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Guidance for a Family-Friendly Response in a Health Emergency Facility

DURING A FILOVIRUS (EBOLA AND MARBURG DISEASE) OUTBREAK

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1. Background

Emergencies whether brought on by natural hazards, public health outbreaks or man-made events have grave effects on the lives of the people and communities they affect. They disrupt life structure, cause catastrophic loss of life, physical destruction, and have devastating lasting effects on families and property. They are also usually unexpected and leave whole communities in shock[1,2]. Emergencies disproportionately affect vulnerable groups (children, adolescents, and women) physically, psychologically, and socially due to the collapse of the established health and social support and protection networks. Parents and caregivers may not be able to care and protect their children Furthermore, children are not always in the position to exercise their rights or draw attention to their needs or any violations of their rights[3]. Health emergencies can also trigger or exacerbate the risk of Gender Based Violence (GBV) and exploitation against women and adolescent girls.

Children, like adults, have age-appropriate needs connected to health, security, comfort, stimulation, play, learning, communication. Children are also less likely to adhere to some behavioural and hygiene practices such as routine hand washing that prevent, or reduce the risk of, infection due to their age, maturity, and evolving capacities. Children will be able to cope psychologically better during and after an emergency if, as much as possible, a structure and routine can be created to allow them to retain a sense of normalcy despite the ongoing disruption and changes around them by mirroring their normal routines and environments[4].

UNICEF champions the development, inclusion, and maintenance of Child-Friendly Spaces (CFS) throughout the setup of a Health Emergency Facility (HEF)[5] for Ebola and Marburg disease and along the referral pathway (community engagement, screening, admission, critical care, recovery, post discharge and the continuity of care). CFSs are supervised environments for children that also provide opportunities for parents and caregivers to be actively involved, share information, provide input and guidance, and increase their self-confidence to protect and care for children. CFSs are also supported by other different agencies during different emergencies. The CFS is not intended to address every problem a child may face in the HEF; however, it is a concept and intervention to provide the essential structure and continuity from their daily life. A CFS provides children with a protected environment and brings them some sense of normalcy, happiness, courage, and protection while helping them be resilient[6]and giving them an effective participation space.

Guidance on the appropriate support measures during health emergency response need to be provided for vulnerable groups, especially for children during outbreaks of Highly Infectious Diseases (HID) such as Filoviruses (Ebola and Marburg diseases): for children with suspected HID – subsequently confirmed, children with suspected HID – subsequently not confirmed, and children within the community that addresses a child's susceptibility to infection and their continued well-being which is influenced by different factors including their developmental stage, their capacities, and their dependence on caregivers. This will help mitigate the negative impact of an Ebola outbreak on children and have a positive influence on their development into their adult lives[7].

1 Child Friendly Spaces in Emergencies. Case Study Report - IFRC 2017
2 Child Friendly Spaces in Emergencies: A Handbook for Save the Children Staff 2008
3 Operational Guidance for Child Friendly Spaces in Humanitarian Settings – IFRC & WV 2018
4 Child friendly spaces impact across five humanitarian settings: a meta-analysis Hermosilla et al.,BMC Public Health 19, 576 (2019). https://doi.org/10.1186/s12889-019-6939-2
5 A Health Emergency Facility (HEF) is a rapidly deployable family-friendly surge health facility that provides screening and isolation of admitted persons in the event of a major disease outbreaks.
6 Planning designing child-friendly and spaces living spaces - UNICEF 2020
7 A Practical Guide for Developing Child-Friendly Spaces - UNICEF

Thus, guidance extends to implementing isolation (in this document referred to as seclusion) and quarantine measures, considerations around the impact on children and the required steps to minimize family separation, whilst adhering to infection, prevention and control measures and guidelines. This document provides guidance to health workers and other care providers (including social workers) in the specialized treatment centers, and those working the community, on how to avoid and mitigate any separation of children from parents/caregivers and siblings affected by Filoviruses (Ebola and Marburg), and how to ensure all activities, services and facilities are safe for children, and have child safeguarding and measures for prevention, mitigation and response of/to gender-based violence, including sexual exploitation and abuse.

2. Scope and purpose of the guidance

This document covers the key consideration for a HEF deployed to in response to a Filovirus, Ebola or Marburg disease, outbreak to support a response that meets the specific needs of a child. It emphasizes the need to consider and institutionalize CFS and Child- and Family-Friendly Spaces (CFFS) as part of the HEF deployment during a Filovirus outbreak, from the HEF's construction to how health personnel should handle cases of children in the Filovirus HEF seclusion and treatment units. It further outlines how health staff should engage with the relevant local authorities and community leaders and other communities' representatives to strengthen community trust and acceptance. This document:

- Provides operational implementation considerations with regards to child protection and community engagement and acceptance for the HEF's location, design layout, and needed supplies as part of the response to a Filovirus outbreak.
- Provides child-friendly operational implementation considerations throughout the HEF, in areas where children will pass through.
- Takes into consideration special Infection Prevention Control (IPC) requirements applied in the HEF including during seclusion and safe humane treatment, limiting mixing, disease mode of transmission, and the clinical condition of the person who is inside the HEF (suspected or diagnosed).

CFS established during a Filovirus outbreak are not limited to children as the only vulnerable group and can be expanded to include adolescents, pregnant women, and mother/caretaker and child pairs as a more comprehensive CFFS. This expanded concept provides the considerations needed to:

- Improve children's mental health and psychosocial well-being[8].
- Ensure a safe, protective space from abuse and violence for family's while being sick and vulnerable.
- Support delivery of child welfare and a space for effective participation.
- Strengthen children's internal and external support systems through positive coping strategies with other children and family members.
- Strengthen family links through normalizing social interactions while isolating and treatment needed during a Public Health Emergency (PHE).
- Reduce harm from the seclusion and loneliness and constitute a healing environment.
- Prepare survivors and those who recover for returning to normal life (hygiene education, psychological support, etc.).
- Ensure providing customized and gender-sensitive care suitable for the children, specifically for girls and women and other vulnerable groups while still providing quality public health response.

8 Global Multisectoral Operational Framework

2.1 Beneficiaries of the Child- and Family-Friendly Spaces in a HEF

The primary beneficiaries of the CFFS considerations summarized in this document are the children and their caregivers admitted to the HEF. While children and families can also be present in other areas within HEF as visitors and survivors, the needs of these groups are out of the scope of this first iteration of the document and will be addressed in later versions.

3. Setting up a HEF

3.1 Family-friendly HEF checklist

The varied steps to be taken for a family-friendly HEF have been broken into sub-categories that should be used to guide implementation activities. The below table summarises the categories and indicates the relevant boxes, with a printable checklist found in Annex 6.1.

Activity
Translation of terminology into local language(s) (Section 3.2/Annex 6.2)
Community briefings and engagement conducted (Boxes 1, 2, 3)
Information desks and briefings to be done by the Psychosocial Center (Boxes 4, 24, 25, 37, 42)
Creating safe spaces for children to be secluded (Boxes 5, 6, 7)
Creation of the child-friendly learning, playing and participation place (Box 8)
Family-friendly HR briefings and screenings (Boxes 9, 10)
Infrastructure to support child-friendly implementation (Boxes 11, 12)
Supplies to support child-friendly implementation (Boxes 26, 27, 28, 29)
Placement and support required for admitted children, caregivers, and breastfeeding mothers (Boxes 13, 14, 15, 16, 17, 18, 19, 20, 21)
Staff working with children, caregivers and breastfeeding mothers trained on appropriate interaction methods and information to be communicated (Boxes 22, 23, 30, 31, 32, 34, 35, 37)
Staff working with family and friends of admitted people trained on appropriate interaction methods and key communication objectives (Boxes 24, 33, 37)
Staff working with non-admitted people trained on appropriate interaction methods and key communication objectives (Box 25)
Family-friendly catering requirements (Box 36)
Discharge communication objectives for discharged individuals and communities (Boxes 37, 40, 41)
Staff working with the family of the deceased (Box 38, 39)
HEF dismantling community briefings conducted (Box 42)

3.2 Terminology

A child and family-friendly HEF begins with the language used to explain and run the HEF, it is a comprehensive journey from when someone within the community begins to feel sick to when the outbreak is declared over, and all facilities are dismantled.

Communication should be driven by the understanding that people are not just admitted persons. People are people. Admitted person is a role that people play when they are sick. However, admitted persons, children, and adults are people. Multi-dimensionality is important, both in person-to-person communication but also in biomedical terms to help them comply with the treatment and accept the services. Thus, the language used to communicate to and dialogue with community members and leaders, to those who are sick but not laboratory confirmed to those who have been laboratory confirmed, will help drive stronger community understanding and strengthen the trust community members have in the HEF.

The vocabulary found in Annex 7.2 details the bio-medical terminology that would be used by medical staff during a HEF deployment, paired with the description and suggested language that can be used to humanise the response. Each term should be adapted to be understood by local languages and phrasing, with discussions between medical and Risk Communication and Community Engagement (RCCE) teams to clarify that the concept has been correctly translated. This is specifically relevant for the translation of disease names into local languages, of symptoms and of what laboratory testing means, to mitigate confusion.

3.3 Community briefings and engagement

Securing engagement, participation, information sharing and negotiating the approval and understanding of local leaders facilitates their capacities to inform their communities about the purpose and functions of the HEF, including how people will be treated within and how those with family members in seclusion can be communicated with.

Community briefings and engagements should be built off prior consultations and existing assessments done as part of the broader response. This Collective Services Drive has compiled Ebola related assessment tools that can be used if no context specific tool has been developed by RCCE team.

These activities should be linked to the broader response, either conducted after the initial rapid assessments and consultations, and updated as the response progresses and feedback mechanism data can be utilised to strengthen community understanding and engagement. This in turn, contributes to community uptake of services and acceptance of HEFs.

Box 1, Box 2 and Box 3 detail the steps to be taken to increase community awareness and while establishing the HEF.

Box 1. Community engagement when a HEF is established within the community

If the HEF is to be established outside the grounds of the local health facilities, community engagement in the leadup to the HEF should ensure that it secures the local authority's permission to establish the HEF, even if land has already been cleared by authorities at a higher level. It is important to contact all pertinent authorities and community representatives, prioritizing women, girls, and people with disabilities, from the area where the centre will be built to explain what will take place in the coming months. The community will explain heir doubts, questions, and requests that will help strengthen concerns related to safety and access. If there is no acceptance of the construction of the HEF, there is need to identify another place and seek for approval. This step prevents security incidents like having the facility burnt (evidence shows this has taken place on several occasions during responses) and enhances the uptake of the services provided.

Additional guidance can be found in Referral pathways for community and HEF briefings and tools (Annex 6.8).

Box 2. Community engagement when a HEF is within an existing health facility

If the HEF is located within the health facility, consultations and briefings should also include the separation between the two facilities, highlighting that it remains safe for people to access the health facility for routine/other emergency needs. Suggested steps for stronger community engagement and buy-in include engaging local authorities/labour offices and other community representatives to hire local workers as part of the HEF processes. This type of engagement aims to build community trust by hiring community members who will then have firsthand experience of the HEF, which will facilitate peer to peer engagement and communication within the community. Additionally, this may relieve some aspects of economic pressure for affected communities, acting as a form of income generation for communities that may have had to shut or slow local businesses due to movement restrictions.

Examples include:

- Hiring semi-skilled/unskilled labourers from the community to construct the HEF and include sensitization sessions within their working day.
- Hiring local restaurants/cooks to produce food required for those in seclusion.
- Hiring local healers to conduct RCCE activities. This will both allow for sensitization of the healers, who may have opposing views on how to respond to the outbreak and are common sources of healthcare in lower-income communities. It can also help in determining appropriate messaging for the provision of MHPSS.
- Hiring local workers, considering women in all local hiring process, as part of the HEF processes.

Box 3. HEF tours and briefings during the construction phase

Independently if the HEF will be built inside or outside the health system structures, interactive briefings and tours of the facility before it opens should be conducted with relevant local authorities and community leaders, as well as those who are in frequent communication with community members, as (to be adapted locally): religious leaders, youth leaders (including girls), female leaders, hairdressers and barbers. teachers, etc.

Teachers should be targeted with specific sensitization activities so that they can also communicate these messages to and dialogue with their students, aiming to reduce the mistrust of children being admitted and discharged from the HEF. These tours should inform participants of the function of each place, the flow from admission to discharge (both those discharged once cleared from Filovirus but also due to death), and how those admitted will access basic services (food, toilet, shower, visiting areas, etc, communication with exterior).

It is an important moment to register FAQ from the leaders and other communities' representatives and collect essential data on socio-cultural aspects and feedback related to the disease and treatment. Consultation should also include separate briefings with women and girls, to gather gender based concerns in an appropriate setting.

3.4 Psychosocial Center

To build trust and strengthen social support from the moment of admission, a Psychosocial Center (PC) should be established adjacent to the HEF. The PC should be located outside of the main HEF structure to allow caregivers, family members and community members to easily access information and psychosocial assistance without entering the clinical area. Although situated outside the HEF, staff at the PC should wear appropriate personal protective equipment (PPE), following protocols similar to those used at screening sites (as advised by medical leadership). The PC should also include two information

desks (Box 4), which ensures that both informational and psychosocial needs are addressed from the outset, helping to foster trust, reduce fear and stigma, and build stronger family and community partnerships throughout the response. All activities should align with MHPSS guidance: MHPSS Minimum Service Package, UNICEF's Global Multisectoral Operational Framework on MHPSS, and the IASC Guidelines on MHPSS in Emergency Settings. See Annex 6.12 for further information.

