tr>
<tr>
<td>If all is well, we</td>
<td>Maintain the behaviour</td>
</tr>
</tbody>
</table>

Multilevel community-based advocacy programmes, interventions and ongoing field research that understands how information, education and communication messages are perceived by

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22 Ethical considerations for use of unregistered interventions for Ebola virus disease: Report of an advisory panel to WHO
23 Towards 100% voluntary blood donation - A global framework for action, WHO 2010
24 The pivotal role of faith leaders in the Ebola virus disease outbreak in West Africa, CAFOD http://www.cafod.org.uk/
26 Blood donor counselling Implementation guidelines, WHO-CDC-IFRC, 2014
people and how queries and doubts are responded to and addressed, rest at the core of all strategies.

Key community engagement and donor mobilization strategies include:

• Strategy 1: Engagement: Reach and engage communities, potential donors and stakeholders to reduce stigma and support people recovered from EVD, for the donation of CWB/CP for EVD empirical treatment, including clinical trials

• Strategy 2: Education and recruitment: Educate and recruit people recovered from EVD to donate CWB/CP, and provide quality donor care and service

• Strategy 3: Retention: Retain CWB/CP donors as regular donors, and as general blood donors for the longer term.

Government commitment, support and leadership, effective and efficient use of resources – technical, financial, availability of basic necessary infrastructure facilities, equipment for implementing the strategies are crucial.

**Strategy 1: Engagement:** Reach and engage communities, potential donors and stakeholders to reduce stigma and support people recovered from EVD, for the donation of CWB/CP for EVD empirical treatment including clinical trials.

**Objectives:**

I. Advocacy and communication fostering a positive attitude towards convalescent whole blood and plasma donation

   • Understand people recovered from EVD in the context of psychological trauma (loss and/or isolation) and economic hardship, focus on listening

   • Inform and educate people recovered from EVD and their communities to demystify EVD, explain prevention, and the role that CWB/CP can play in treatment

   • Advocate for community involvement in EVD survivor and patient support.

The stigma related to survival from a highly infectious, life-threatening disease, often combined with related economic hardship (loss of personal effects, loss of jobs) places people recovered from EVD in a highly vulnerable position. Many are already involved in outreach teams, and participate in activities related to outbreak management. Participation in a blood donation programme for compassionate use in the treatment of EVD patients, including clinical trials to validate this treatment, has the potential of re-enhancing self-determination and social integration of the recovered individuals.

Full transparency over the scope, requirements, outcome and importance of CWB/CP donation given in clear and simple language is likely to motivate this heterogeneous group of people (all ages and education levels) to donate. Recognizing that not all EVD recovered people will qualify as CWB/CP donors, care should be taken not to stigmatize candidate donors who fail to meet eligibility criteria (subject to either temporary or permanent deferral).

Information is fundamental in overcoming fear, and building and maintaining public confidence towards people recovered from EVD and the blood donation process. Endorsement by opinion
leaders, whether from communities, corporations or religious groups can be decisive in reducing stigma and motivating donors. Local authorities, traditional media and community leaders in formal and informal networks (faith leaders, village chiefs, traditional healers, elders of the community, survivor organizations) could be effective channels to disseminate this information.

A Community Engagement Team (CET), responsible for reaching out and coordinating community education and participation, if already constituted, can work in close collaboration with the National Blood Transfusion Service (NBTS) and the ETU/CCC staff to initiate the programme for donation of CWB/CP.

II. Organizational aspects facilitating a conducive environment for CWB/CP donation:

- Build on pre-existing resources, the work of the NBTS, Red Cross societies and other organizations involved in blood donation.
- Make use of the existing infrastructure of ETUs or defined hospital sites in urban or rural areas
  - as information channels aimed at people recovered from EVD: i.e. inform during their discharge of the possibility of becoming a blood donor for CWB/CP;
  - to establish donation sites where feasible, making a clear separation between the blood donation and the patient treatment areas.
- Train staff and volunteers involved in the promotion of blood donation/collection/donor care, and consider their outreach in the community as part of cohesive education programmes.
- Establish and maintain a database/register of potential donors from people recovered from EVD, linked with the national EVD survivor registry where constituted as in Sierra Leone.

