2019 | Facilitator Guide

Culture and Ethical Values in One Health and Infectious Disease Management

https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/hosted-initiatives-and-groups/global-health--development-group/

USAID FROM THE AMERICAN PEOPLE | One Health WORKFORCE | OHCEA Championing One Health | University of Minnesota | Tufts University

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First Edition

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OHCEA
8 Countries
16 Universities
24 Institutions

Contents

Preface

This module is One of the 16 One Health Training Modules developed by the One Health Central and Eastern Africa Network (OHCEA). OHCEA is an international network, currently of 24 institutions of higher education in public health, veterinary sciences, pathobiology, global health and environmental sciences. These are located in 16 universities in 8 countries in Eastern, Central and Western Africa regions.

The universities currently forming OHCEA are: Universite des Montagnes and University of Buea (Cameroon), University of Lubumbashi and University of Kinshasa (DRC), Jimma University, Addis Ababa University and Mekelle University (Ethiopia), Moi University and University of Nairobi (Kenya), Université Cheikh Anta Diop (Senegal), Muhimbili University of Health and Allied Sciences and Sokoine University of Agriculture (Tanzania), University of Rwanda and University of Global Health Equity (Rwanda), Makerere University and Mbarara University of Science and Technology (Uganda).

The OHCEA network's vision is to be a global leader in One Health, promoting sustainable health for prosperous communities, productive animals and balanced ecosystems. OHCEA seeks to build capacity and expand the human resource base needed to prevent, detect and respond to potential pandemic disease outbreaks, and increase integration of animal, wildlife and human disease surveillance and outbreak response systems.

The overall goal of this collaboration is to enhance One Health policy formation and implementation, in order to contribute to improved capacity of public health in the region. OHCEA is identifying opportunities for faculty and student development as well as in-service public health workforce that meet the network's goals of strengthening One Health capacity in OHCEA countries.

The 16 modules were developed based on One Health core competencies that were identified by OHCEA as key elements in building a skilled One Health workforce. This network is supported by two United States University partners: Tufts University and the University of Minnesota through the USAID funded One Health Workforce Project.

Acknowledgements

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OHCEA extends her gratitude to those who participated in earlier works that informed the development of this module as well as reviewers and editors of the module. Sections/parts of the materials for this course were adopted from RESPOND SEAOHUN One Health Course Modules: https://seaohunonehealth.wordpress.com/ecosystem-health/

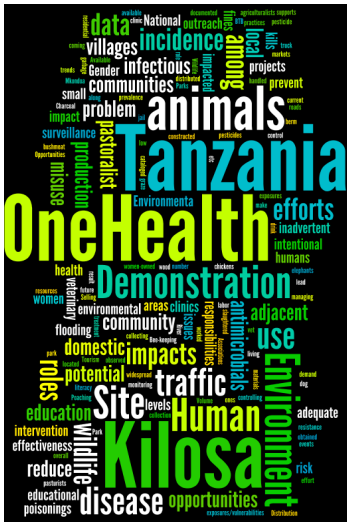
General Introduction

Training the Current and Future Public Health Workforce Using a One Health Approach

There is abundant evidence that no single sector or department can sufficiently manage the challenges of public health in any country, region or continent. Experiences from the fight against Ebola and the highly pathogenic avian influenza in the past few years demonstrated the effectiveness of multi-sectoral, multiagency approaches and the need for specific training targeting multi-sectoral and multi-disciplinary public health professionals not limited by national or regional borders in dealing with public health threats. In response to this challenge, the One Health approach has been advocated as the global framework for strengthening collaboration and capacities of the sectors and actors involved in health service delivery.

One Health Central and Eastern Africa (OHCEA) is a network of universities in Central, Eastern and Western Africa which are collaborating to build One Health capacity and academic partnerships between the member institutions in the region and with governments. The overall goal of this collaboration is to enhance One Health policy formation and implementation, to contribute to improved capacity of countries to respond to any emerging pandemics in the region.

OHCEA seeks to expand the human resource base needed to prevent, detect and respond to potential pandemic disease outbreaks, and increase integration of domestic animal, wildlife and human disease surveillance and outbreak response systems. OHCEA has identified One Health core competencies and developed modules based on the identified competencies that are key to delivering knowledge and skills to a multidisciplinary workforce and



One Health is defined as the collaborative effort of multiple disciplines working together locally, nationally, and globally to attain optimal health for people, animals and the environment

www.AVMA.org

The One Health paradigm emerged from the recognition that the well-being of humans, animals and the ecosystem are interrelated and interdependent and there is a need for more systematic and cross sectoral approaches to identifying and responding to global public health emergencies and other public health threats arising at the human animal ecosystem interface.

building a framework on which One Health curricula can be designed and implemented. They combine human health, animal health, infectious disease management with principles of ecology, social and environmental sciences.