Box 4. Information desks in the Psychosocial Center will house two distinct information desks

- Desk One: Family and Visitor Information: Desk One will welcome and receive family members and visitors. It will serve as the primary point of contact for providing accurate, accessible information on: the functioning and procedures of the HEF; the management and care of admitted relatives or friends; key information about the Filovirus (including symptoms, transmission pathways, prevention, and treatment). In addition to information sharing, Desk One will systematically collect essential data — including frequently asked questions, rumours and myths, community feedback, and concerns — to inform and strengthen the overall response without disrupting the admission process.
- Desk Two: Mental Health and Psychosocial Support (MHPSS): Desk Two will be staffed by MHPSS personnel who will provide immediate mental health and psychosocial assistance to individuals identified or referred for support. This includes those experiencing distress, stigma, grief, or anxiety related to the HEF or the illness. The MHPSS team will also engage with key community figures — such as religious leaders, elder women, and traditional healers — to ensure that mental health and psychosocial interventions are inclusive, culturally appropriate, and aligned with existing community support structures and coping mechanisms.

3.5 Locations of CFFS within the HEF

The placement of CFFS within the HEF should be designed around steps taken to ensure they are as safe for admitted people as possible, and that the process of seclusion has a minimal impact on the admitted person (Box 5).

Box 5. Place children and vulnerable groups centrally in the HEF

- Avoid dedication of periphery wards to vulnerable groups. Ensure places for the vulnerable groups in centre wards or as close as possible to the nursing wards (Figure 1).
- Where possible, limit physical access from adult wards to the wards where adolescent and paediatric admitted peoples are being treated.
- Paediatric chambers should be placed at the entrance to the wing (Figure 2, Number 1) and caretakers should be provided beds within their chambers (Figure 2, Number 4).
- Adolescent chambers should also be placed as close to the entrance to the wing as possible (Figure 2, Number 2), with access to the adult wards capable of being restricted for safety (Figure 2, Number 5). The separator should not block the flow of support staff, rather blocking access for admitted peoples to move from the adult ward into the child's ward.
- Ensure proper lighting around wards and in the corridors.

If the HEF module is used as a surge facility together with an existing hospital or centre, children/adolescent/female wards should be placed in the existing building, not in the tent annex (for example, Filovirus treatment centres are feared due to seclusion and other conditions)[9]. A well-thought-out layout

9 New recommendation by HEF project based on child protection principles.

and setup of the wards should be ensured to protect children/adolescents/women from sexual abuse according to the principles of protection from GBV, including Protection of Sexual Exploitation and Abuse (PSEA)[10].

The required proportions for child and adolescent wards can be found in Box 6 and may be adjusted to the local population demographics (per age and sex). Summary recommendations for the seclusion practices per age group and gender are found in Section 4.2 and 4.3, with specific case scenarios for children and breastfeeding women.

Figure 1. Location of child (in yellow) and adolescent (in blue) seclusion wards (whole Ebola HEF)

10 UNICEF DRC Consultation, June 2022

Box 6. Location of child-friendly beds, with capacity suggestions, within the HEF

For confirmed cases that require seclusion, the design, and the layout of the seclusion wards need to consider the above recommendations in Box 5 and in this Box. A design example is shown on Annex 6.7.

Bed capacity requirements: Bed capacity and separation for admitted children is an estimated 20% of the HEF bed capacity for admitted children and their caretakers. If a separate paediatric ward is established, a child-friendly set up always includes the needs of the child + their caretaker (50% admitted person bed capacity as 50% of the beds are for caretakers).

Example: In a HEF with beds for 50 admitted people, 10 beds should be for admitted children. If the normal setup in the facility is beds for 10 admitted people in a ward, there should be two paediatric wards, and each should have beds for 5 admitted children and 5 beds for caretakers.

Child placement and separation from caretaker requirements: Children under 5 years should always be placed with a caretaker/guardian. When a caretaker is required, they should be of the same-sex or female supervisor, with space for the supervisor to be considered in the layout Ideally children from 5-9 years should not be placed alone per child protection in outbreaks, mini guide, however girls and boys should be separated. The yellow boxes in Figure 1 shows the suggested location of paediatric beds. Adolescents should be separated from adults and children, with the suggested location of their beds indicated in the blue boxes in Figure 1.

Gender considerations: Women and men should have beds in different sections to mitigate the risk of sexual abuse and exploitation.

Consider safe and comforting sleeping arrangements for children and adolescents, including overnight monitoring of both different and same-sex wards (Box 7)[11][12][13].

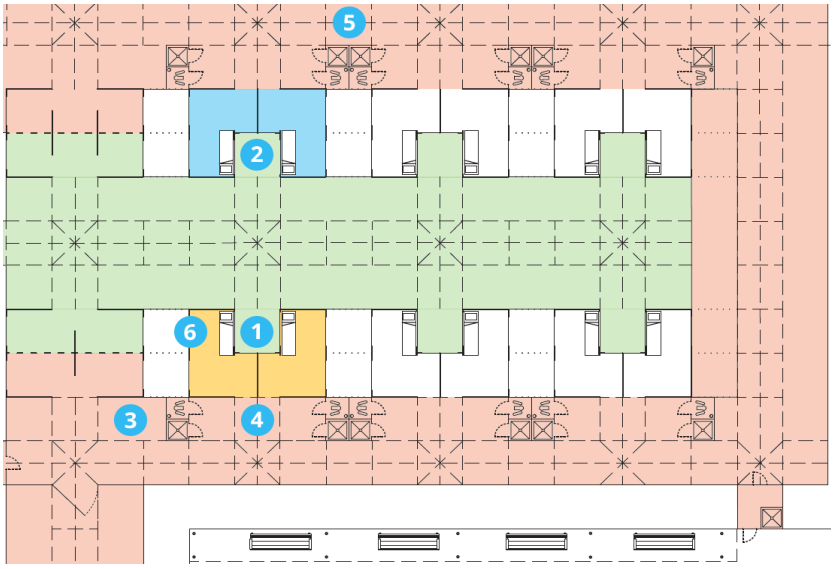
Box 7. Safe sleeping arrangements

- If the child is not confirmed, the parent stays with them during the observation.
- Distance to parents that are being treated should be considered and optimized when allocating rooms to children and parents.
- Create space for making the family visit possible and comfortable, with scheduling clearly communicated to both admitted persons and their families (inclusive of potential delays and the confirmation status of the visiting hours).
- Provide colourful grids to the beds.
- If the child is more distressed by eye contact with their parent while being unable to physically contact them (potentially common with children under the age of 4), the external window covers in the high performance tents may be temporarily closed.
- Have a system in place so children or caretakers can call for assistance (e.g., a bell or whistle), as well as communicate with the outside world), explaining how this works to the child in a way that they understand (language, culturally and age specific).
- Ensure age and ability appropriate, gender-specific toilets are in place, well separated and well lit.
- Ensure facilities and resources for menstrual health and hygiene management. Bed structure should be inclusive of other diseases (eg. malaria), thus have netting.

If possible, create access to a safe and protected outdoor space for children to play and move freely when they do not need to nap/sleep.

11 Child Protection in Outbreaks: Adapting child protection programming in infectious disease outbreaks. Available at: 1_mini_guide_adapting.pdf (alliancecpha.org)
12 Key contributions from the UNICEF Public Health Emergency team
13 Child Protection, NY Consultation, June 2022

A designated multi-use 'child-friendly and participation space' should be established as a separate space (Annex 7.6, Number 51) for children and families to play and learn (Box 8).



Design considerations:

1. Paediatric chamber
2. Adolescent chamber
3. Child-friendly toilet and shower
4. Caretaker bed for paediatric admitted persons
5. Access blocked from adult wards for safety
6. Bed rails for paediatric beds

Figure 2. One finger - paediatric and adolescent wards within the HEF

Box 8. Child-friendly space for playing and learning for confirmed children and families

Child-friendly spaces should not be on corners, or in locations where there is limited supervision.

- Consider that different age groups have different needs. Four age groups have been accommodated:
  - Babies/toddlers.
  - Pre-school children (under six years).
  - School-aged children (ages 6 to 12).
  - Early (10–14), middle (15–17), and late (18–19) adolescents.
- Develop a calendar of activity for children (in collaboration with all expertise available on the ground) that is age and culturally relevant. Consultations with children (if age appropriate) and/or caregivers on the activities and calendar should take place.
- Access to the space should be scheduled to allow for each age group to play freely.
- Provide formative supervision to caretakers on how to implement the calendar of activity.
- Provide formative supervision on interactive lunch with children.
- Provide age-appropriate toys.
- Consider suitable access and participation for children with disabilities.

Facilitating regular structured group MHPSS activities provides opportunities for children to develop social and emotional skills and to foster supportive social connections. For a list of structured activities to be used in CFS, see the technical brief on MHPSS in Child Protection at UNICEF (p. 6). Where these structured group activities cannot be adapted in line with IPC needs (e.g., including by setting up video-calling between children to facilitate the activities), then it is helpful to develop a list of safe, child-friendly and age-appropriate, web-based supports for interactive activities, peer interaction, and positive expression of feelings. Additional guidance on planning and designing relevant programming for children within the space can be found via UNICEF's A Practical Guide for Developing Child Friendly Spaces and in the IFRC's Activity Catalogue for Child Friendly Spaces in Humanitarian Settings.

3.6 HR guidance and requirements for staff working within the HEF and CFFSs

Emergency responses take place in particularly fragile situations and reach the most vulnerable populations. Affected populations are at particularly high risk of abuse and exploitation by those serving them who are supposed to protect them and provide care. Safeguarding affected populations from all forms of harm is the responsibility of all service providers and organisations operating in the emergency response, including government and non-government actors. Steps taken to mitigate any form of Protection from Sexual Exploitation and Abuse (PSEA) are found in Box 9.

Box 9. HR, GBV risk mitigation/response and PSEA requirements for HEF staffing and services

- Conduct background checks for all workers in the response to ensure all staff have no history of violence, exploitation and abuse and are safe for working with vulnerable populations including children.
- Ensure all staff are trained on using the GBV Pocket Guide to be able to safely handle any disclosure of GBV incidents and to link survivors with specialists, and have signed a Code of Conduct that includes zero tolerance for any form of PSEA.
- Appoint a senior member of staff as the safeguarding focal point.
- Ensure all staff treating children can undertake child-friendly methods for providing services.
- Ensure safe and confidential feedback and complaint mechanisms are available for admitted persons and families, that are also accessible for children; and ensure people know how to report incidents or concerns.
- Ensure Sexual Exploitation and Abuse (SEA) survivors have access to appropriate GBV services, as provided by an expert, according to the GBV referral pathways in the targeted districts.
- Provide briefing notes to all emergency responders on PSEA and child safeguarding on deployment and or when it's possible during the response.
- When IPC appropriate, display child-friendly visual material on PSEA (including complaint mechanisms and available services).
- Orient all HEF staff on basic psychosocial support (PSS) skills for children and adults: Basic PSS skills include: listening carefully, assessing basic needs, promoting social support, protecting people from further harm, and connecting people with relevant services and resources. These skills equip workers to provide a humane and supportive response. Anyone who is likely to encounter children, caregivers, and community members who are distressed should develop these skills, including doctors, nurses, case identifiers/contact tracers, burial teams, social workers, education personnel, faith leaders, youth leaders, and helpline staff. Trainings in Psychological First Aid (including trainings that are child-focused) serve well in this regard.
- Care for HEF staff: Provide accurate and timely information on the infectious disease, relevant HEF policies, healthy habits, and coping strategies; create opportunities for social support (e.g. peer support through remote messaging, voice or video calls); regularly assess workers' well-being (e.g. through individual check-ins, brief surveys, team meetings); and ensure access to MHPSS services for all frontline workers involved.

The hiring of emergency workers, particularly those hired as caregivers for children, should take local ethnic, political, and socioeconomic into consideration (Box 10).

Box 10. Understanding the local context in relation HR requirements for staffing

A HEF may bring together different social and ethnic groups into the one location and keep them there in close quarters during seclusion. These groups may potentially be those that traditionally may have experienced varying levels of conflict or misunderstanding. When hiring staff for the HEF, especially those who will care for children, how the child's direct community engages with the caregiver's community should be taken into consideration. The hiring of women, as well as survivors to act as caretakers, should be prioritized.

3.7 Key infrastructure and equipment consideration within the CFFS and child-friendly wards

The HEF provides a detailed supply list for all the commodities and supply needed to establish the HEF. Some of these supplies are key for contributing to the safe and best use of the CFFS within the HEF (Box 11) and to facilitate a psychological and mental stimulating child-friendly setup (Box 12).