Protecting the health and safety of donors and staff is a central responsibility of the blood transfusion service/health service where these activities occur. This requires physical infrastructure and basic amenities for each stage of blood donation and collection process complying with safety standards. It includes space for post-donation observation and provisions for managing potential donor adverse reactions, and effective storage facilities for collected blood (reliable cold chain).

Staff trained in blood donor education, donor selection, blood collection and donor care should receive specialized training in communication for effective and empathic interactions with people recovered from EVD. Particular attention is required in pre- and post-donation counselling and informed consent procedures.

Data pertaining to people recovered from EVD from hospitals and ETU/CCCs collated at local/regional/national level should be used for verification, post-disease health status monitoring, and to identify individuals suitable for blood donation. A dedicated donor database/register (drawing from national EVD survivor data) should be established, covered by full confidentiality.

III. Partnership in mobilizing community partners and networks for initiating and maintaining convalescent whole blood and plasma donations
This complex process requires the joining of forces (national and international on the ground) in refurbishing existing infrastructure, common use of physical locations suitable for donation and counselling, provision of training courses to staff and volunteers, sharing information and supporting the professional and social networks. The involvement in/of national survivor conferences (e.g. October 2014 event supported by UNICEF in Kenema, Sierra Leone31, and January 2015 in Monrovia, Liberia) can provide through better understanding and advocacy, an information and education platform to enhance this work.

**Strategy 2: Education and Recruitment:** Educate and recruit people recovered from Ebola to donate CWB/CP, and provide quality donor care and service

**Objectives:**

I. Make donation sites reachable and provide pre-donation counselling

II. Assess suitability of people recovered from Ebola for donation and obtain informed consent

III. Make blood donation a pleasant and empowering experience

IV. Follow up with recognition of the CWB/CP donation gesture (see strategy 3).

Donation sites have to be prepared to receive these special donors, in terms of staff and logistics. The BTS are based within the hospital premises in most cases, in the affected countries, and EVD recovered people are geographically scattered. Donation arrangements should consider the best options available in each context (mobile versus fixed donation venues), to increase donor accessibility to the donation site.

Transportation could be provided for potential donors from and to specified donation sites according to a planned schedule. Streamlining the donation process through an appointment system could help reduce waiting time and donor anxiety.

The designated site for donation from EVD recovered people should be separate from usual blood donation, to avoid a potential negative impact on general blood donations and to ensure appropriate handling of this special donor group and collected CWB/CP.

The process and outcome should be clearly explained to the potential blood donor for an informed consent for the procedure32. The role of the family/household, and extended kin group in which the donor lives, should be observed, as this will vary according to the age and gender of the donor (Annex 3).

The potential donors should be interviewed to assess general health, medical and risk behaviour history using a donor questionnaire, and a basic health check. The donors should also be screened for transfusion-transmitted infections and monitored after the donation.33,34 All donors that are deferred should receive counselling and support linked with specialized services available.

In all circumstances, the donors (retained or deferred) should be treated with empathy, and can be invited to participate in activities related to donor education and motivation.

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33 WHO Guidelines on assessing donor suitability for blood donation, 2012
34 WHO interim guidance for the use of convalescent whole blood and plasma collected from patients recovered from EVD for transfusion, version 1.0, 2014
Donation should take place in a relaxed atmosphere and any concerns should be responded to promptly and courteously. Donors should be invited to provide feedback on their donation experience as part of monitoring and evaluation mechanisms.

Bearing in mind the context and to preserve the EVD recovered person’s health, a support package with vitamins/food supplements should be provided by the relevant body, as part of a national rehabilitation programme for EVD recovered people, irrespective of their donor status. Iron supplements should be considered for donors recently recovered from disease, also in the context of apheresis procedures, in line with national provisions.

Small gifts or tokens of recognition along with the reimbursement of costs incurred by transportation to the blood donation site should be provided to all CWB/CP donors.