A total of 16 modules have been developed including One Health soft skills such as communication, culture, leadership, gender and core technical skills such as ecosystem health, infectious disease epidemiology, One Health concepts and outbreak response. The modules are intended to:

- create a framework for One Health curriculum.
- improve workforce capacity to prevent, detect and respond to threats posed by infectious diseases and zoonosis.
- generate a shift in countries' workforce culture and training structure.
- enable working across sectors and disciplines for a stronger and more effective public health sector.
- allow universities to be key drivers of the future workforce as they forge partnerships and drive change.
- combine human health, animal health and infectious disease with principles of ecology and environmental sciences.

The modules can be used at both pre-service and in-service levels as full courses, workshops or integrated into course materials for professionals who impact disease detection, prevention and response, allowing them to successfully function as an integral part of a larger, multi-disciplinary, team of professionals. This is key to creating a stronger sustainable Public Health workforce.

Each module contains a Facilitator Guide, Student Guide, PowerPoint slides and a folder of resources/ references for users. These modules are iterative and are continuously being revised.

These 16 modules were developed by collaborative efforts of multiple disciplines and teams of people from seven different OHCEA partner countries with the support of two US university partners namely Tufts University and University of Minnesota. A team of 66 people were engaged in the development of these modules. All the materials represent contribution by the faculty and leadership of the OHCEA network institutions and the technical and managerial support of the OHCEA Secretariat.

The modules were built off previous One Health modules developed by SEAOHUN-network: https:// seaohunonehealth.wordpress.com/ecosystem-health/ with addition of more Africa-specific materials, examples and case studies relevant and applicable to the region. Each module was reviewed by OHCEA network faculty including US university partners with technical expertise as well as partners with field

experience that allows for One Health application and appreciation of the local African context.

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Module Overview

OHCEA recognizes the role that culture and ethical values play in shaping human behavior, choices and efforts in disease detection, prevention and response. This module exposes participants to a clear understanding of the role that culture plays in the management of diseases, particularly infectious diseases and how it affects the adoption of One Health practices. Participants will appreciate the various cultural dimensions, the complexities and sensitivity of culture, beliefs, values, gender, family and ethics. Participants are also supported to develop culturally sensitive and appropriate tools that are useful during the management of infectious diseases using a One Health approach. The One Health approach provides a holistic approach to control and manage infectious diseases. Participants are expected to focus on promoting effective communication, interactions amidst diversity of cultures and communities and yet working professionally among One Health stakeholders.

The importance of gender differences, roles, perceptions and behavior is critical in shaping outcomes of One Health interventions. Gender identities and relations are important aspects of culture because they shape the daily life in the family, community and even at the workplace. Therefore, this module incorporates gender sensitive and gender responsive training approaches alongside the training on culture and ethical values for effective One Health interventions to control and manage infectious disease.

This Module is part of a complete series of One Health educational and training materials designed to be used in whole or in part, to serve as a context- and culturally-relevant source of information for teaching undergraduate and graduate students and for training workshops focused on One Health professionals responsible for human, domestic animal, wildlife and ecosystem/environmental health. The module builds on already existing culture related courses in the health learnings/teachings such as sociology of health and illness and medical sociology already offered by universities worldwide.

Target Audience

This module on epidemiology can be used by undergraduate and postgraduate learners, middle cadre trainees, and in-service personnel from multiple disciplines and sectors (private, NGO's, civil society). The module can be adapted for continuous professional development by health professional organizations that directly and indirectly champion health practice from a One Health perspective such as medical and veterinary associations, nursing, public health, environmental scientists, biotechnologists as well as community, social and gender development professionals and practitioners.

Goal of the Course

This module is designed to enable participants gain capability to design One Health interventions that address differences associated with culture and ethical values in the management of infectious diseases.

Learning Outcomes of the Course

Participants are able to:

i) respond to culture and gender sensitive issues in the management of infectious diseases using a One Health approach.

ii) demonstrate cultural-based ethical considerations of human and animals during infectious disease management.

Learning Objectives of the Course

Participants will be able to:

i) define concepts of culture and gender in the context of One Health and infectious disease management.
ii) describe the role of culture and family in the management of infectious diseases.
iii) describe the role and implications of gender and the other silent voices in the management of infectious diseases.
iv) demonstrate the five essential behavioral elements that a culturally competent person must have to enable effective work in cross-cultural situations.
v) demonstrate the ability to assess cultural issues that impact on disease transmission and management particularly infectious diseases.
vi) demonstrate cultural-based ethical consideration of humans and animal welfare during One Health interventions.