Box 11. Key infrastructure for child-friendly HEF setup

- Access to electricity through solar (or other) solutions is a critical consideration.
- Ensure lockable and well-lit toilet facilities that are accessible to smaller children.
- Hygiene spaces & toilets should be designed for children's needs and be of reasonable distance from the child-friendly wards. Local bathing customs should also be considered (e.g., if bucket showers are common, do not only provide showers for small children.
- Consider child-friendly hospital furniture:
  - Bed height is an issue for children (some kids have never slept in a high bed as they have no beds at home).
  - Railings to provide safety so that kids don't fall over.
- Include a paediatric ward where caretakers can stay with small children demands additional tents and beds. In calculations for tents and hospital furniture, count the needs of paediatric beds as: paediatric beds = total number of admitted persons * 0.2 (20% of all admitted persons) * 2 (number of beds needed per admitted person) (HEF recommendation).

Box 12. Additional supplies to facilitate a psychological and mental stimulating child-friendly setup

- Provide colourful linen (consider dark linen for those who may be menstruating).
- To provide psychological and mental stimulation for the children, consider having:
  - A camera and a printer for taking and printing photos of the family.
  - A device for lamination to laminate documents and photos for proper disinfection. Make laminated child-friendly drawings or posters that can be removed.
  - Tablets/personal devices for children to use (age appropriate).
  - Televisions/projectors that can be moved so viewable from seclusion rooms.
  - Identify a series of videos (educational, recreative) and load them on tablets.
  - Download recreational, educational, and age-appropriate videos.
- Make age-appropriate music available (download music and record local traditional music).
- Have age-appropriate plastic toys available that can be given to the child once (s)he is cured (part of the discharge kit).
- Encourage children's participation in the selection of age appropriate activities, as listed in the Admission Kits (Box 28 and Box 29).

4. During the response - inside the HEF

4.1 Guidelines for child-friendly screenings

While children typically present at a facility with a caregiver or parent, who will remain with them throughout the screening process, some children may arrive alone. In addition to the health care staff member, a member of the RCCE team (or equivalent person) should be present in the waiting area and triage, to be able to guide those waiting on the next steps, while establishing a communication and trust bond. The approaches outlined in Box 13 detail the additional steps to be taken if someone under the age of 18 presents alone to the HEF.

Box 13. Unaccompanied child presents to the HEF

If an unaccompanied child presents at the initial screening and is found not to meet initial criteria required to enter the HEF for more comprehensive screening, the child should be guided to the Psychosocial Center (Annex 6.6, Number 48 on layout map) for further guidance.

If an unaccompanied child presents at the initial screening and is found to meet initial criteria required to enter the HEF for more comprehensive screening, a dedicated nurse/social worker should be assigned to them while they are processed through screening and are in the waiting rooms (4 on layout map). The assigned dedicated work should be able to speak with the child in their mother tongue, someone who is culturally appropriate (e.g., the same gender, same ethic group or from a group which shares a common respect with the child) and ensure a communication channel is available to ensure the child can contact their family and/or someone of trust.

4.2 Case scenarios for admitted children

Children and their caregivers will present with several different infection statuses, and dependent on the child's age and caregivers' status the methods to separate them from the general population safely will vary. The approaches are detailed in Box 13, Box 14, and Box 15 but ensure that they are conducted while remaining in line with the Seclusion and management of suspect or confirmed cases guidance[14].

Box 14. Overarching requirements for admitted children

HR and communication requirements:

- No negative caregiver should be admitted with child inside the HEF red zone: it is strongly discouraged as it involves high risk exposure for caregiver.
- Assign dedicated nurse/social workers per shift as their focal point, to ensure care for the child.
- The assigned dedicated work should be able to speak with the child in their mother tongue, someone who is culturally appropriate (e.g., the same gender, same ethic group or from a group which shares a common respect with the child).
- A Social Welfare Officer (SWO) or relevant local officer to ensure contact is provided between child and care giver, ensuring a communication channel is available to establish contact.
- SWO should provide regular updates to the child's family (daily if possible).
- SWO should be part of HEF team taking care of the admitted person and must be done in full Personal Protective Equipment (PPE). They should participate in the prerequisite PPE training.
- Support IPC measures that do not put the parent/assigned caregiver at risk of infection whilst maintaining familial contact with their child – done through scheduled visits, phone and video calls, and other relevant means/communication channels.

Nutritional requirements:

- Health and nutrition team to provide adequate and appropriate nutritious feeds to the child as necessary and per the guidelines[1].

The following steps to facilitate contact tracing should be taken:

- Before separating a child from their family, all the child's details and those of their family members must be documented, and transferred with the child if they are moved to another facility or team within the facility.
- If the child was in school at the onsite of symptoms and there is possibility that other children in school may be contacts, comprehensive case investigation must be done in the school and decision on what happens into the school especially in the setting of extensive number of contacts in the school should be made in consultation with the Incident Commander (IC).
- Integrate data on comorbid mental health conditions in clinical forms and health information systems and ensure that the HEF is equipped with needed supplies of essential psychotropic medications. Ensure at least one staff member is trained to identify and provide care for people with common and severe mental health conditions, and to recognize potential interactions between medications for managing the disease and psychotropic medications.
- Provide basic psychosocial support to people, including providing information about common reactions to isolation, such as worrying about finances, health, or feeling anxious and irritable, and offering positive coping strategies like relaxation exercises or engaging in activities available at the HEF.

1 Nutritional care of children and adults with Ebola Virus Disease in treatment centers. WHO. 2014

14 WHO. 2023. Infection prevention and control guideline for Ebola and Marburg disease

Box 15. Child 5 years or younger has tested positive for a Filovirus or has symptoms and is admitted to HEF/seclusion site, their caregiver has tested negative or has no symptoms

- Assign dedicated nurse/social workers per shift as their focal point, to ensure care arrangements for the child. Inform the child (if they are old enough to understand) about shift changes and who their focal point is.
- The assigned dedicated work should be able to speak with the child in their mother tongue, someone who is culturally appropriate (e.g., the same gender, same ethic group or from a group which shares a common respect with the child)
- Provide play materials to the child as outlined in Box 28.
- Explain to the child that these toys belong to them only while in the facility, and that when released they will be given another set.
- To help children be able to easily identify their caregivers/focal points and to help them build relationships children could use soft felt tip pens while safely drawing on the PPE of their caregivers (with the caveat that the caregiver can ensure IPC protocols continue to be met and the PPE is not broken).

Box 16. Child 6 years or older has tested positive for EVD or has symptoms and is admitted to HEF/seclusion, their caregiver has tested negative or has no symptoms

- Admit the child to the seclusion site/HEF without a caregiver; detailing to the caregiver that the decision consider their individual condition, capacities and needs; in the decision consider both the best interest of the child and the need to avoid possible transmission/infection of the assigned caregiver.
- Assign dedicated nurse/social workers per shift as their focal point, to ensure care arrangements for the child. Inform the child about shift changes and who their focal point is.
- The assigned dedicated work should be able to speak with the child in their mother tongue, someone who is culturally appropriate (e.g., the same gender, same ethic group or from a group which shares a common respect with the child)
- Provide play/educational materials to the child, as outlined in Box 28.

Box 17. Child tested positive or has symptoms, their caregiver also tested positive or has symptoms

- Admit child and their caregiver to the seclusion site/HEF together; keep child with caregivers as much as possible through the utilization of the patient liner in the same tent.
- Assign dedicated nurse/social workers per shift as their focal point, to ensure care arrangements for the pair. Inform the pair about shift changes and who their focal point is.
- In case the situation of the caregiver is deteriorating and at risk of dying, consider separating the child and identifying an assigned caregiver to stay with the child and provide support (to avoid a scenario where the child stays with a dying parent alone).
- Provide adequate and appropriate nutritious feeds to the child as necessary and per guidelines.

4.3 Case scenarios for admitted caregivers/pregnant and breastfeeding women

Caregivers/pregnant and breastfeeding women will present with several different infection statuses, and dependent on the child's age and caregivers' status the methods to place them into seclusion will vary, as detailed in Box 18, 19, 20 and 21.

Box 18. Breastfeeding woman and their nursing child have both tested positive or has symptoms

In addition to Boxes 14 and 15 the following steps should be taken for breastfeeding women.

If a breastfeeding woman and her child are both diagnosed with a Filovirus, breastfeeding should be discontinued, the pair should be separated, and appropriate breastmilk substitutes provided. However, if the child is under six months of age and no safe and appropriate breastmilk substitutes are available, or the child cannot be adequately cared for, then the option to not separate and continue breastfeeding may be considered. This is a conditional recommendation.

Box 19. Parent/caregiver has tested positive and/or has symptoms, their child(ren) has not

- Admit the parent/caregiver to the treatment/ seclusion unit as per standard protocol.
- Inform the parent/caregiver that the below steps will be referred to the contact tracing and SWO:
  - Inform the contact tracing team to determine if there are any children under the usual care of the caregiver who is admitted.
  - Contact tracing/surveillance team needs to inform the relevant local social welfare officials about any children left without care; and using the documents Nutritional care of children and adults with Ebola in treatment centres for children[1], and Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease[2] for children who are normally breastfed for guidance on nutrition feeding for this child – in conjunction with the nutrition team.
  - HEF staff to advise relevant SWO working in the community so that they can provide case management services to separated children. SWO to determine interim care solutions for each child in line with the alternative care guideline.

1 Nutritional care of children and adults with Ebola Virus Disease in treatment centers. WHO. 2014
2 Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease (who.int)

Box 20. Breastfeeding woman has tested positive and/or has symptoms, their nursing child has not

In addition to all actions in Box 19, the following steps should be taken for breastfeeding women:

- Breastfeeding should be stopped if an acute Filovirus is suspected or confirmed in lactating women or in a breastfeeding child. The child should be separated from the breastfeeding woman and provided a breastmilk substitute as needed.
- Children without a confirmed Filovirus status who are exposed to breastmilk of women with a confirmed Filovirus status should be considered contacts. The child should stop breastfeeding, be given a breastmilk substitute as needed, and undergo close monitoring for signs and symptoms of a Filovirus for 21 days. Post-exposure prophylaxis for Filovirus can be considered for children exposed to breastmilk of women infected with a Filovirus on a case-by-case basis and in accordance with existing research protocols. This is a conditional recommendation.

Box 21. Breastfeeding woman has recovered, the child is not positive

A woman who has recovered from a Filovirus, cleared viremia, and wants to continue breastfeeding should wait until after two consecutive negative EBOV breastmilk tests by RT-PCR, separated by 24 hours. During this time, the child should be given a breastmilk substitute.

Additional guidance for the management of pregnant and breastfeeding women can be found in WHO's 2020 guidelines cover specific recommendations broken into six topics[15]. These are:

- The management of acute EVD in pregnant women.
- The management of pregnancies in women who develop EVD during pregnancy and those who survive EVD with an ongoing pregnancy.
- Infection prevention and control (IPC) measures for pregnant women with acute EVD or who have recovered from EVD with ongoing pregnancies (with conception prior to EVD).
- IPC for women who become pregnant after recovering from EVD (with conception after EVD).
- Breastfeeding women with acute EVD or who have recovered from EVD.
- Vaccination recommendations for pregnant women who are at risk of acquiring EVD.

4.4 Family-friendly admission communication requirements

4.4.1 Structured communication with admitted persons, family members and visitors

When admitting admitted persons, briefings, interactive dialogue regarding the workings of the HEF and how the admitted person will be treated once admitted are needed. Different briefing topics can be found below, dependent on whether it is for the admitted person being admitted or family members bringing someone to the HEF.

Box 22. Structured communication topics to discuss with the admitted person

The below should be discussed with the admitted person, with the contents adjusted to be age appropriate (e.g., children may be more familiar with mealtimes as opposed to times of the day for visiting times):

- Explain the Filovirus (eg., Marburg or Ebola), symptoms, transmission, etc. using the translated terminology guidance from Annex 6.2.
- Explain how the response works: surveillance, alert system, etc.
- Explain the layout of the HEF (Annex 6.6, 6.8, 6.9).
- Explain the functioning of the HEF, visiting arrangements, communication channels.
- Take admitted person's information (Annex 6.3).
- Suggested FAQ to be adapted to local context and used found in Annex 3.
- If it is a child/care giver/breastfeeding mother, explain the relevant case scenario for seclusion as per Section 4.2 and 4.3.
- If it is a child, explain the relevant continuity of learning steps that will be taken as per Sections 4.8.
- Provide space and time to address the admitted person's doubts, concerns, etc. (feedback).

15 Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease (who.int)

Box 23. Structured communication topics to discuss with family members and visitors

- Explain Filovirus, symptoms, transmission, etc.
- Explain how the response works: surveillance, alert system, etc.
- Explain the functioning of the HEF, visiting arrangements, communication channels.
- Take admitted person's data (Annex 6.3).
- In case of admitted person's death, see actions and narrative in Box 38 and 39.
- If a child is being admitted, explain the steps taken to ensure age, gender and culturally appropriate support is being provided.
- If a child/care giver/breastfeeding mother is being admitted, explain the relevant case scenario for seclusion as per Section 4.8.
- If a child is being admitted, explain the relevant continuity of learning steps that will be taken as per Section 4.8 and what support may be needed from them.
- Provide space and time to address the family members doubts, concerns, etc. (feedback).
- Have available information of available care services to survivors of GBV/SEA, and referral pathways.
- Include messages on the impact of PHEs on women, support services available.
- If someone (survivor of GBV or someone else) discloses an incident of GBV, explain the referral pathway, care services available, and how to safely.
- How to access MHPSS for the child/adult admitted and for their visitors, including caregivers and community members.