**Strategy 3: Retention**: Retain convalescent blood and plasma donors as regular donors for the duration of empirical treatment application and clinical trials, and then as general blood donors for the longer term.

Objectives:

I. Establish post-donation counselling, follow-up communication and care

II. Retain suitable blood donors and provide regular updates on health needs

III. Recognize the special contribution of the donors to the community

Support mechanisms for pre- and post-donation counselling and follow-up are necessary to ensure the good health status of people recovered from EVD who have agreed to become donors of CWB/CP. Potential donors should be informed about the existence of these provisions.

The CWB/CP donor should be closely monitored during and after the donation procedure, with particular consideration to the recovery phase, to ensure that blood donation does not cause any harm.

Establishing a network of post-donation counselling services is part of the overall strengthening of the NBTS. In addition to donor support, it should scrutinize if and when a donor can be fit for enrolment in a regular donation programme.

Retention of enrolled CWB/CP donors should be induced by a pleasant donation experience. The regular health check at the time of each donation may be an additional incentive to donor social integration, a valid proof of donor’s own health status and a personal contribution to the well-being of the community.

Public recognition of blood donor contribution is an important factor in retention and further recruitment, and should be initiated as a social integrator force. Recognition aims to acknowledge the extraordinary gesture made by EVD recovered people having acted as CWB/CP donors. It should generate a sense of pride and is essential for keeping donors willing to repeat their donations.

Recognition also allows the BTS to develop a good donor relationship. This can be done either immediately after the donation or in connection with a donor’s preceding donations, through social recognition of their gesture. To avoid creating a layer of apparently favoured individuals in a society subject to social tensions fuelled by the outbreak (recent civil war history considered)

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35 www.redcrossblo.org last visited 19 January 2015
and economic hardship, recognition of CWB/CP donors should be done in parallel with recognition of voluntary non-remunerated blood donations (VNRD) from the general population (other than EVD survivors).

The organization of youth clubs (e.g. Club 25 International[36]) and advocacy networks can be part of this public visibility and recognition process, further increase the sense of value, and encourage multiple donations from the wider general population in the longer term.

Annex 4 presents a tabled diagram summarizing the key interventions per strategy, resources and related expected outputs.

6. Stages in implementation

Preparatory phase

Preparatory work with involved actors on the ground should be initiated under the authority of the national response structure and Minister of Health, and integrated with other community engagement strategies in implementation. This should involve the CET, ETU/CCCs and the NBTS, in assembling core groups (identifying and involving community-based organizations and networks that have credibility, social acceptability and can access and influence the general population), tasked to coordinate their efforts and contribute to developing the standard operating procedures[37] for initial engagement and dialogue, preparation and planning.

A standard operating procedure (SOP) and training materials will consist of information sheets and role-play activities (learn to listen) on conversations about being a donor and other issues of concern such as survivor reintegration into society. Training in the application of the SOPs should start with staff carrying out local level preparations and planning.

The role of peer educators[38] is especially important in cross-cultural and sensitive contexts, such as reaching people recovered from EVD for convalescent blood and plasma donations. The intention of peer education is that familiar people, giving locally relevant and meaningful suggestions, in a local language and taking account of the local context, will more successfully reach the target communities.

In the preparatory phase, it is equally important to reach agreement on the support package to assist recovery and social reintegration of people recovered from EVD, to be provided by the relevant body and part of a national dedicated programme. It is proposed that such a package should include regular health screening (for donors this should be part of the pre-donation medical check), vitamins/food supplements to maintain nutritional status, counselling and support towards social reintegration, if needed.

Consistent with international recommendations for safe blood donation, the costs of transportation to and from the donation site should be reimbursed. It is important to ensure that CWB/CP donation does not become a commercial activity, and that the ethical principles of safe unpaid donations are maintained.

The stages described below correspond to the field implementation of the three strategies, and often require concomitant interventions using a multi-stakeholder approach. The boxes present a short narrative of practical applications, and an example of field application is presented in the form of a diagram in Annex 5.