Training Program Structure

Session 1	Session 2	Session 3	Session 4	Session 5
Unfolding concepts of culture and gender in the context of One Health and infectious disease management	The role of and philosophy behind culture and family in the management of infectious diseases	The role of gender and the silent voices in the management of infectious disease	Cultural competency Applying ethical values and principles for humans and animal's welfare during One Health interventions	Community assessment and management of infectious disease

Topic	Objectives	Instructional Activity	Materials	Time
Introduction to culture, cultural dimensions and cultural diversity	*i)* Define concepts of culture and gender in the context of One Health and infectious disease management. *ii)* Describe the role of culture and family in the management of infectious diseases	▪ Reflections ▪ Brainstorming ▪ Small group discussions ▪ Plenary discussions ▪ Self-assessments ▪ Classroom presentations ▪ Lecture ▪ Video watching ▪ Field work	▪ Sticky notes ▪ Markers ▪ Flip charts ▪ Masking tape ▪ PowerPoint Presentations ▪ Computer and internet access ▪ LCD projector ▪ Screen/blank wall ▪ Handouts on case studies	360 minutes
Gender and the other silent voices, One Health and Infectious Disease Management	*iii)* Describe the role of gender and the other silent voices (ethnic minorities, children and the elderly and society's very poor) in the management of infectious diseases	▪ Small group discussions ▪ Drawing pictures ▪ Gallery walk ▪ Brainstorming ▪ Classroom presentations ▪ Lecture ▪ Reading/ surfing internet	▪ Case studies ▪ Flip charts ▪ Markers ▪ Masking tape ▪ Sticky notes ▪ LCD projector ▪ Screen/ blank wall ▪ Handouts ▪ Computer and internet access	240 minutes
Cultural competency	*iv)* Demonstrate the five essential behavioral elements that a culturally	▪ Classroom presentation ▪ Brainstorming ▪ Small group discussions ▪ Assessment tool	▪ Computer and internet access ▪ LCD projector ▪ Screen/blank wall	120 minutes

	competent person must have to enable effective work in cross-cultural situations	development ▪ Self-assessment ▪ Internet searches	▪ PowerPoint presentation ▪ Computer ▪ LCD projector screen/blank wall ▪ Handout	
Applying ethical values and principles during One Health interventions	*v)* Demonstrate ethical considerations of humans and animals during One Health interventions	▪ Case studies ▪ Self-reflection ▪ Brainstorming ▪ Small group discussions ▪ Simulation	▪ Manila paper ▪ Markers ▪ Notebooks ▪ Pens ▪ Computer ▪ LCD projector ▪ Screen/blank wall ▪ Handouts ▪ Student Guide	120 minutes
Assessment of cultural issues that influence community health and disease management by reflecting on social and community determinants of health	*vi)* Demonstrate the ability to assess cultural issues in a community that influence infectious disease transmission and management	▪ Classroom presentation ▪ Field activity ▪ Report back session	▪ Student Guide ▪ Notebooks ▪ Recorders ▪ Pens	360 minutes

SESSION 1: Unfolding Basic Concepts of Culture in One Health and Infectious Disease Management

Session Overview: Introduction to Basic Concepts of Culture, Gender and One Health in the Context of Infectious Disease Management

This session will give participants an opportunity to learn more about each other's background, disciplines, and skills. It will provide an overview of the course goals, learning objectives and outcomes. Key terms and concepts on culture, gender, One Health and emerging pandemic threat (EPT) will be introduced. An overview of culture and changing traditions and implications on One Health practice will be provided and an introduction on interactions of cultures, environment and health delivered. Through interactive group activities, socio-cultural factors related to health beliefs and ethical principles will be explored, while identifying local cultural beliefs and practices related to human, animal and environmental health.

Session Learning Objectives

By the end of this session, participants will be able to define culture in the context of One Health and infectious disease management. They will be able to explain the meaning of culture, beliefs, values, gender and the One Health concept.

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
 30 min	Participant Registration		**Participant Registration** *i)* Have participants sign the attendance register. *ii)* Provide participants with the pre-training evaluation form and ask them to fill it in. *iii)* Explain logistics (e.g., breaks, meals, accommodation, transportation etc.).
	Welcome		**Welcome Remarks &**

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
30 min	Participant Introductions		**Introductions** *i)* Give welcoming remarks and introductions. *ii)* Guide participants on introducing themselves to each other through the following steps: **Group Activity:** *i)* In pairs, have participants share their: o Name o Where they are from o Type of work and position o A story about an experience they had that made them aware of the difference between men and women *ii)* Let them prepare 1-minute introduction of their partner to the class. *iii)* Go around the room and have each pair present their partner to the class.
 20 min	Participant Expectations		**Expectations** **Set up:** *i)* Have two flipcharts in the front of the room: one titled "Expectations" and the other "Concerns." *ii)* Give each participant two different colored sticky notes. *iii)* Ask participants to write down their expectations for the short course on one of the sticky notes (specify