4.4.2 FAQ from family and visitors and data collection

Facilitating strong communication pathways between admitted children and their parents/caregivers will strengthen community buy-in for the HEF. The below Q&A should be adapted for the context and running of the HEF and can help guide discussions with families and admitted people (Box 24).

Box 24. FAQs for families, visitors, and general data collection

- Can the family visit the admitted person in the HEF?
  - Yes, the family can visit the admitted person by coordinating the visit with staff on duty during visiting hours.
  - The family can bring food from home to the admitted person (confirming with the doctor if he/she can eat what will be brought to him/her).
  - The admitted person can keep their phone to communicate with the family.
  - When possible, other devices should be made available at the HEF for a communication between the admitted person and family.
  - Visitors must adhere to the principles of privacy, confidentiality, and consent when visiting HEF or interacting with women and children, particularly girls.
  - Do not collect or seek information on GBV and SEA experiences or incidents.
  - Do not share personal information of people without their permission. Doing so can put them at risk.
- What happens inside the HEF? This section explains the circuit of the HEF and what happens at each state.
  - Walking admitted person and ambulance entrance.
  - Referral pathways.
  - Family-friendly layout – explain design considerations and show layout map (Annex 6.8).
  - Visitor centre area.
  - Triage: questions about symptoms, etc.
  - Observation.
  - Hospitalization.
  - Red and green zones.
  - Showers/toilets.
  - Morgue: In case of death, clarify if and how the family can assist in the preparation of the body, e.g.: will they be supported with the coffin and transportation to the burial, what are the requirements for a safe burial in this context.
- Explain staff at the HEF and their roles:
  - Physicians/nurses.
  - Hygienists.
  - Psychologist[1].
  - Caregivers for children.
  - Sensitizer/social support.
  - Other staff working in the HEF.

Keep space/time to address the specific questions from the family, concerns, etc. (feedback).

1 If a psychologist is not available, then a social/case worker, community health worker, etc. can be trained to provide support related to MHPSS. Where needed, others can be trained using the mhGAP Humanitarian Intervention Guide.

4.4.3 Communication guidelines for people not admitted

To address miss-information and to clarify why people are not admitted to the HEF, all those who present to the HEF but do not meet the admitting criteria should be re-directed towards the Psychosocial Center to be briefed. This is done so to ensure any confusion or misinformation about admission or discharge is addressed, so that the person can understand and communicate the reasoning to community members and feels confident in their health status (Box 25).

Box 25. Information provided to those who were not admitted to the HEF via the Psychosocial Center

When people present to the HEF and do not meet the requirements to be admitted for additional screening, prior to be released they should be sent to the Psychosocial Center to be briefed about the HEF and the outbreak. Information should be adapted to be age appropriate and include:

- The functioning of the HEF and when people need to be admitted.
- Why they have not met the criteria to be admitted.
- The Filovirus (symptoms, transmission pathways, prevention, treatment and care services for survivors).
- Who they can reach out to in the community, with reference to the type of information they need (e.g. psychological support).
- Engagement with relevant community key people responsible for these areas will take place (e.g., religious leaders, elder women, etc.) and methodologies will be inclusive of existing community support processes.
- Keep space/time to address the specific questions, concerns, etc. (feedback).

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4.5 Admission kits

In addition to admission kids for adults, separate admission kits should be procured for children and adolescents, using gender, and sizing appropriate items for the local population (Box 26). Extractable tables can be found in Annex 6.10.

Box 26. Admission kits for children

To be provided in addition to the toy box. Sizes and relevant religious requirements should be accordance with local standards.

13-24 months	0-12 months	2+ years
1x Soap	1x Soap	1x Soap
1x Bath sponge	1x Bath sponge	1x Bath sponge
1x Towel	1x Towel	1x Towel
1x Toothpaste	1x Toothpaste	1x Toothpaste
1x Toothbrush	1x Toothbrush	1x Toothbrush
1x Body cream	1x Body cream	1x Body cream
1x Pyjamas	1x Pyjamas	1x Pyjamas
5x T-shirt	5x T-shirt	5x T-shirt
5x Skirt/pants	5x Skirt/pants	5x Skirt/pants/dress
5x Underwear	5x Underwear	6x Underwear
Nappies	1x Slippers/shoes	1x Slippers/shoes
	Nappies	

Nappies/diapers may also be needed for older children, but to be discussed with their caregivers when the child is admitted, and dependent on the local context. Teenage boys may require razors and additional soap for shaving.

Menstrual hygiene materials for girls and needs to bel planned for and provided for, to be provided to all girls and women of a relevant age (Box 27).

Box 27. Menstrual hygiene kits

As the items will be destroyed once the individual leaves the HEF, products should be sufficient for one cycle but also disposable. All admitted and age relevant girls and women should receive these kits, distributed by female staff, as questioning them regarding their menstruation cycle (for young girls) may be culturally inappropriate.

- 20x disposable pads (2x pack of 10).
- Plastic or paper bags to store the used pads.
- Additional pair of underpants in case of leakage.

To keep children entertained and reduce the stress of seclusion while keeping strict IPC measures in place, age-appropriate child-play boxes should be provided. Boxes should be adapted to the local context (e.g., toys that children are familiar with and can use when alone) and the RCCE team can be engaged to identify toys that are locally and culturally appropriate, while also consulting with children, caregivers, educators and/or community representatives.

Important note: All materials procured need to be reviewed to ensure safety/non-toxicity. Once procured, HEF staff should ensure that materials are handled properly, in a sanitary way, prior to delivering them to children.

For all toys, stick to hard or soft plastic so that they can be easily cleaned and sanitized or destroyed after use. Avoid toys with materials that cannot be cleaned and hollow toys. Also avoid toys (like balls) that can inadvertently travel outside the seclusion/treatment zone.

Each box is intended for one child only. Materials need to be able to be sanitized and disposable, each child should be given one box, when child is dismissed, content should be burned.

Some children may grow attached to toys given to them while in the HEF. To avoid additional stress to the child when leaving the facility, case workers should also prepare smaller children for leaving their toys behind and advise them that they will be given the same toys, that are safe, to take home with them when they leave.

A detailed breakdown of suggested supplies per age group and purpose can be found in Box 28 and Box 29.

Box 28. Entertainment and education supplies for children

1 child aged 0-3:

- 2x toys (either puppet/soft ball, puzzle, building blocks, book, small soft toy, etc.).
- Playing materials (different options):
  - Soft plastic squeeze toys (puppets – no fur so that is easily cleaned and sanitized).
  - Wooden toys (ex. building blocks, jigsaw puzzle – large size, no choking hazard).
  - Plastic toys (ex. building blocks, stacking set – large size, no choking hazard).
  - Books for children (cardboard or plastic).

1 child aged 3-6:

- Exercise book.
- Coloured paper.
- Colouring books.
- Small box of crayons.
- 2x toys (either puppet/soft ball, puzzle, building blocks, book, small soft toy, etc.).
- Playing materials (different options):
  - Soft plastic squeeze toys (puppets/balls – no fur so that is easily cleaned and sanitized).
  - Wooden toys (ex. toys building blocks, jigsaw puzzles, chain puzzle).
  - Plastic toys (ex. building blocks, stacking set).

Entertainment and education box content for 1 child aged 6+:

- Coloured paper.
- Plain paper/exercise book.
- Coloured pencils or crayons.
- Erasers.
- Sharpener (for adult use only to prep the coloured pencils if needed).
- Pencils and/or pens.
- Colouring book.

1 teenager:

- Discussions with teenagers while admitting them into the HEF can guide the materials they may be appropriate to provide them for seclusion. Teenagers may be provided with the kits given to children 6+ years of age with extra blank paper/exercise books to write in.

Box 29. Additional supplies for children in seclusion

- Educational and recreative videos.
- Portable televisions to screen age-appropriate tv shows/movies in communal areas seen from seclusion.
- Tables able to be disinfected following use for individual use of age-appropriate tv shows/movies.
- Speakers to play age and language appropriate songs.
- Mobile phones/credit/mobile data/Wi-Fi to facilitate means for voice communication from the seclusion areas to allow communication between children and their parent(s)/caregiver(s)/families inside and outside seclusion areas. A list of items can be found in Annex 6.10 and 6.11.

4.6 Workforce interacting with children in seclusion

Interaction with children is usually based on recruiting survivors as caretakers in the seclusion and quarantine areas and they become trained on the basic of childcare. When possible, survivors can be hired as caretakers: to provide job opportunities once discharged and to reduce further spread of outbreak in the community as survivors have a higher level of immunity, and to engage and empower them in the response. Box 30 details the actions required to facilitate appropriate scheduling requirement with children in the HEF. Box 31 breaks down how to interact with children in during examination and treatment and Box 32 the specific considerations for health staff interacting with children.

Box 30. Daily scheduling structures for children in the HEF

In both the suspected cases and confirmed cases fingers, develop an age and language specific (0-1/2-5/6-10/11-14/15-18) plan of activities during shifts:

Essential activities include:

- A daily explanation to the child what is happening, to be done at each shift change so that the child knows who it their primary point of contact.
- Organize interactive sessions to explain to the child what has happened and where they are.
- Allow time for questions and answers and collect children's feedback.

Recommended activities include:

- Educational and recreative games.
- Interactive feeding.
- Reading of laminated books.
- Organize structured visit with the family providing tools and support, including psychological support, to the family members to engage with the child.
- Print photos of family members if possible.
- Consider skin to skin with survivors for newborns (considering implication in terms of IPC – potentially by making disinfectant shower available for survivors when they leave the seclusion area).

Facilitation of these activities can be strengthened through:

- Consider 8 hours per shift and 3 survivors per child (instead of 24 hours per shift).
- Prioritize health worker survivors to be recruited to work in the HEF with the children.
- Consider increasing health worker incentives considering intensity of the work.

Box 31. Interacting with children in during examination and treatment

- The health care worker should be accompanied by the child's carer and at least one must be of the same sex as the child.
- Communication with the child(ren) should be sensitive to their age and level of understanding.
- No child should be left alone without immediate supervision.
- The healthcare worker should use, at minimum, basic psychosocial support skills in order to facilitate a trusting, safe, and empathetic experience for the child.

Box 32. Specific considerations for health staff interacting with children

- Health staff should work with surveillance team to identify for each adult admitted to the HEF if any children or other vulnerable individuals are under the usual care of the admitted person. Ensure that this is documented, and information handed to the district's Probation and Social Welfare Officer or relevant team for follow up, provision of case management and alternative care services.
- Health staff should inform the relevant local authorities if a child is admitted to the HEF so that they can start reaching out to the family with the PSS team, including to prepare the family once the child is ready for discharge.
- Training of relevant healthcare providers and or frontline staff on child friendly principles, GBV case management- including caring for child survivors
- Health staff should maintain a list of survivors discharged, female survivors and provide details to SWOs to support identification of interim care arrangements for children in need.
- Health staff/discharge team should inform SWOs whenever a child is discharged from the HEF to provide follow-up CP case management.
- Health staff should inform the psychosocial team whenever a child is discharged from the HEF to provide follow-up psychosocial care.
- Health staff should assess the child/adults who were admitted in a comprehensive way not to miss on other services in an approach of continuity of essential health services.
- Consider specific care arrangements for children in HEF by dedicated and trained nurses with background in social service delivery or social worker trained on disease prevention risk and management, with basic ECD training, and strong interpersonal communication skills.
- Keep in mind that people admitted may also be survivors of GBV (including SEA) or at risk. Therefore, it is important to take into consideration the below considerations when hiring and training staff:
  - Ensure social workers are trained on GBV case management.
  - Ensure other frontline workers trained on safe referrals (on the GBV Pocket Guide)
  - Ensure the availability of functional referral pathways.
  - Include messages on available services to address GBV.

4.7 Workforce interacting with children in the community, with family members in seclusion

Not all children accompany their primary caregiver to the HEF facility and may remain within the community once their caregiver has been admitted. Staff working in the community with children of caregivers that reside within the community should take special considerations and for older children who may be overlooked/classified as able to look after themselves (Box 33).

Box 33. Specific considerations for Social Welfare and Community Development staff

Considerations to work with health and psychosocial actors:

- Social Welfare Officers (SWO)/Community Development Officers (CDO)/relevant staff should work closely with health staff working in the HEFs and with the surveillance team conducting contact tracing and follow-up. They should receive and review the contact listing forms, and follow up with children who may be left home without adequate care and support to provide case management and care services.
- SWO/CDO/relevant staff should work closely with the health team when a child is discharged from the HEF to ensure follow-up case management can be provided based on needs, support reintegration into the family, community and school based on age.
- SWO/CDO/relevant staff should work closely with the psychosocial team to ensure coordinated provision of PSS to children and families they are working with, and be trained on PSEA and the use of the GBV Pocket Guide.