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[37] Ethics of use of convalescent whole blood and convalescent plasma in Africa, WHO internal document under development
Stage 1: Create a favourable environment for the engagement of people recovered from EVD for CWB/CP donation

Interventions

✓ Map and prepare contact with organizations, community and faith leaders able to provide support. Explain the interventions

Action points

- Provide clear and simple information on EVD and people recovered from EVD
- Explain limits in treating EVD and the role that recovered patients can play
- Show how engaging communities can help in treatment provision

✓ Contact the Ebola teams (including safe burials teams) to identify enrolled EVD recovered members who could act as social interface

✓ Develop the message and use media channels, informal networks, education materials

Action points

- Train traditional healers as educators and advisers
- Engage ETU to provide information to recovered patients at the time of release
- Conduct school sessions and face-to-face education/promotion
- Build/strengthen peer education and kinship networks
- Disseminate leaflets, taxi stickers, posters, songs

✓ Define key support interventions for people recovered from EVD

Action points

- Mobile teams to follow and provide health education and support
- Network of counselling and referral health services (primary care, specialized care, as applicable and available)
- Integration support: basic amenities package where these have been destroyed

Peer educators and recruiters can first engage with established networks and associations to contact Ebola survivors, such as Ebola Survivor Unions, Ebola Treatment Units, and associations of Ebola Survivor Clinics that operate in Guinea and in Sierra Leone. Ebola survivors can also be identified and located at hospitals where survivors congregate, faith-based organizations and through the Ministry of Health records and the WHO database in each country. For peer educators visiting rural communities, it is important that they be a member of the community to avoid any risk of conflict and resistance. Once a person recovered from Ebola is identified, information is provided and concerns clarified to allow an informed choice on enrolment as a potential donor for convalescent blood and plasma. Once provisional agreement to become donor has been reached, the normal procedure will be to ascertain when the person will be ready to donate, and to verify their status of recovered patient through the relevant health centre or personal discharge records.

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✓ Collect information and trace EVD recovered patients with donor potential

✓ Establish contact with recovered patients and their families

*Action points*

- Facilitate compassionate dialogue with affected families, and recovered patients
- Make information available explaining the interventions, why and what they are for
- Create a bond by getting to know the potential donor

✓ Give particular attention to gender, in relation to existing social structures (i.e. female headed households) and possible related medical requirements

✓ Build staff capacity in blood transfusion services

*Action points*

- Train staff to communicate with empathy
- Ensure staff are trained to use the SOPs

✓ Identify and prepare intervention sites

*Action points*

- Ensure basic safety standards are in place
- Devices and cold chain are available
- Premises allow confidentiality for counselling and post-donation observation

**Stage 2: Educate and recruit people recovered from EVD as donors for CWB/CP**

*Interventions*

✓ Recruit donor

✓ Plan and organize the first visit to the donation site

*Action points*

- Develop an appointment system to reduce waiting time
- Arrange transport for EVD survivor groups where mobile collections cannot be organized and other transport means are unreliable

✓ Prepare health-care workers to explain the donation process, and to listen and respond to potential donor concerns with empathy

The person recovered from EVD should be provided transport to the donation site. The procedure and outcome should be explained and informed consent should be obtained. Following a medical check, the collection of whole blood or plasma should be completed as per WHO standards. The BTS should provide good care, refreshments, counselling and support at the time of donation. Once the process of donation and support is completed, the donor should be provided transport and sent home.
✓ Conduct donor interview in an environment that ensures confidentiality, explain and explore risk behaviour and assess suitability to blood donation

✓ Explain the informed consent procedure and obtain informed consent before blood donation

✓ Provide counselling and psycho-social support to donors when needed

**Action points**

- Counselling occurs at several stages during the donation process
- Staff need to be trained to be able to provide effective counselling

✓ Invite donor feedback on the experience of donation

✓ Offer (deferred) donors the opportunity to get involved in education and recruitment activities

✓ Record the information on (potential) donor medical assessment, donation experience and outcomes in the EVD recovered donor database