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
			color) and their concerns about the course on the second the sticky notes (specify color). *iv)* Have participants place their `expectation' sticky notes on a flipchart titled "Expectations" and their `concerns' sticky notes on another flipchart titled "Concerns" *v)* Organize the sticky notes according to common themes.
20 min	Introduction to the Course	PPP No. 1	**Introduction to the Course** i) Present the PowerPoint **(PPP No.1)** on **Goal and Learning Objectives** of the course [Slide No 2 to 4] ii) Organize the expectations and concerns according to the goal and learning objectives of the short course, highlighting the expectations that will be met over the week and those that will not. iii) Explain that this course was developed by OHCEA, as one of the 16 course modules on One Health. iv) Present the PowerPoint slides **(PPP No. 1 Slides No. 4-17)** on the overview of the 16 One Health modules and on the culture, beliefs, values, gender and ethics module goals and activities. - If participants are not knowledgeable about OHCEA, make a presentation about OHCEA. - OHCEA has identified gender, culture, beliefs, values and ethics

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
			as a critical component to achieving their vision. For this reason, they have developed this course. v) Explain the agenda for the week.
 15 min	Guest Speaker: Official Workshop Opening		**Guest Speaker: Official Workshop Opening** *i)* In advance, be sure the speaker is prepared to address the group. Share with her / him the short course goals and desired outcomes and what you would like her / him to emphasize in her/his address. *ii)* Introduce the invited guest speaker to "officially open the course."

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
45 min	Definitions of Culture, Belief, Value and Gender		**Definitions of Culture, Belief, Value and Gender** **Confirm that participants have read the reading material on gender that was sent out to them to read before they come to the training:** 1. Ebola's Lasting Legacy by Erika Check Hayden: Nature: volume 519, 5 March 2015 2. Gender Issues in Human, Animal and Plant Health using an Eco Health Perspective by Brigitte Bagnol, Robyn Alders and Robyn Mcconchie: Environmental and Natural Resources Research Vol 5 No1, 2015 3. What the Solution Isn't: The Parallel of Zika and HIV Viruses for Women: Susan T. Fried and Debra J. Liebowitz: The Lancet global health blog; February 2016
20 min	What is Gender?	Discovery Activity	**What is Gender?** Ask the class to think as far back as possible and write down their first experience of realizing they/or someone they know were different from members of the opposite sex / were expected to act differently/were treated differently. Have them record the following: 1. How old were you? 2. Who was involved? 3. Where did the incident take place? 4. What incident was it? 5. How did you feel?

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
			6. How did the other aspects of your identity (race, religious identity, nationality, social status, and ethnicity) come into play? 7. If not, ask them to share a story about an experience that made them aware of the difference between men and women.
20 min	What Does It Mean to be Gender Sensitive?	Group Activity	**What Does It Mean to be Gender Sensitive?** Divide the class into two groups. Provide each group with a separate activity. Allow them 5 minutes to review the activity provided and then have them discuss it and present their findings to the rest of the team. **Group 1:** In this community, there is conflict between the people and the national parks because the community is collecting medicinal plants and firewood from the national parks - an area that is protected. The wildlife has also been destroying the villagers' crops and killing their domestic animals. The national park management decides to create awareness about the role of wildlife by delivering a training and awareness program primarily through night classes. **Group 2:**

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
			For several years, a community organization has announced its meetings and events through the use of a local grocery store and day-care bulletin boards, and has held its meetings in the local Women's Institute Hall. **Group 3:** The government in the country you work in wants to target farmers for training in poultry production and management on Avian Influenza prevention and control. They ask the animal health workers in the communities to identify people for training. Since men are the heads of households and the decision makers, they are selected to attend the training. **Group 4:** There is an outbreak of brucellosis in this community. Humans have been presenting at the health center with undulating fevers. They also have increased abortions among their animals. The disease is transmitted through contaminated milk and milk products. The department of human health decides to create awareness by informing people through the radios that they should boil their milk and cook the meat thoroughly. They are puzzled when the outbreak continues.
	What is One Health?		**What is One Health?**

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
20 min			**Preamble:** Introduce the concept of One Health based on the philosophy of multi-disciplinarity and inter-disciplinarity in the management of infectious disease. Present the PowerPoint **(PPP No. 2)** on "Position of Inter-disciplinarity in Infectious Disease Management (IDM)" **Discovery Activity:** i) Have each participant take 5-7 minutes to think about and legibly write down on separate sticky notes the answers to the following questions: 1. Give the meaning of One Health approach. 2. Identify two examples of One Health in practice. 3. Identify two to three advantages to multiple disciplines working together to promote One Health. ii) Have them display these sticky notes on the wall in the three separate sections. Then in a plenary, review the following: 1. What are the common things identified? 2. What are the differences? 3. Is there anything that surprised anyone? iii) Come up with a group description of what One Health is. **The Need for One Health**