Provision of alternative care:

- Children should be provided with interim care with (extended) family as much as possible or trusted adults in the community.
- Essential services should be ensured for children under alternative care arrangements.
- Keep siblings together as much as possible even with alternative care options.
- If there is no one to take care of the child, they should be provided with temporary care with support from the SWO and following the alternative care guidelines.
- Before placing children in temporary care, explain the situation to them including other close relatives that could be available in appropriate language.
- SWO/CDO/relevant staff should consider reaching out to (female) survivors of EVD to provide interim care if care within extended family cannot be arranged.
- Those taking care of the child(ren) temporarily should practice prevention and self-care as per guidelines.
- Children in temporary care should be provided with psychosocial support through community structures and with support from the district EVD MHPSS team; they should receive follow-up from the surveillance team to monitor their status.
- Children should be supported to have regular contact through phone with their parents/caregivers. Space and time to answers children's doubts, concerns or any other feedback should be prioritised by those taking care of the children.
- **Putting children into an institution should only be the last option!**

4.8 Continuity and recovery of learning within the HEF

4.8.1 Early Childhood Care and Development/Early Childhood Development

One of the most sensitive phases in human development occurs in early childhood. This time is characterized by rapid brain development and the acquisition of foundational skills and competencies. Children who experience extreme and adverse stress in their early years are at greater risk for developing cognitive, behavioural, and emotional difficulties. Caretakers should aim to include Early Child Development (ECD) activities to ensure that children's basic rights to survival, protection, care, education, development, and participation continue to be met while in seclusion. An integrated approach to childcare is needed to ensure their wellbeing, development and learning needs and may mitigate the impact of seclusion on their mental health through the provision of routine and normalised activities. Learning should be age-relevant, and free from harsh discipline. It may include basic pre-math and early-literacy skills, as well as art, music, and dance. Activities should be instructed in the mother tongue to ensure the child understands. Child-driven free play can be a powerful tool for enabling children to regain a sense of normalcy, order, and hope during crisis. This approach promotes resilience and allows children to take part in their own recovery, as detailed in Box 34.

Box 34. Provisions for Early Childhood Care and Development/Early Childhood Development

The following provisions can be provided to support continued learning:

- Individual child kits (toys, paper, colouring materials, pencils, etc.), as detailed in Section 4.5.
- Tables and mats.
- Trained caregivers, as detailed in Section 4.6.
- Adapting mental health and psychological support interventions to the local context.

4.8.2 Primary and adolescent aged children

Children of primary and secondary school age will need specific support to address their individual learning needs. There is need for close collaboration with the school to identify appropriate learning content based on current syllabus coverage and general competence of the learner, as per Box 35. The timing and scope of all learning activities should be provided with guidance of a physician. There should be no formal assessment of the child. Learning can also be enhanced through the provision of MHPSS. In some cases, school-age children will benefit from specialized support services, including counselling from specialized health care workers.

Box 35. Activities for primary age children and adolescent development

The following activities are proposed:

- Provision of learning materials (books, notes, appropriate learner self-assessment materials, etc.).
- Scholastic materials based on needs.
- Support with audio and TV lessons and digital learning platform (where available/appropriate).
- Trained teachers to assess and support learning through routine visits.
- Open dialogues sessions to answers children and adolescents' doubts, concerns (feedback).
- Provision of counselling support to young people to prepare them for returning to school/home. For adolescent boys and girls, there is need for routine counselling based on assessed needs for social, emotional, and psychosocial wellbeing.

4.9 Food

Every person who has been admitted to the HEF should receive nutritional support that has been adapted to their age and conditions. Detailed guidance for relevant food and nutritional protocols can be found in Appendix G of the Clinical management of patients with viral haemorrhagic fever: a pocket guide for front-line health workers: interim emergency guidance for country adaptation (2016)[16] and feeding schedules can be found in the Interim Guideline: Nutritional care of children and adults with Ebola virus disease in treatment centres (2014). Extracted in Box 36 are the considerations for nutritional care of infants and children:

Box 36. Considerations for nutritional care of infants and children for food and feeding schedules

- For children aged from 6 to 59 months, mid-upper arm circumference (using disposable tapes) and the presence or absence of oedema could be used to screen for malnutrition, if feasible.
- Treatment should be applied according to the national protocol for severe acute malnutrition, while simultaneously considering the principles of treatment for EVD.
- For the breastfed infant of a Filovirus-infected mother where the infant is asymptomatic, it is recommended that the infant is separated from the mother and is replacement fed.
- For the breastfed infant of a Filovirus-infected mother where the infant has developed Filovirus or is a suspected Filovirus case, the risks of not breastfeeding (considering community infection control and infant nutrition) outweigh any possible benefits of replacement feeding. If the mother is well enough to breastfeed, she should be supported to continue to do so. If the mother is too ill to breastfeed, then replacement feeding is needed.
- The safest replacement feeding in the current context for infants aged less than 6 months is Ready-to-Use Infant Formula (RUIF). Wet nursing is not recommended.

As mealtimes are commonly a time of less stress and admitted persons may be more open to engaging, they can also be used as a moment to check in on the mental health status of the child. These check-ins are also important for children being held in the nursery, those who tested negative so may have a higher ratio of children to caregiver.

Relevant hygiene promotion activities and interactive dialogue session should also be conducted in the leadup to the meal, especially with younger children in seclusion who may require additional guidance and support[17].

4.10 Visiting and communication facilitation

Facilitating communication with admitted people, both those in a condition to receive visitors and those who are bedridden, is an important part of decreasing the impact on children and adolescents in seclusion (Box 37). All communication and visits should adhere to the principles of safety, confidentiality and consent, and data collected should be treated confidentially.

16 Clinical management of patients with viral haemorrhagic fever: a pocket guide for front-line health workers: interim emergency guidance for country adaptation. 2016 (WHO)
17 Infection prevention and control guideline for Ebola and Marburg disease, August 2023 (who.int)

Box 37. Scheduling and communicating visits to admitted persons and families

Dependent on the HEF staffing scheduling, timing for potential visitors could be included during the daily shift change/other relevant meeting format. During these meetings, the following should be defined:

- Timing for visits: of day and duration of time.
- Identification of support staff required to admit and escort family members throughout the HEF, and answer questions they may have.
- Steps taken to confirm with RCCE/MHPSS/relevant community engagement officers or with those responsible for informing family members/relevant community members.
- A backup plan, in case primary plan does not work due to changing circumstances (e.g., surge in admissions, issues with security).
- For admitted persons who are bedridden, or unable to see family members, alterative means including phone calls or video calls should be supported.

4.11 Deceased individuals within the HEF

4.11.1 Coffins

For the instances where the family is unable to bring a coffin, local procurement of a suitable structure should be conducted while the HEF is being established to remove delays in a dignified and safe burial.

4.11.2 Visiting the morgue

Visits to the morgue to visit deceased family members should be facilitated when safe and possible, and with the appropriate staffing (i.e., staff with expertise in MHPSS,at minimum, staff with experience in basic psychosocial skills). Timing and how family members are to be escorted throughout the HEF and areas of the morgue they're able to view should be planning and then communicated with the staff who are responsible for communicating the passing of the deceased to the family (as in Box 38).

Box 38. Topics to be covered when communicating with the family of the deceased

The below should be edited for the HEF's context and capacities of and done in conjunction with MHPSS staff

- Consult with the HEF team about the time of preparation of the body to coordinate the entry (to the HEF and to the morgue) of a family member to accompany the process if they wish to do so.
- In case they request the support of a coffin, explain the steps required (needed to be adapted to the context).
- In case the family would like to transport the body for the burial, explain the steps required (needed to be adapted to the context).

4.11.3 Actions and communication with relatives of a deceased admitted person

The death of a family and community member is a time of great distress and can increase fears around contagion. In addition to the steps provided in WHO's 2014 protocol for How to conduct safe and dignified burial of an admitted person who has died from suspected or confirmed Ebola or Marburg virus disease[18], Box 39 provides a script of the core information to be communicated to the family.

18 How to conduct safe and dignified burial of an admitted person who has died from suspected or confirmed Ebola or Marburg virus disease

Box 39. Script to guide informing the family of the deceased their family member has died

When informing a family about the loss of a loved one, it is important to speak gently, briefly, and with compassion. Families may not be able to absorb too much information at once. The following provides a script for information related to burial procedures, and should be adapted to local protocols:

- We are deeply sorry for your loss. Please know that the doctors, nurses, and care teams did everything possible to care for your loved one and to ease their suffering in their final moments.
- To protect the health and safety of all families and communities, we must now organize a dignified and safe burial. Our trained team, using protective equipment, will respectfully prepare your loved one. A family member may witness the preparation from a safe distance, if they wish.
- Your loved one's body will be gently cleaned, placed in a burial bag, and then in a casket. You may provide a casket, or we can provide one for you. Before the casket is closed, family members will have an opportunity to view their loved one from a safe distance.
- The casket will then be transported to the burial site that the family has prepared. Our team will accompany the burial to ensure everything is handled with respect and care.
- Please be reassured: family members who are healthy do not pose any risk to others.
- We also have psychological support available to help you through this difficult time.
- Do you have any questions or anything you would like us to explain further?

4.12 Discharge

When an admitted person is discharged from the HEF, clear communication should be conducted with the family and admitted persons to facilitate their return to the community. If RCCE/MHPSS/community engagement workers are working in collaboration with the HEF, they may assist in communicating with the relevant communities (beyond the direct family that comes to collect the discharged admitted person) (Box 40). The additional relevant services that are available within the community, for example GBV services, should be identified and shared with the person being discharged.

Box 40. Child has been cleared to be discharged

- Ensure that the child is handed over to a recognised caregiver upon discharge, and that the care giver is briefed about how to welcome the child back into the community.
- Upon discharge of the child, inform the Psychosocial Support (PSS) or relevant teams to continue providing PSS; also inform the child protection staff to conduct a child protection needs assessment and provide case management services based on needs.
- Upon discharge of the child, inform the caregiver to continue providing care and support to the child and, if present in the community, enrol them in the survivor's programme. If a survivor's programme is not available, provide referrals to community-base structures are in place to support their full return.
- Prior to discharge, the destruction of toys and items that the child used within the HEF should be explained to the child in terms they understand and they should be made aware that they will not take the same set of toys with them.
- Upon discharge, the health team should collect all play materials and have them destroyed and not carried home.

Children may grow attached to certain toys/items used while in the HEF. If it is possible to appropriately disinfect the toys and if they child may face excessive stress if from a specific, this option may be discussed.

4.12.1 Discharge briefings

Before individuals are discharged from the HEF, child or adult, briefings should be held for the individual being discharged. Box 41 summarizes the key points, which need to be edited for the local context and to match the capacities of the support team. It is key to express that those who have been released are no longer sick and cannot contaminate anyone, and allow for sufficient time to answer any questions the discharged individual or caregiver may have. Offer for a member of the communication/MHPSS team (and/or a trusted actor from the community) to be present to make the necessary communications with community leaders, neighbours, and the community, explaining that the discharged individual does not represent any danger to others and that they will need the support and solidarity of the entire community.

Box 41. Discharge briefing for the admitted person

Important: all admitted people discharged from the HEF are free of the specific Filovirus. When being discharged should receive messaging on the available services in their communities and how to access them.

Return to Home and Community (adults):

- You are cured and immunized against the Filovirus during this outbreak.
- You cannot contaminate anyone.
- To ensure a smooth return to the community, our MHPSS team can accompany you to your neighbourhood/village.
- HEF staff will provide you with a discharge kit and explain what the items in the kit are used for.

Return to Home and Community (child and their caretaker):

- Summarize what the child experienced in the HEF to the child (age-appropriate explanation).
- Summarize what the child has experienced to their caregiver within the HEF.
- HEF staff will provide the discharged child with a discharge kit and explain what the items in the discharge kit are used for – to the child if old enough and to the care giver if the child is too young.

Psychosocial support for everyone:

- If available, psychosocial support to the discharged admitted person, advising that they may feel sad, depressed, discouraged, frustrated, tired, rejected. Where it is not available, referrals will be made to community-based structures for MHPSS and/or discharge support processes.

Reminder of referral pathways:

- If admitted persons feel that they have, or that someone they know has symptoms of Ebola, explain the steps they need to take (needed to be adapted to the context).

4.12.2 Discharge kits

Discharge kits should mirror what was given during admission (Box 26 for clothing and bathing materials and Boxes 28 and 29 for educational and entertainment supplies). Additional items can be based on local contextual needs: e.g., in locations with limited access to strong hygiene practices, hygiene kits should be provided to ensure the child is supported to continue to practice good hygiene behaviours. Discharged women and girls of menstruating age should also be allocated a menstrual hygiene kit, with reusable items replacing the disposable materials found in Annex 6.10.2. Further guidance on suitable materials can be found here.

5. Dismantling the HEF

5.1 Community briefings and engagement

In the leadup to the HEF's closure, the date must be agreed upon with the local authorities – to be conducted during the 42-day period of interruption of human-to-human transmission – the "end of the outbreak". Maintain communities' representatives informed of the process (Box 42). Once the date has been agreed upon, regular briefings need to be held with the community leaders (echoing those done while the HEF was established). Briefings should detail why the HEF is closing (detailing the three possible scenarios for identifying the last case[19], what the different recommended activities are being conducted during the 42-day period to identify further cases and support survivors[20], and how both are being conducted in their specific communities. Details of how the HEF is being dismantled, with emphasis given on how the grounds it was constructed on will be disinfected and not pose a risk to the community should be provided – both if the HEF was established within a health facility and if the HEF was established outside of the health facility.