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**Stage 3: Retain people recovered from EVD as regular blood donors**

**Interventions**

✓ Establish a system for post-donation health monitoring and follow-up, including links with ECC and specialized services (where these exist)

✓ Emphasise the importance of regular health checks before each donation

✓ Send periodic appeals for donation (through the post, via social workers, or the mobile phone system) for donor retention

✓ Socially recognize the blood donors for their gift of blood donation by

  - Reporting successful cases of lives saved by convalescent CWB/CP donations
  - Creating a system with donor greeting cards on public holidays or birthdays
  - Launching social network initiatives, with the support of EVD recovered patients associations
  - Giving medals and certificates to recognize blood donors’ contribution to the health and well-being of the community, use blood donation as a social integrator

To ensure continuity of this work, it is also important to retain the services of the peer educators and recruiters in the programme, both the volunteers and employed personnel.
Efforts should be made to retain the CWB/CP donors as regular donors for the longer term: for compassionate treatment and clinical trials for their duration, and subsequently at least one year following the disease episode as part of the general donor population.

7. Monitoring and evaluation

Strategies implementation follows a living cycle that requires permanent adaptation to context. To ensure these are effective in reaching planned objective and outcomes, and to identify where improvements and changes are required, the process requires close monitoring and evaluation (regular checks against early set targets and how these have been reached).42

The COMBI approach43 proposes a set of simple questions to be asked in monitoring and evaluation exercises (see table 3).

**Table 3: COMBI questions for monitoring and evaluation**

<table>
<thead>
<tr>
<th>Are we doing the right things?</th>
<th>Identifying indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are we doing them properly?</td>
<td>▪ Who?</td>
</tr>
<tr>
<td>Are we making a difference?</td>
<td>▪ How many?</td>
</tr>
<tr>
<td></td>
<td>▪ How often?</td>
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<td></td>
<td>▪ How much?</td>
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</tbody>
</table>

Monitoring and evaluation, imbedded from the planning phase, should be foreseen for each stage of implementation. Simple and easy measurable indicators (e.g. how many local communities have been reached, how often potential donors present themselves to the donation site, how much CWB/CP is available for experimental use, etc…) should be defined locally and used to follow the pace of implementation.

8. Conclusions

The engagement of people recovered from EVD in donating CWB/CP is part of a larger communication strategy that is addressing an increased level of health literacy and participation in the community.

Educating and recruiting people recovered from Ebola as blood donors for experimental treatment of the disease has a time-limited duration, in relation to the potential efficacy of CWB/CP. The long-term impact and evolution of this process should be fully understood, as supporting health consolidation and social integration of a group rendered vulnerable by the disease it has survived, and strengthening the safe donor pool.

It also gives the opportunity of reviewing the infrastructure of health service provision and blood service operations, in order to remedy existing deficiencies and promote general advancements.

The expected outcomes of the required multi-stakeholder efforts in this endeavor are:

a. Functioning and effective blood donation sites/intervention sites established that support

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42 Approaches to measuring more community engagement, Liz Weaver editor, Tamarack – An Institute for Community Engagement, Ontario, 2010,
the compassionate treatment of EVD patients, and clinical trials with CWB/CP.

b. Resilience of people recovered from EVD is strengthened, and their health status monitored during the regular presentations for donating CWB/CP

c. Contribution to reduction of stigma and addressing inequities faced by EVD recovered patients

d. Increasing adherence to convalescent blood donation within the scope of the intervention and inclusion in the national blood or plasma donor pool.

Substantial strengthening of the existing NBTS is required, as part of securing health systems capacity to effectively respond to potential future outbreaks, emergency situations and daily population needs.