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
	The Need for One Health	**Group Activity**	i) Introduce the next activity to participants. Inform them that in this activity, they shall appreciate the different stakeholders involved in addressing a complex health challenge such as an Ebola outbreak. ii) Explain **Case Study 1** on Ebola Virus: Adapted from Compendium of Case Studies by VSF Canada, 2010 iii) Provide the groups with Case Study 1 handout. Ask the groups to read their assigned parts, respond to the questions below the case study and write down their responses on a flip chart. iv) Instruct the groups to present their responses to the plenary and process their responses.
 30 min			**Group Activity** i) Introduce the next activity to participants. Inform them that in this session, participants shall examine a case study on Ebola in West Africa to appreciate the role of culture, beliefs and values in infectious disease management. ii) Mention that the case study that shall be used for this group activity shall be the one developed by Marshall, Katherine, and Sally Smith. "Responding to the Ebola Epidemic: What Role Does Religion Play? Case Study. Berkley Center for Religion, Peace and World Affairs. May 2016. **Case Study 2: Ebola in West Africa,**

Duration	Topic and Sub-topic	Activity Type	Facilitator Instructions
			2014/ 2015 **iii)** Mention that the case study that shall be used for this group activity is an extract from an article; **Garrett, Laurie. "Ebola's Lessons: How the WHO Mishandled the Crisis." Foreign A airs. September/October 2015.** iv) Make 3 groups, ensuring that different disciplines and gender are evenly distributed. v) Ask the groups to read the provided case study, respond to the questions below and write down their responses on a flip chart: From the case study provided: 1. What were the factors responsible for the spread of Ebola in West Africa in 2014? 2. What cultural considerations need to be taken into account when designing a public health response? 3. Identify any gender issues you see in this scenario. 4. What does this mean for One Health? 5. Reflect on your own cultures related to the above and summarize your findings. 6. Using the One Health approach, how would you manage this problem in your community? vi) Instruct the groups to present their responses to the plenary and process their responses.

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<tr><th>Duration</th><th>Topic and Sub-topic</th><th>Activity Type</th><th>Facilitator Instructions</th></tr>
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Summary of Session 1

Summarize Session 1 by delivering PowerPoint presentations on:

i) "Introduction to Culture, Gender and Ethical Values in Infectious Disease Management Using the One Health Approach" **(PPP No. 3)**
ii) "Family, Health and Disease"- **(PPP No. 4)**
iii) One Health and EPT terms and definitions
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End of Session Evaluation

i) Create the flip chart shown below.
ii) Give the class sticky notes to evaluate the training sessions for the day.
iii) Ask the class: "How did it go today?"
iv) Ask them to answer the question by drawing one of the faces below to represent their answer and adding comments that they would like to bring to your attention.

How did today go? ☺😐☹ *Comments:*
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Facilitator Notes for Session 1

What is One Health?

There are many different definitions of One Health by different health organizations, but for the purpose of the course, we will adopt the American Veterinary Medical Association (AVMA) definition of One Health (www.avma.org)

AVMA defines One Health as the integrative (collaborative) effort of multiple disciplines working together locally, nationally, and globally to attain optimal health for people, animals, and the environment. Together, the three make up the **One Health** triad, and the **health** of each is inextricably connected to the others in the triad.

The common theme of One Health is multiple disciplines working together to solve problems at the human-animal and environmental interface. Collaborating across sectors that have a direct or indirect impact on health involves thinking and working across silos and enhancing resources and efforts while valuing the role each different sector plays. To improve the effectiveness of the One Health approach, there is a need to create a balance and a greater relationship among existing groups and networks, especially between veterinarians and physicians, and to amplify the role that environmental and wildlife health practitioners, as well as social scientists and other disciplines, play to reduce public health threats.

In less than 10 years, One Health has gained significant momentum. It is now a movement and it is moving fast. The approach has been formally endorsed by the European Commission, the US Department of State, US Department of Agriculture, US Centers for Disease Control and Prevention (CDC), World Bank, World Health Organization (WHO), Food and Agriculture Organization of the United Nations (FAO), World Organization for Animal Health (OIE), United Nations System Influenza Coordination (UNSIC), various Universities, NGOs and many others.

The current One Health movement is an unexpected positive development that emerged following the unprecedented global response to the Highly Pathogenic Avian Influenza. Since the end of 2005, there has been increasing interest in new international political and cross-sectoral collaborations on serious health risks. Numerous international meetings and symposia have been held, including major initiatives in Winnipeg (Manitoba, Canada, March 2009), Hanoi (Vietnam, April 2010), and Stone Mountain (Georgia, US, May 2010), as well as four international One Health scientific congresses, the last of which took place in Saskatoon, Canada, in 2018.

Discovery activity: What does it mean to be gender sensitive?

Group 1:

The classes are held primarily through night classes which limits women who are care providers for children from attending. In some communities, women are not even allowed to go out at night. The park does not consult the community members on its plans. Considering the fact that most of the people who collect medicinal plants and firewood are women, they should be a key stakeholder in the decision making.