Engagement meetings should be held on a weekly basic with leaders and other communities' representatives, to update them on developments in the epidemiological situation (increase/decrease of cases, of if the situation remains the same and on track to shut the HEF). The same frequency of briefings should be held with the community, and here the emphasis should continue to be on the work being conducted to ensure the grounds are safe for the community once the HEF is dismantled. Ensure the briefings are interactive and communities' concerns, questions and other feedback are addressed. When established, briefings should provide information on additional services, for example where survivors, caregivers/families, and community members can go receive MHPSS.

The departure date should be established with local authorities and communicated to community. There is evidence in grey literature of incidents now of closure of facilities, especially when they are outside of health structures (in stadiums, parks, etc.) so it is recommended to incorporate a risk analysis to understand local dynamics and proceed according to the findings. If there is a risk commodities may be taken during the closure, the team should discuss with the relevant security officials to determine the most peaceful way to dismantle the HEF.

Box 42. HEF dismantling community briefings

- Closure dates to be agreed on with the local authorities.
- Once dates agreed upon, weekly meetings should be held with community leaders and other communities' representatives to communicate the message and address questions (e.g., regarding the safety of the grounds once closed).
- A risk assessment should be done prior to the closure of the HEF (specifically for those in public grounds/ outside of a health facility), and if a risk that commodities may be taken during the closure, the team should dismantle the HEF in one day prior to the officially publicised closure date.

19 WHO recommended criteria for declaring the end of the Ebola virus disease outbreak
20 Ibid

6. Annexes

6.1 Family-friendly checklist

The below checklist should be used to guide the thinking behind and implementation of creating a family-friendly HEF, broken into categories and with the relevant boxes indicated.

Activity	Conducted by	Conducted on	Comments
Translation of terminology into local language(s) (Section 3.2/Annex 6.2)			
Community briefings and engagement conducted (Boxes 1, 2, 3)			
Psychosocial Center to facilitate information, briefings, and provision of or referrals to MHPSS (within HEF and in community) (Boxes 4, 24, 25, 37, 42)			
Creating safe spaces for children to be secluded (Boxes 5, 6, 7)			
Creation of the child-friendly learning, playing and participation place (Box 8)			
Family-friendly HR briefings and screenings (Boxes 9 and 10)			
Infrastructure to support child-friendly implementation (Boxes 11, 12)			
Supplies to support child-friendly implementation (Boxes 26, 27, 28, 29)			
Placement and support required for admitted children, caregivers, and breastfeeding mothers (Boxes 13, 14, 15, 16, 17, 18, 19, 20, 21)			
Staff working with children, caregivers and breastfeeding mothers trained on appropriate interaction methods and information to be communicated (Boxes 22, 23, 30, 31, 32, 34, 35, 37)			
Staff working with family and friends of admitted people trained on appropriate interaction methods and key communication objectives (Boxes 24, 33, 37)			
Staff working with non-admitted people trained on appropriate interaction methods and key communication objectives (Box 25)			
Family-friendly catering requirements (Box 36)			
Discharge communication objectives for discharged individuals and communities (Boxes 40, 41 and 37)			
Staff working with the family of the deceased (Box 38, 39)			
HEF dismantling community briefings conducted (Box 42)			

6.2 HEF terminology

The below terminology covers the key technical terms needed to be communicated to admitted persons and their families to facilitate effective communication. It should be done to recognize the humanity of individuals rather than reducing them to their roles as patients, fosters community trust and understanding, particularly when translating medical terminology into local languages to avoid confusion.

Breastfeeding Ebola disease survivor

For the purposes of this document, a breastfeeding Ebola disease survivor is defined as a person:

- With two confirmed negative ebolavirus RT-PCR test from a sample of any breastmilk and who has subsequently recovered.

AND/OR

- With IgM and/or IgG positive on ebolavirus serological testing.

Suggested phrasing should be a culturally appropriate local language translation for 'someone who is breastfeeding'. "Ebola disease survivor" should be defined as below.

Child

'Children' constitute any a young human between birth and up to 18 years of age.

Suggested phrasing should be a culturally appropriate local language translation of 'A human between birth and 18 years of age'.

Child-Friendly Space (CFS) and Child and Family-Friendly Spaces (CFFS)

A secure, safe, stimulating, and supportive environment for children that offers children opportunities to develop, learn, play, participate and build/strengthen resiliency. The space that evolves to identify and find ways to respond to relevant threats to all children and/or specific groups of children. Although CFFS is an actual physical structure, not all activities and services required to address the specific needs of children will take place within this actual structure. In principle, many activities and services will take place in other locations, even though they would be organized and managed by the CFFS staff.

Suggested phrasing should be a culturally appropriate local language translation of 'a safe and age-appropriate space for children and their families'.

Ebola disease (EBOD)[21]

Formerly known as Ebola haemorrhagic fever, EBOD is a severe, often fatal illness affecting humans and other primates, and is caused by different species. Case fatality rates range from 25%-90%. The virus is transmitted from wild animals (such as fruit bats, porcupines, and non-human primates) to people; it then spreads in the human population through direct contact with the blood, secretions, organs, or other body fluids of infected people, and with surfaces and materials (e.g., bedding, clothing) contaminated with these fluids.

21 Infection prevention and control guideline for Ebola and Marburg disease, August 2023. Geneva: World Health Organization; 2023 (WHO/WPE/CRS/HCR/2023.1). Licence: CC BY-NC-SA 3.0 IGO.

Suggested phrasing may already exist within the community. RCCE staff working within the community should identify whether a local word or expression exists and is related to positive transmission lowering practices: if it does, this term should be used. If phrasing or the word does not exist or would be detrimental to community engagement, Ebola disease may be used as the term following a translation of the above translated into a local language.

Ebola disease survivor[22]

For the purposes of this document, an Ebola disease survivor is defined as a person:

- With a confirmed positive ebolavirus RT-PCR test from a sample of any bodily fluid and who has subsequently recovered.

AND/OR

- With IgM and/or IgG positive on ebolavirus serological testing.

These definitions may be changed during an epidemic to correspond to the local situation on the round. In most cases, government/laboratory issued EVD Survivor's Certificates have been issued and should serve as the basis for verification of survivor status. However, cross-checking with HEF and health facility records and other databases and, in some cases, antibody testing, may be required.

Suggested phrasing should be a culturally appropriate local language translation of 'someone who medical workers confirm does not have Ebola'. "Ebola" should be defined as above.

Health Emergency Facility (HEF)

A family-friendly Health Emergency Facility (HEF), developed by UNICEF, the World Health Organization (WHO) and Medicins Sans Frontieres (MSF), with support of the Techne Network, capable of being rapidly deployed and equipped in the event of future disease outbreaks.

Through collaborative inter-agency procurement planning and coordination, the HEF draws on guidelines and a digital planning tool which includes pre-designed layouts and products lists that emergency staff can select based on the needs for each location. It includes products, equipment and structures needed for establishing and operating HEFs, including new and innovative products to support the response. It includes layouts with guidance for setting up family-friendly surge facilities that ensure safe case management.

Suggested phrasing should be a culturally appropriate local language translation that addresses the way that the HEF has been deployed in the area. Most commonly it will be the layout of the structures that allow for family-friendly surge facilities that ensure safe case management.

Interruption of human-to-human transmission – the definition of the "end of the outbreak"

The acute phase of the outbreak is defined by the propagation of the virus within communities through transmission of the virus from one person to another. This phase will be considered to have been interrupted when no confirmed or probable Ebola virus disease (EVD) cases are detected for a period of 42 days (i.e., twice the maximum incubation period for Ebola infections) since the last potential exposure to the last case occurred).[23]

22 Clinical care for survivors of Ebola virus disease WHO 2016
23 WHO recommended criteria for declaring the end of the Ebola virus disease outbreak

Suggested phrasing should be a culturally appropriate local language translation that expresses that there are no more confirmed or suspected cases in the community and that the outbreak is over.

Isolation

The separation of sick people with a contagious disease, in this instance Ebola or Marburg disease, from people who are not sick.

Suggested phrasing should be a culturally appropriate local language translation that expresses a person is being who tested positive for EMD safely and respectfully secluded from the community while they are feeling unwell.

Laboratory confirmed case[24]

Any suspected or probably cases with a positive laboratory result. Laboratory confirmed cases must test positive for the virus antigen, either by detection of virus RNA by reverse transcriptase-polymerase chain reaction (RT- PCR), or by detection of IgM antibodies directed against Marburg or Ebola.

Suggested phrasing should be a culturally appropriate local language translation of 'a person who is sick and this has been confirmed by a laboratory test'. If a child, then 'a child who is sick and this has been confirmed by a laboratory test'.

Marburg disease (MARD) [25]

A highly virulent disease that causes haemorrhagic fever, with a case fatality rate of up to 88%. Marburgvirus, which causes MARD, is in the same family as the virus that causes Ebola disease. Human infection with Marburgvirus results from prolonged exposure to mines or caves inhabited by Rousettus bat colonies. Once a person is infected with the virus, it can spread through human-to-human transmission via direct contact (through broken skin or mucous membranes) with the blood, secretions, organs, or other body fluids of infected people, or through indirect contact with surfaces and materials (e.g., bedding, clothing) contaminated with any of these fluids.

Suggested phrasing may already exist within the community. RCCE staff working within the community should identify whether a local word or expression exists that is related to lowering transmission practices, and if it does, this term should be used. If phrasing or word does not exist, Marburg disease may be used as the term following a translation of the above translated into a local language.

Mental Health & Psychosocial Support[26]

This is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing or prevent or treat mental disorders. Originally coined by the IASC MHPSS reference group for use in emergency settings, this term is now widely accepted and used by UNICEF and partners across settings to safeguard the dynamic relationship between psychological aspects of experience (a person's thoughts, emotions, feelings and behaviour), the wider social experience (relationships, traditions), and values and culture.

24 Case definition recommendations for Ebola or Marburg virus diseases (who.int)
25 Infection prevention and control guideline for Ebola and Marburg disease, August 2023. Geneva: World Health Organization; 2023 (WHO/WPE/CRS/HCR/2023.1). Licence: CC BY-NC-SA 3.0 IGO
26 Global Multisectoral Operational Framework

Suggested phrasing should be a culturally appropriate local language translation that expresses this is support to help those who experience a range of emotions when being admitted to the HEF, or may have already past experiences and those who may have mental disorders.

Outbreak

Synonymous with epidemic. Cases of a disease are more than what normally expected: for Marburg and Ebola it is a single case.

Suggested phrasing should be a culturally appropriate local language translation that explains a surge in cases of a specific disease – in this case Marburg and Ebola.

Patient[27]

A person who is the recipient of health care.

Suggested phrasing should be a culturally appropriate local language translation for an admitted person who is inside the HEF (suspected or diagnosed), and can be broken into:

- A child who is sick but not lab confirmed.
- A child who is sick and lab confirmed.
- An adult who is sick but not lab confirmed.
- An adult who is sick and lab confirmed.

Probable case

Any suspected case evaluated by a clinician, or any deceased suspected case (where it has not been possible to collect specimens for laboratory confirmation) having an epidemiological link with a confirmed case.

Suggested phrasing should be a culturally appropriate local language translation of 'a living person who believed to be sick, following a evaluation by a health professional/clinician, or a deceased person where testing was not possible but they had a epidemiological link with a confirmed case. If a child, then 'a child who is sick and this has been confirmed by a laboratory test'.

Public Health Emergency (PHE)

The occurrence or imminent threat of an infectious disease outbreak or other threat whose scale, timing, or unpredictability threatens to overwhelm routine capacities to respond, and poses a substantial risk to the public's health including excess deaths and/or disabilities.

Suggested phrasing should be a culturally appropriate local language translation that expresses there is an increase in the pathogen (in this case a Filovirus, Ebola Marburg Disease), and it requires the public to be careful and practice relevant health seeking behaviours.

Quarantine

Separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

27 Definitions of Key Concepts from the WHO Admitted person Safety Curriculum Guide (2011)

Suggested phrasing should be a culturally appropriate local language translation that as a disease is contagious, those that have been near someone who was diagnosed, or those with symptoms need to stay in a safe place where they are able to stay a safe distance from friends and family.

Screening[28]

In geographic areas where a Filovirus, Ebolavirus or Marburgvirus is circulating, all persons (people inside the HEF, visitors, health, and care workers) should be screened using a no-touch technique at the first point of contact with any healthcare facility to enable early recognition of suspected cases and rapid implementation of source control measures.

Suggested phrasing should explain that when entering (as a visitor, guest, health care worker or other member of staff) will be checked through means that are not physical before the enter the HEF. Local language should express that this is done to help quickly identify those who may be sick to provide faster relief and treatment.

Suspected case[29]

A suspected case definition that is used by mobile teams, health stations and health centres. During an outbreak, the definition may be adapted to new clinical presentation(s) or different modes of transmission related to the local event:

- Any person, alive or dead, suffering or having suffered from a sudden onset of high fever and having had contact with:
  - a suspected, probable, or confirmed Ebola or Marburg case.
  - a dead or sick animal (for Ebola).
  - a mine (for Marburg).
- Any person with sudden onset of high fever and at least three of the following symptoms:
  - Headaches.
  - Anorexia/loss of appetite.
  - Stomach pain.
  - Vomiting.
  - Diarrhoea.
  - Lethargy.
  - Aching muscles or joints
  - Difficulty swallowing.
  - Difficulty breathing.
  - Hiccups.
- Any person with inexplicable bleeding.
- Any sudden, inexplicable death.