This will implicitly require a profound strengthening of blood services, with refurbished infrastructure and trained personnel, to reduce transfusion-related risks and make safe blood supplies accessible and available. The functional integration of blood services with related health services (primary, secondary and tertiary levels) will ensure their sustainability and contribute to self-sufficiency and system responsiveness in safe blood supplies, as well as protect increasingly health literate populations.
Annex 1

Community Engagement Checklist – Questions for researchers

<table>
<thead>
<tr>
<th>Respect Autonomy</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Have you included the community in situational assessment?</td>
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<tr>
<td>- Have you assessed the relevance of the research and potential response from the community?</td>
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<tr>
<td>- Have you assessed the interest amongst the community, as well as current infrastructure (or lack thereof)?</td>
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<tr>
<td>Have you assessed the willingness of your research institution to respect, protect and fulfil the rights of participants?</td>
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<tr>
<td>Have you conducted a comprehensive identification process with stakeholders, including:</td>
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<tr>
<td>- community stakeholders, NGOs, CBOs, FBOs community groups, informal networks, etc.;</td>
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<tr>
<td>- government ministries, leaders, etc.;</td>
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<td>- local health care facilities and services;</td>
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<td></td>
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<td>- local formal/informal/traditional religious and spiritual leaders;</td>
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<tr>
<td>- the media?</td>
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<tr>
<td>Have you clearly defined the roles and responsibilities of all stakeholders?</td>
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<tr>
<td>Will you provide research literacy training to key stakeholders?</td>
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<td></td>
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<tr>
<td>- Local NGOs, CBOs, informal networks</td>
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<td></td>
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<tr>
<td>- Health-care service providers</td>
<td></td>
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<td>- Media</td>
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<tr>
<td>- Government</td>
<td></td>
<td></td>
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<tr>
<td>- Influential community and religious leaders.</td>
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<tr>
<td>Have you developed a MoU with community-based organizations, involving them in all aspects of the research?</td>
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<tr>
<td>Have you secured funds for community involvement (e.g. providing incentives, translation, etc.)?</td>
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<tr>
<td>At what level and how will community stakeholders be involved in the research process?</td>
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<tr>
<td>Who will be involved in decisions concerning how data and results are disseminated?</td>
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<tr>
<td>How will the data be used to improve the situation for the target population?</td>
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</table>


## Fulfil Responsibilities

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Have you (or others) conducted formative research activities to learn about:</strong></td>
<td></td>
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<tr>
<td>- community needs and specific priorities;</td>
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<tr>
<td>- prior research in this community;</td>
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<tr>
<td>- local perceptions of past research or clinical trials?</td>
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<tr>
<td><strong>Have you planned for community capacity-building and informed participation?</strong></td>
<td></td>
</tr>
<tr>
<td>- Secure funding to build capacity of community members</td>
<td></td>
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<tr>
<td>- Allow local groups to use resources such as meeting spaces</td>
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<tr>
<td>- Train community members to be involved as study staff to build capacity for the future.</td>
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<tr>
<td><strong>In disseminating results, do you have plans to work with community leaders on data dissemination and utilization plans, including media advocacy?</strong></td>
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<tr>
<td><strong>Do you plan to build the skills of activists to disseminate/use data locally for advocacy?</strong></td>
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<tr>
<td><strong>Once the study is completed, can you offer assurances that prevention, and care services will continue?</strong></td>
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</table>
Annex 2
Communication Information Gathering Template

Knowledge, awareness, perceptions

• What do individuals and communities know about the interventions, transmission and prevention of Ebola and the purpose of the clinical trials?
• What are the local terms, descriptions and stories that are told in relation to giving and receiving blood?
• How do local communities feel about blood donation to family members and non-family members?
• What are the individual and community perceptions of receiving and giving blood?
• What kinds of conversations are taking place and between whom within the communities related to the interventions?
• How are people recovered from Ebola perceived and treated by their families and communities?

Information sources, channels and settings

• Where/who do people get information from (health and other types advice) and why? Who are ‘trusted’ and ‘credible’ information sources and what makes them so? E.g. health-care staff/local leaders/religious leaders/influential individuals
• What media or channels of communication are available? What channels are most popular and influential among the different affected groups? What traditional media are used?
• What are the current patterns of social communication? What active community networks and structures exist, and how does the local population perceive them?
• What other organizations are currently addressing the issue in the community? (e.g.: fact sheets, face-to-face communication, newsletters, posters and brochures, public service announcements, news media, web sites, podcasts, text messages and other new technologies, email messages, secure and proprietary networks)?
• What settings are relevant to deliver communication materials and messages? (e.g. clinic, home, village etc.)?