Group 2:

In this scenario, most backyard poultry farmers and people who keep less than 50 birds are women. If they are not compensated and yet they have lost their birds, they lose their livelihoods. As a result of this policy, whenever the women detect any sick birds, they quickly slaughter them and bring them to the markets for sale, thereby spreading the disease and exposing more people.

Group 3:

In most communities that were affected by avian influenza, the poultry caretakers were women. The women should therefore have been a key target for disease prevention training. However, since they are not part of the leadership circle in many communities, they are not involved in identifying trainees and cannot voice their opinion. Therefore, even if the men are trained, they will not deliver and the disease will still spread.

Group 4:

In this community, women do not generally listen to the radio. In fact, most radios are owned by men, and they usually listen to the news communally when they have men's gatherings between the hours of 2 and 5 pm at the market place. Women are not allowed in these gatherings. This is also the time when women are busy completing other household chores like collecting firewood.

Case Study 1: Case Study on Ebola Virus: Adapted from Compendium of Case studies by VSF Canada, 2010

The Disease

Ebola hemorrhagic fever (EHF) is a caused by a virus of the family filoviridae (same family as Marburg virus). The disease in people ranges in severity from a mild to fatal illness. Case

fatality rates in outbreaks may be as high as 90%. Initially the virus causes weakness, muscle pain, headache, fever and sore throat, followed by vomiting, diarrhea, rash, limited kidney and liver functions, and both internal and external bleeding. Symptoms appear 2 to 21 days after infection. To date, there is no vaccination. The only means of treatment is general supportive therapy and quarantine. Forest duikers (antelope species) and great apes are sensitive to lethal Ebola virus infection. The natural reservoir of the Ebola virus is believed to be in fruit bats, as they are capable of having asymptomatic infections. According to the World Health Organization, Ebola haemorrhagic fever is one of the most virulent viral diseases in the world. The Ebola virus was discovered in 1976 in Sudan and the Democratic Republic of Congo (DRC) after epidemics in Nzara, southern Sudan and Yambuku, northern Zaire (now known as the Democratic Republic of the Congo). Of the five different types of the Ebola virus - Bundibugyo, Sudan, Zaïre, Côte d'Ivoire and Reston – only the first three types have caused sizeable outbreaks. Ebola-Reston has been a concern in the Philippines, and in captive primate colonies, but is not considered a serious human concern. Pigs in the Philippines were recently shown to have antibodies.

Ebola haemorrhagic fever is transmitted via direct contact with an infected individual's (people or animals) blood, body fluids or tissues. Most outbreaks have spread through hospitals, family members taking care of ill people, or hunters of bush meat (primarily primates such as gorillas and chimpanzees, but also fruit bats). These groups, in addition to people living or traveling to areas where there is an Ebola outbreak, are considered vulnerable populations.

Animal-Human-Ecosystem Dynamics

Bats comprise 20% of all mammalian species and are essential for the functioning of the biosphere. Fruit bats in particular are essential for the pollination of flowering trees, and, through the carriage of seeds, the sustainability and diversity of tropical forests. Many fruit bats live in caves or mines. The mines, often in remote areas, and which are extracting some of the immense mineral wealth present in African soils for use in industrial products in developed countries, attract poor people in search of work and income. Wild primates and duikers, exposed to Ebola virus from fruit bats, get very sick, and are therefore easy to hunt as bush meat. Bush meat is eaten by poor people living in those marginal areas, with poor access to agriculturally-based foods, poor understanding of the nature of infectious diseases, and where medical care is poor to non-existent.

Response and Conclusions

In many cases, rapid responses have been mobilized by some combination of the World Health Organization, United Nations Children's Fund (UNICEF), Médecins Sans Frontières and other medically-oriented non-governmental organizations, the Global Outbreak Alert and Response Network (GOARN), the United State Centers for Disease Control, European Epidemiology Programs, and the Health Protection Agency in the United Kingdom. Social

mobilization, which involves working closely with anthropologists and local community groups, is now recognized as an important component of these responses. The Wildlife Conservation Society (WCS) has worked with hunters, villagers and local health care professionals to detect Ebola virus and report disease and death in wild primates, who are often the first point of contact for disease outbreaks. They have also developed a non-invasive test of feces for Ebola in these primates. Research to develop Ebola vaccination has been underway for years, but has yet to bear results. Wildlife groups such as WCS are hopeful that vaccines used in people might be used in related primates, as the disease is a serious threat to these endangered populations. This would have the double benefit of reducing the risk for human populations, in the way that vaccinating animals against rabies protects human populations.

Policy Implications

Development of vaccines for wildlife may have health benefits for people as well – and vice versa. Policy makers and corporate leaders might consider how some of the economic benefits enjoyed by mineral-importing countries and business could be more effectively invested in hospital, education, agriculture and road infrastructure in the countries where the minerals are being mined. This would be a win-win situation for both companies and exporting countries, enabling the creation of healthy, supportive communities. Furthermore, the continued collaboration with wildlife agencies working with non-human primates can help both with prevention and early reporting.