Suggested phrasing should be a culturally appropriate local language translation of the above methods of contact, description of at least three of the symptoms.

28 Guideline Infection prevention and control guideline for Ebola and Marburg disease (who.int)
29 Case definition recommendations for Ebola or Marburg virus diseases (who.int)

6.3 HEF admitted person and visitor follow-up sheet

This questionnaire is a required document for the admission of the individual to the HEF. The information you provide is essential for ensuring appropriate care and support for the admitted person. While participation is mandatory, all responses will be treated with the utmost confidentiality and used solely to enhance the quality of care provided at the HEF. By proceeding, you consent to share this necessary information, which will help us better understand and address the needs of patients and their families.

Admitted person's name: _____ Admission date: _____

Address (neighbourhood/village/street and number):

_____

Phone number (if available): _____ Email (if relevant): _____

Age: ____ Sex: _____

Onset of symptoms: _____

Symptoms: ☐ fear ☐ agitated ☐ pain ☐ trembling ☐ crying ☐ weakness ☐ screaming

Admitted person's condition: _____

Family members names and kinship (or friends): _____

_____

Name of family members/friends in the HEF: _____

_____

Admitted person/family member/friends number: _____

_____

6.4 Questionnaire for family members of Filovirus admitted person on admission to the HEF

We invite you to participate in this questionnaire to share your experiences and perceptions regarding the HEF. Your insights will not only contribute to our understanding of patient care for those affected by Filoviruses, including Ebola and Marburg, but also help strengthen the HEF and improve services for future patients. Participation is entirely voluntary, and you can withdraw at any time without any consequences. All information collected will be kept confidential and used for both enhancing healthcare practices and research purposes. By continuing, you consent to share your valuable experiences, which will aid in improving care for individuals admitted to the HEF.

Age: ___ Gender: _____ Relationship to the admitted person: _____ Education: _____

How would you describe the HEF?

_____

What are your perceptions when someone is admitted to the HEF?

_____

What are your perceptions when someone is discharged from the HEF?

_____

How has the experience of having a family member diagnosed affected your perception of the disease?

_____

How did you first become aware of the admitted person's symptoms?

_____

What actions did you take upon noticing the symptoms?

_____

How did you decide to bring the admitted person to the HEF?

_____

What have you heard about the HEF before?

_____

What challenges did you encounter while transporting the admitted person to the HEF?

_____

How would you rate the accessibility and availability of healthcare services for treatment in your community?

_____

Please use this space to provide any additional comments, concerns, or feedback related to the admitted person's experience with and journey to the HEF.

_____

_____

Thank you for your participation. Your input is valuable in helping us improve our understanding of the kind of care we can provide to people who have been admitted to the HEF.

6.5 Satisfaction questions, for the admitted person and family, on discharge from HEF

We invite you to participate in this questionnaire to share your feedback on the care and support provided at the HEF. Your insights will help us enhance the quality of care for individuals affected by Filoviruses, including Ebola and Marburg, and improve community awareness and prevention strategies. Participation is voluntary, and you may withdraw at any time without any consequences. All information collected will be kept confidential and used to strengthen healthcare practices and inform future improvements to the HEF. By continuing, you consent to share your valuable experiences, which will contribute to better care and support for patients and their families.

How satisfied are you with care and support provided to the admitted person at the HEF? If not very satisfied, why?

Is there any additional support or information you feel would have been helpful during the admitted person's treatment? What kind of information or guidance (support) would have been helpful?

What recommendations do you have for improving Filoviruses, including Ebola and Marburg awareness, prevention your community?

What recommendations do you have for improving the HEF?

Please use this space to provide any additional comments, concerns, or feedback related to the admitted person 's experience with a Filovirus and their journey to the HEF.

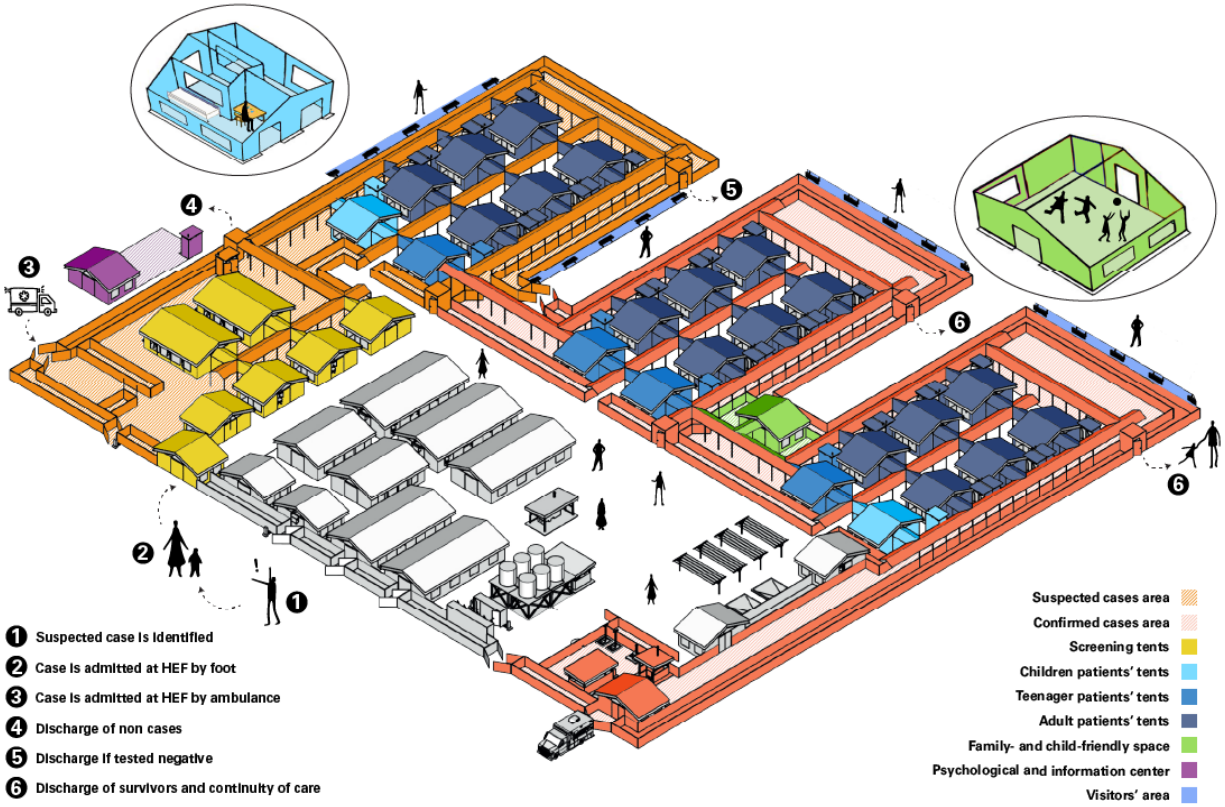
Thank you for your participation. Your input is valuable in helping us improve our understanding of by Filoviruses, including Ebola and Marburg, transmission and the kind of care we can provide to people who have been admitted to the HEF.

6.6 HEF layout

A blueprint of the HEF layout can be created via the Partner's Platform, that can be tailored according to the number of surge beds, time period, number of staff and assumptions of staff ratios by type, and human resource schedule (number of shifts). An example is below.

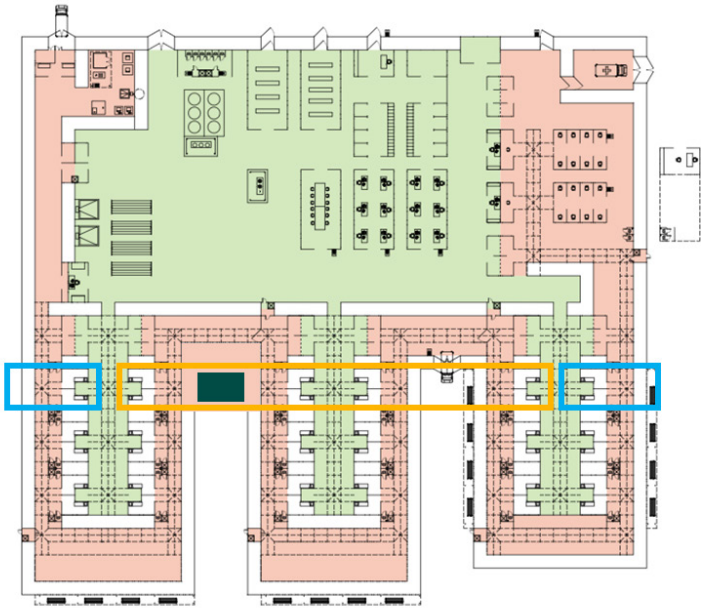
1. screening
2. patients' entrance
3. confirmed patients' entrance
4. ambulance entrance
5. ambulance disinfection
6. waiting room
7. triage
8. discharge negative
9. donning
10. doffing
11. staff's entrance
12. scrubs distribution area
13. staff changing rooms
14. staff latrine
15. staff shower
16. medical office
17. tech office
18. staff canteen
19. kitchen
20. chorination banks
21. water tanks
22. laundry
23. drying stand
24. waste zone
25. chlorination taps
26. water tap stand
27. grease trap
28. soakaway pit
29. waste storage
30. ash pit
31. sharp pit
32. organic pit
33. incenerator
34. logistic warehouse
35. pharmacy
36. electtrical equipment area
37. vehicles entrance
38. patients' treatment area
39. patients' latrine
40. patients' shower
41. laboratory
42. morgue
43. discharge survivors
44. care givers' shower
45. visitors' area
46. discharge non case
47. patients' resting area
48. psychosocial center
49. Pediatric room
50. Adolescent room
51. Family- friendly space for confirmed children and their caretakers

6.7 Family-friendly HEF layout for CFFS discussions

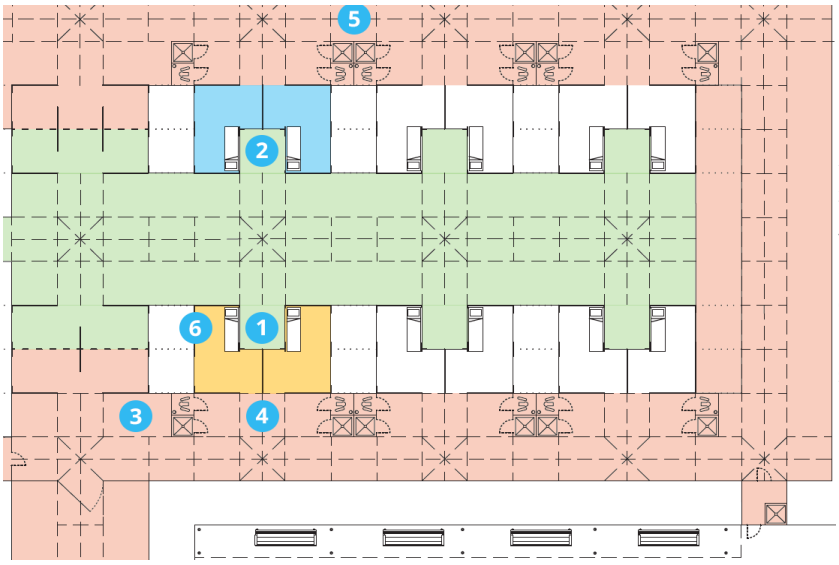


6.8 Family-friendly HEF layout for pediatric and adolescent beds

Below is a suggested layout for the child-friendly HEF during a Filovirus outbreak to guide admission discussions with families/caregivers/etc.