Current health-seeking practices in the household and community

• How are local communities preventing and seeking care in the Ebola outbreak?
• Who is providing health care at the local level and how is this service?
• What are the decision-making processes within communities and the household related to seeking health care?


49 Communication for behavioral impact (COMBI), UNICEF-WHO, 2012
Socio-cultural, economic and environmental context

- Are there any social and political tensions that may affect the clinical trials in general, and consent and donation in particular?
- What resources are available to people recovered from EVD, their families and the surrounding communities?
- What existing traditional religious beliefs and social norms may inhibit acceptability of the clinical trials, consent and blood donation?
- What existing traditional religious beliefs and social norms may support the acceptability of the clinical trials, consent and blood donation?
Annex 3:  

Ethical protocols for counselling and obtaining informed consent from blood donors in most Western countries are grounded in the concept of the autonomous acting subject; an individual empowered to make decisions about his/her own body and its products. The right to exercise “ownership” over one’s own body is generally assumed to commence at the age of 18, but in a West African context, deep bodies of scholarly research document the concept of relational age and wealth in people (Bledsoe, 1980; Coulter, 2009; Ferme, 2001; Moran 1990, 2006; Murphy 1980, 2003). An individual’s “adult” status is dependent upon their relationships with others, rather than on chronological age. People in their 30’s and 40’s may be considered “youth” or “small boys and girls” if they have failed to establish an independent household, remain unmarried or childless, or are dependent upon others economically or for protection. Individuals become recognized as powerful elders to the extent that they are able to accumulate rights in the labour and loyalty of others. Threats to the solidarity of the household and extended kin group are often understood within a discourse of sorcery, selfish appropriation of group resources for personal gain, and the illegitimate quest for power by structural inferiors. A Liberian proverb, “if the house will not sell you, the street cannot buy you,” summarizes these complex ideas: loyalty within households is rewarded by spiritual protection; personal calamity is a sign that powerful family members have withdrawn their support.

Given the fact that in the present context of the Ebola epidemic: a) survivors appear to be disproportionately young people (under the age of 40), b) high rates of youth unemployment characterize both the pre-outbreak and present economy, leading to larger extended households with many people contributing and depending on each other to survive and c) a wide circle of family and/or patrons may believe they have decision-making power over the bodies of younger people, it is important that the concept of informed consent be broadened beyond the potential individual donor. In other words, in order for anyone to make a “culturally acceptable informed decision” about blood donation, they may need the permission of others in their extended network. Failure to consult with and take the advice of the larger group could result in Ebola survivors, who already suffer stigma and isolation, becoming even more suspect in their communities, particularly if they are believed to profit from the “sale” of bodily fluids not considered their property to give away.