Questions for Case Study 1:

After reading the case study on Ebola and using your personal experience in your communities,

1. Identify the different categories of stakeholders that would be useful to work with to design a culturally sensitive control program for Ebola or similar disease.
2. List and discuss some of your core values that would be applicable to foster an appropriate response to Ebola or a similar disease.
3. Identify local beliefs and cultural practices in your own communities that would jeopardize efforts to respond to and control Ebola or a similar disease in your own communities.

Case Study 2: Porous Borders: The 2014 Ebola Epidemic in West Africa

Meanwhile, hundreds of miles away from the Liberian capital of Monrovia, at the edge of a great rainforest where Guinea, Liberia, and Sierra Leone meet, a two-year-old boy named Emile crawled about a water-soaked tree stump with other toddlers and discovered a bunch of little, furry winged creatures. Grabbing at them and poking them with a stick, Emile reportedly played with the nest of *lolibelo*—the name locals use to describe musk-smelling, dark gray bats with bodies about the size of

a child's open hand. Many months later, a team of German anthropologists and biologists would visit the Guinean village of Meliandou and determine that Emile's *lolibelo* were Angolan free-tailed bats or perhaps members of a similar species of mammal found across most of sub-Saharan Africa. Surviving children in the village told visiting scientists and reporters that youngsters had smoked *lolibelo* out of the tree, filled up sacks with the flying mammals, and eaten them. The men in the village often hunted larger fruit bats with roughly foot-long wingspans, called little collared fruit bats—one of only three bat species thought to carry the Ebola virus.

The global response to new pathogens continues to be limited, uncoordinated, and dysfunctional.

Whether he caught something from a tiny *lolibelo* or from a bigger fruit bat, on December 26, 2013, Emile came down with a soaring fever, bloody diarrhea, and nausea, and soon others in the village got sick, too. Emile died on December 28, and over the following six weeks, at least ten other villagers succumbed. Before dying, a Meliandou midwife went to seek help from her family in the nearby village of Dandou Pombo, passing the strange disease on. She then died in a hospital in the town of Guéckédou, after infecting one of her attending traditional healers. That ailing health-care worker went to a government clinic in the town of Macenta; after he died, four members of his family who had prepared his body for burial brought the disease home with them to a fourth area, Guinea's Farako District.

Back in Meliandou, baby Emile's grandmother died of the disease on January 11, 2014. Relatives from Dawa village attended her funeral, returning home before dying themselves. Soon, a primary chain of transmission was spreading the still-unidentified disease throughout Guinea and into Sierra Leone.

By February, terrified villagers were pouring into medical facilities across the region, including an MSF malaria clinic in Guéckédou, close to the Liberian border, where the 36-year-old Guinean physician Marie-Claire Lamah and her colleagues struggled to figure out what was wrong. "When I arrived, the mortality toll was between 80 and 90 percent," Lamah told *Le NouvelObservateur*.

Villagers and health-care workers could already see a pattern emerging, with the people who cared for their ailing loved ones and prepared their bodies for burial being the most likely to contract the mysterious disease. But the villagers continued to wash the cadavers, dress them in finery, ritually kiss and caress the deceased to wish them well in the afterlife, and bury the dead, all according to ancient traditions meant to ensure that angry spirits would not return to haunt the families of the dead for failing to provide proper entry for them to heaven. (People across the region later whispered to me that they were more afraid of angering their ancestors than they were of the disease.)

Meanwhile, near Guéckédou, a second line of transmission went untraced by health officials for weeks. It began, according to an investigation by *The New York Times*, with a woman named Sia Wanda Koniono, who visited the Guéckédou area and died after returning to her home across the border in Sierra Leone, on March 3. Although Guinean authorities knew about Koniono's death, they apparently made no attempt to notify their Sierra Leonean counterparts. The second line of transmission spread, unobserved, from Koniono's funeral across a broad swath of Sierra Leone and eventually into Liberia.

At this point, Gbanya knew nothing about Meliandou, the deaths in Guinea, or the strange outbreak that had crossed into Sierra Leone. What she did know was that all the doctors and nurses in Liberia

were demanding that she somehow raises enough funds to put everybody on the payroll. Negotiations with health-care workers and their unions broke down when Gbanya tried to explain how the pool fund worked and why she had enough money to pay only a quarter of them. "We had many discussions with health workers," Gbanya recalled. "But it's complex. They don't get it." So Liberia's government health work force went on strike. Gbanya pleaded for understanding, and eventually the disgruntled doctors, nurses, midwives, lab technicians, ambulance drivers, hospital managers, and Ministry of Health personnel returned to work, tentatively accepting vague promises of future payment. But it was a challenge. "I'm used to coping," Gbanya told me last December, shaking her head. "But from the moment of that health-care worker crisis in February, we haven't stopped. Not for one minute."