- Pediatric beds (20% of the total bed capacity)
- Adolescent beds, (Adolescent patients considered within the 80% of adult patients)
- Family-friendly space for confirmed children and their caretakers (within the patient area)



Design considerations:

1. Paediatric chamber
2. Adolescent chamber
3. Child-friendly toilet and shower
4. Caretaker bed for paediatric admitted persons
5. Access blocked from adult wards for safety
6. Bed rails for paediatric beds

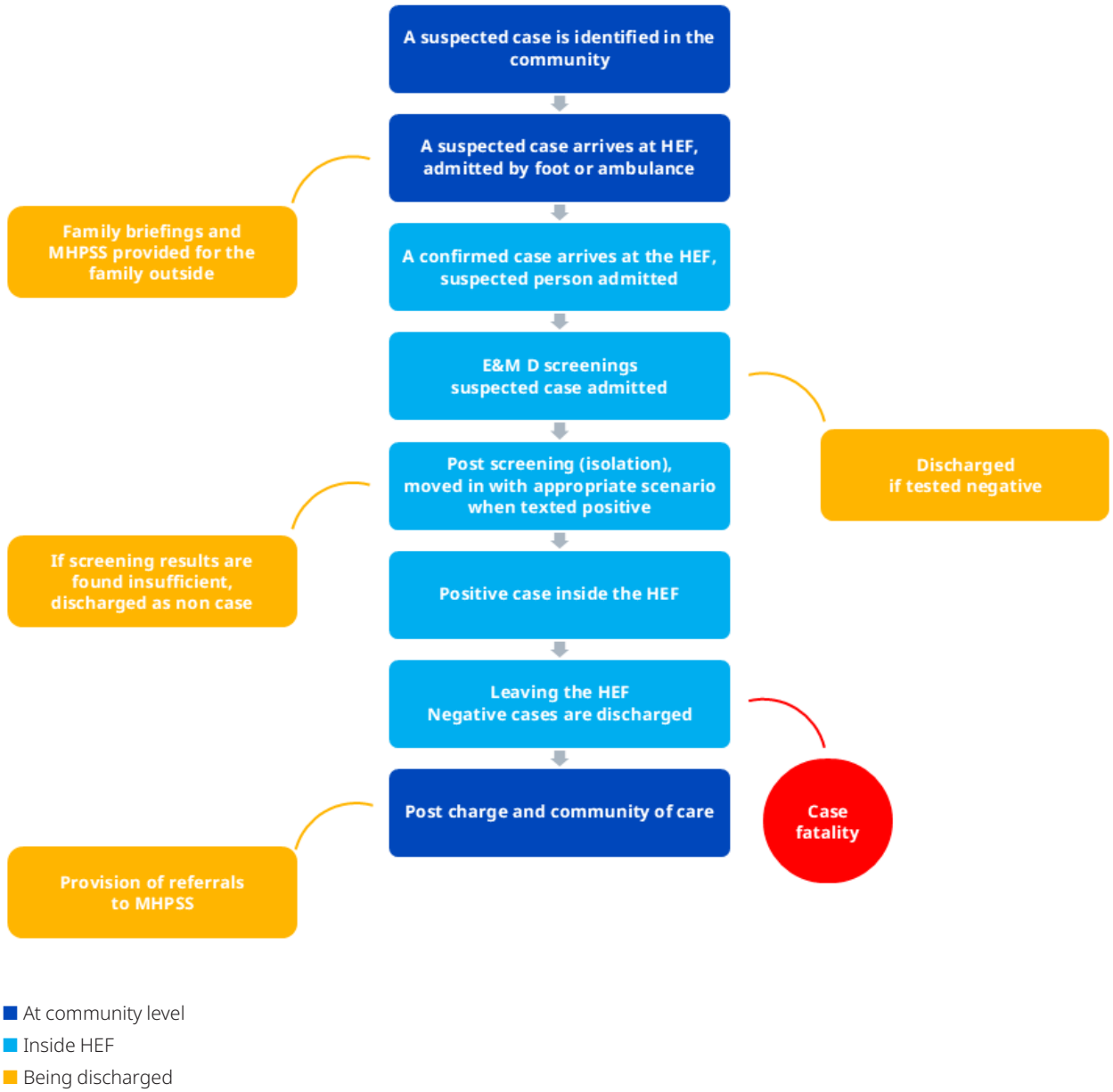
Services and product considerations in the wards:

- Well-lit spaces
- Multi-colored/dark bedsheets for adolescent patients
- Colorful walls, posters and pictures for children
- Toys & gadgets to look at/play with if there is energy

- Adolescent beds (Adolescent patients considered within the 80% of adult patients)
- Pediatric beds (20% of the total bed capacity)

6.9 Family-friendly HEF referral

This document can be used to guide children through the referral pathways for admission and discharge from the HEF. This can be used to help explain to a child what may happen if they feel sick and need to be admitted. The arrows indicate the pathway, from feeling ill while in the community, how the child could move through the HEF, and leave the HEF, and once released.



6.10 Admission kit tables

6.10.1 Admission kit for children (local procurement)

The below quantities are per kit, per child. Guidance quantification numbers for numbers of kits would be 20% of the admitted population. Items should be locally procured, with sizes and relevant religious requirements in accordance with local standards. Teenage boys may require razors and additional soap for shaving.

Item	0–12 months	13–24 months	2+ years
Soap	1	1	1
Bath sponge	1	1	1
Towel	1	1	1
Tooth paste (tube)	1	1	1
Tooth brush	1	1	1
Body cream	1	1	1
Pyjamas	1	1	1
T-shirt	5	5	5
Skirt/pants	5	5	5
Underwear	5	5	5
Nappies*	60	40	0
Slippers/shoes	0	1	1

*Nappies/diapers may also be needed for older children, but to be discussed with their caregivers when the child is admitted, and dependent on the local context.

6.10.2 Menstrual hygiene kit (local procurement)

As the items will be destroyed once the individual leaves the HEF/isolation facility, products should be sufficient for one cycle but also disposable. All admitted and age relevant girls and women should receive these kits, as questioning them regarding their menstruation cycle (for young girls) may be culturally inappropriate. An estimated for the number of kits can be derived from the expected number to be admitted by the gender breakdown (eg., 51% female, 49% male).

Item	Quantity
Disposable pads	20
Plastic or paper bags to store the used pads	20
Additional pair of underpants in case of leakage	1

6.10.3 Entertainment and education box content for children (local procurement)

To keep children entertained and reduce the stress of seclusion while keeping strict IPC measures in place, age-appropriate child-play boxes should be provided. Boxes should be adapted to the local context (e.g., toys that children are familiar with and can use when alone) and the RCCE team can be engaged to identify toys that are locally and culturally appropriate, while also consulting with children, caregivers, educators and/or community representatives.

1 child aged 0-3:

- 2x toys (either puppet/soft ball, puzzle, building blocks, book, small soft toy, etc.)
- Playing materials (different options):
  - Soft plastic squeeze toys (puppets – no fur so that is easily cleaned and sanitized).
  - Wooden toys (ex. building blocks, jigsaw puzzle – large size, no choking hazard).
  - Plastic toys (ex. building blocks, stacking set – large size, no choking hazard).
  - Books for children (cardboard or plastic).

1 child aged 3-6:

- Exercise book.
- Coloured paper.
- Colouring books.
- Small box of crayons.
- 2x toys (either puppet/soft ball, puzzle, building blocks, book, small soft toy, etc.).
- Playing materials (different options):
  - Soft plastic squeeze toys (puppets/balls – no fur so that is easily cleaned and sanitized).
  - Wooden toys (ex. toys building blocks, jigsaw puzzles, chain puzzle).
  - Plastic toys (ex. building blocks, stacking set).

Entertainment and education box content for 1 child aged 6+:

- Coloured paper.
- Plain paper/exercise book.
- Coloured pencils or crayons.
- Erasers.
- Sharpener (for adult use only to prep the coloured pencils if needed).
- Pencils and/or pens.
- Colouring book.

Box content for 1 teenager:

- Discussions with teenagers while admitting them into the HEF can guide the materials they may be appropriate to provide them for seclusion. Teenagers may be provided with the kits given to children 6+ years of age with extra blank paper/exercise books to write in.

Important note: All materials procured need to be reviewed to ensure safety/non-toxicity. Once procured, HEF staff should ensure that materials are handled properly, in a sanitary way, prior to delivering them to children.

For all toys, stick to hard or soft plastic so that they can be easily cleaned and sanitized or destroyed after use. Avoid toys with materials that cannot be cleaned and hollow toys. Also avoid toys (like balls) that can inadvertently travel outside the seclusion/treatment zone.

6.11 Additional child and family-friendly supply items

Quantity per 100 children	UNICEF Material Description and Number	Comments
60	10x Sanitary pads, female, w/wings, disposables (S5006282)	From a gender perspective, it is important that adolescent girls have access to adequate menstrual hygiene supplies. There are also more sustainable alternatives in UNICEF offering, but may need to be considered from a cultural perspective, such as reusable menstrual set and reusable menstrual cup.
20	100x Animal/people set, wood (S2595000)	It is important for children in isolation/treatment to have access to individual play materials. Access for at least a toy per child will also allow for improved interactions between workforce and children in isolation. Note on these toys being made of wood, not plastic.
4	5x Ball, sponge rubber, 60mm (S2702801)	
20	1x Radio, multiband, solar, wind-up, MP3, SD (S4590001)	To provide psychological and mental stimulation for children, including for audio educational/development materials that can be played via USB. For example, UNICEF and Spotify's Our Minds Matter mental health podcast for adolescents can be included on the USBs to promote resilience and equip adolescents with mental health and psychosocial coping strategies.
7	3x Posters, plasticized paper (S4420000)	These posters can be beneficial for workforce interaction with children, available in Arabic here.
20	Product to ensure children and youth can call for assistance/alert workforce in case of emergency (ex. Whistle, referee's, non-metalic) (S2797300)	
20	Pediatric beds (locally procured)	Additional note to procure beds for sufficient capacity to accommodate caretakers.
20	Solar-powered clock (locally procured)	Reference Box 30. To ensure children and youth can be informed of their routine and structure in the treatment facility.

20	Tablet (locally procured)	This product would allow for children and youths' continued access to educational materials, as well as interactive supports for mental health and promotion of resilience. This will be especially relevant for adolescents.
6	Toilets, including to be accessible for children and youth with disabilities (locally procured)	Add-on kit for use with standard squatting plate of dimensions 120 cm x 80 cm. This kit is designed for children and disabled people to facilitate the use when installed on one squatting plate.
1	Psychological First Aid for children, adolescents and families experiencing trauma (digital version)	
1	Materials to support in destigmatizing cholera in a child and adolescent-friendly format	This could be digital materials or posters.
1	Adolescent Kit (S5034001)	Serving 50 adolescents.
1	Recreation Kit (S9935024)	Serving 90 children. Items will be particularly relevant for outdoor activity areas
1	ECD Kit, 2016 (S9935064)	Serving 50 children.
1	Activity Catalogue for Child-Friendly Spaces in Humanitarian Settings (digital version)	Reference Section 2.6, Box 6. Can be loaded onto flash drive. Available in English, Arabic, and Ukrainian. Recommended by UNICEF MHPSS multi-sectoral Operational Framework.
5	Child Rights Cards (not in UNICEF Supply offering)	Either cards/posters should be developed in a culturally- and developmentally-appropriate way to ensure children and adolescents have easy access to information on their rights.

6.12 Core activities for the MHPSS personnel at Desk two of the PC

MHPSS personnel should facilitate the following activities to children, caregivers, family members and community members. Each activity is linked to the accompanying actions from the MHPSS Minimum Service Package and the MHPSS MSP Guidance for using the MHPSS MSP in the public health emergency response to infectious disease outbreaks ("guidance for the PHE response").

6.12.1 Coordination and integration

- Support integrating MHPSS in all HEF response activities, such as:
  - in community briefings and engagement during set-up and dismantling of the HEF.
  - for key infrastructure and equipment considerations.
  - in family-friendly communication requirements.
  - for continuity and recovery of learning.
  - in communication with relatives of a deceased admitted person.
- Collaborate across HEF staff teams to organize orientations on basic psychosocial support skills (e.g. Psychological First Aid) and MHPSS messaging (e.g. on common stress reactions, coping mechanisms).
- Promote MHPSS information exchange and use referral pathways adapted to the infectious disease.

Linked to MSP Activity 1.1; and see the guidance for the PHE response.

6.12.2 Assessments and services updates

- Conduct rapid assessments on MHPSS needs and resources, impacts on vulnerable groups, service availability, and trainings gaps for HEF frontline workers.
- Update assessments as the situation evolves, focusing on accessibility of MHPSS services and training.

Linked to MSP Activity 1.2; and see the guidance for the PHE response.

6.12.3 Support the community

- Train HEF staff teams on basic psychosocial support skills (e.g., Psychological First Aid).
- Engage community leaders and groups in MHPSS activities to reduce distress, promote dignity, and ensure psychosocial well-being.
- Disseminate culturally appropriate information and messages about the infectious disease that reduce stigma and empower communities.

Linked to MSP Activities 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8; and see the guidance for the PHE response.

6.12.4 Ensuring access to MHPSS services

- Use accessible formats (e.g., mobile apps, text, voice) to deliver MHPSS messages and services to people with disabilities and other minority groups.
- Ensure continuity of care (mental health services, medication) through alternative platforms (e.g., video calls, distance support).
- Adapt referral pathways for MHPSS services to comply with safety protocols.

6.12.5 Supporting people in quarantine and isolation

- Provide basic psychosocial support (e.g., Psychological First Aid) through helplines, virtually or through protective barriers.
- Offer information on isolation-related anxiety and coping strategies (e.g., relaxation exercises, and maintaining routines for learning).
- Facilitate "virtual safe spaces" and peer support through online platforms for recreation and self-care.
- Linked to MSP Activities 3.5, 3.6, 3.7; and see the guidance for the PHE response.

6.12.6 Support people in treatment units

- Propose how the HEF infrastructure can promote well-being, including by ensuring privacy and space for social and recreational activities.
- Facilitate communication between patients and loved ones via video calls and/or other modes in line with safety protocols.
- Avoid family separation where possible and provide alternative care for children when necessary.
- Provide basic psychosocial support and ensure mental health data and medications are integrated into clinical care.

Linked to MSP Activity 4.1; and see the guidance for the PHE response.

6.12.7 Support HEF frontline workers

- Provide accurate, timeline information on the infectious disease, healthy habits, and coping strategies
- Create opportunities for peer support, e.g., through remote messaging or video calls
- Regularly assess worker well-being through check-ins and surveys
- Ensure access to MHPSS services for all frontline workers involved in the HEF

Linked to MSP Activity 2.3; and see the guidance for the PHE response.

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