Extensive scholarly research in this region indicates that blood is a potent symbol with multiple and overlapping meanings for personal and family health, fertility, and potential reproduction (Fairhead, Leach, and Small 2006; Geissler, et. al. 2008; Grietens et. al. 2014). As the link between members of a patrilineage, blood may be regarded as not belonging to the individual body in which it circulates but to the kin group as a whole. Young people who make the choice to participate in blood donation groups without consultation may signal their desire to break away from the authority of elders, an act which may have serious negative consequences, particularly given their already vulnerable position as Ebola survivors. Furthermore, blood and other bodily products are intimately connected with understandings of sorcery and the ability of some powerful humans to alter the physical world, ideas that are prevalent across the African continent (Shaw, 2001; Weiss 1998; White 2000). As anthropologists have shown, these concepts are not rooted in “ancient tradition” but rather serve as flexible explanatory frameworks for interpreting local histories of colonialism, state predation, and encounters with earlier waves of Western medical researchers (Moore 2001). These ideas cannot be dismissed as “superstition” nor expected to dissolve in the face of “true” biological facts and education. It is not uncommon, nor inconsistent even, for well-educated people to interpret life events within this framework, when other explanations fail to resolve contradictory evidence.
Potential donors should certainly be asked if there are other family members who should be consulted and if they would like these people included in the counselling and psychosocial support offered to the donors as individuals. Family members may need to be reassured that there will be no future consequences for the health of a younger household member whose labour may be crucial to the survival of the larger group. Families may also be concerned that the future fertility of young women may be compromised, since menstrual blood is considered a powerful and dangerous substance and women are understood to have this in limited supply (Feldman-Savelsberg 1999). Family members should be allowed to share in the food or transportation reimbursement given to the donors, and this may require larger supplies of commodities than originally planned. Involving the entire household and extended family may contradict other Western ethical considerations like “confidentiality,” but it is important to realize that an individual “choice” may have consequences for the group as a whole. This strategy may serve the dual purpose of preserving the position of survivors within their families and households and easing their reintegration into the community at large, where they may still be stigmatized. Knowledge by the broader community that the donors’ family has been consulted and supports their choice to participate will surely strengthen both the programme and the outcome for individual participants.

References Cited
http://www.who.int/entity/bloodsafety/voluntary_donation/Blooddonorcounselling.pdf?ua=1
Annex 4: Priority actions for implementation of strategies for mobilization of EVD recovered people as potential donors of CWB/CP

<table>
<thead>
<tr>
<th>National level pre-planning involving CET, ETU/CCC and NBTS teams. Assemble core team (including communication, health promotion, anthropology). Develop standard operating procedures for initial engagement and dialogue. Briefing/training and materials for staff engaging with key stakeholders who are carrying out local level preparation and planning.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement, Education, Recruitment and Retention</td>
</tr>
<tr>
<td><strong>Phase 1</strong></td>
</tr>
<tr>
<td><strong>ACTIONS</strong></td>
</tr>
</tbody>
</table>

**Outputs**
1. Selection of sites.
2. Support package for survivors validated.
3. Revision of protocols, development of SOPs for consent, donation, management of adverse events
4. Engagement strategies for communities and donors
5. Communication and advocacy strategies with implementation plan that link local and national levels.
6. Training gaps and needs identified.
7. Consent to donate clearly articulated.

**Outputs**
1. Donation site ready.
2. Health-care workers trained.
3. Cold chain established.
5. Documentation of process set up.
6. Other health issues identified.

**Outputs**
1. Donor database – mindful of confidentiality and mitigating risk of stigmatization.
2. Social recognition schemes established.
3. Increase in VBD.
4. Evaluation of progress challenges for continuous adaptation and improvement.
Annex 5: An example of the engagement process of EVD recovered people for CWB/CP donations

(Verified EVD survivors (in good health) at least 28 days following negative testing and discharge from a health-care facility and willing to participate as convalescent whole blood or plasma donors)

**STAGE 1**
- Develop SoP and training materials
- Select and train the peer educators and recruiters in-country
- Peer educators and/or investigators (male and female) as recruiters
- Ebola Survivors Unions (ESU)
- Ebola Survivors Clinic (ESC)
- Hospital and MoH records
- Community/households
- WHO database
- Identify and contact potential donors
- Inform through dialogue using SoP
- Donor makes an informed choice

**Support package**
- Health screening
- Treatment
- Counselling
- Integrate into society
- Nutritional status
- Solidarity support

**STAGE 2**
- Develop a register of potential donors
- Identify time to begin donation
- Verify status
- Medical check
- Maintain contact with donors
- Establish blood and plasma donor club or network
- Provide transport and bring the donor to BTS site
- Respond to donors’ queries
- Obtain informed consent from donors

**ONGOING**
- Perform whole blood donation or plasmapheresis
- Provide care, and counselling
- Provide transport and send the donor back home
- Maintain contact with donors
- Continue blood and plasma donations

**Notes**
- Maintain contact with donors
- Continue blood and plasma donations