On March 12, 2014, Liberia's traditional Decoration Day, Gbanya joined thousands of fellow citizens to honor ancestors by festooning their graves with flowers and memorabilia—not realizing the epidemic had now crossed into Liberia, striking Foya, a town of 20,000 people in Lofa County. A week later, Guinea's top health officials released their first official statement on the mysterious Meliandou outbreak, with the Ministry of Health saying that 35 cases of a hemorrhagic ailment had been confirmed. The statement made no mention of the Koniono case or of evidence that infected individuals were crossing back and forth across the porous borders between Guinea, Liberia, and Sierra Leone, giving rise to the first multinational Ebola epidemic in history. The Health Ministry spokesperson, Sakoba Keita, told local reporters that most of Guinea's victims had been in contact with dead bodies and suffered "diarrhea and vomiting, with a very high fever. Some cases showed relatively heavy bleeding." He went on: "We thought it was Lassa fever or another form of cholera but this disease seems to strike like lightning. We are looking at all possibilities, including Ebola."

Finally, on March 23, the WHO announced that the cause of the outbreak had been conclusively identified as Ebola by France's Institut Pasteur. By then, the epidemic had already sickened many people in Guinea's capital city, Conakry, marking the first time in history that the disease had spread to a metropolitan center with an international airport. On March 24, in Guéckédou, MSF opened the first of what would become several Ebola treatment centers and began calling for international help to find and isolate infected individuals so as to stop the outbreak. Because it had carried out such actions in Kikwit in 1995 and for a dozen other Congo Basin Ebola outbreaks since, the organization was able to mobilize quickly. But little help was forthcoming.

The WHO reported that two suspected Ebola patients in Conakry had tested negative for the virus. But the next day, the organization acknowledged that 86 cases of the disease, including 59 deaths, had occurred in Guinea; that labs in Europe had confirmed the presence of the Ebola virus in 13 samples; and that it was investigating rumored cases in Liberia and Sierra Leone. At the same time, the Liberian Ministry of Health confirmed the country's first Ebola cases. The next day, a WHO field investigator sent a memo, later obtained by the Associated Press, to the WHO's African regional office, in Brazzaville, Congo, calling for urgent help, as "there is evidence of cross-border transmission." Then, on March 27, the WHO issued health alerts for all of Guinea, Liberia, and Sierra Leone, as panic took hold in Conakry. On the last day of March, Senegal closed its borders with all three countries, foreign businesses began withdrawing their expatriate employees, commercial air carriers started negotiations that would lead to a cessation of services, and the EU made the first pledge of international funds in response to the Ebola outbreak: $690,000.

By April 1, the number of cases in Guinea had jumped by almost 50 percent, to 122, with 80 deaths. Liberia now had eight confirmed cases. The WHO mobilized protective equipment for health-care workers in Conakry, but local health-care providers complained that what they really needed was water, electricity, basic medical equipment, and sanitation supplies, none of which were available. Air France began quarantining flights from the region, and a mob attacked an MSF treatment center in Macenta, Guinea, accusing the foreign doctors and nurses of bringing the disease to Africa and forcing MSF to abandon the clinic.

Source: Garrett, Laurie. "Ebola's Lessons: How the WHO Mishandled the Crisis." Foreign Airs. September/October 2015.

Questions for Case Study 2

From the case study provided,

1. What were the factors responsible for the spread of Ebola in West Africa in 2014?
2. What cultural considerations need to be taken into account when designing a public health response?
3. Identify any gender issues you see in this scenario.
4. What does this mean for One Health?
5. Reflect on your own cultures related to the above and summarize your findings.
6. Using the One Health approach, how would you manage this problem in your community?

Reading Materials

Zion. S., & Kozleski, E. B. (2005). Cultural responsiveness. Uncovering diversity: race, ethnicity, religion, gender, personality, economic classes, ability (The Iceberg Model. Three Models for Understanding)

John DeFrain et al. (2012). Getting connected, Staying Connected: Values, Beliefs, Behaviors and Cultural Differences

Johanna Shalkwyk, Culture: Culture, Gender Equality and Development Cooperation" (CIDA)

SESSION 2: The Role of Culture & Family in the Management of Infectious Diseases

Session Overview

In this session, participants shall recognize the role of culture and family in the management of infectious diseases. The session shall assist participants to better understand culture using different models, explore the issue of cultural diversity and of cultural responsiveness and its effect on transmission and management of infectious diseases. It shall also demonstrate the value of family in the care of patients and other affected family members. Participants shall be exposed to these issues through video watching, small group discussions, narratives, brainstorming and presentations.

Session Learning Objectives

By the end of this session, participants should be able to describe the role of culture and family in the transmission and management of infectious diseases. They will:

i) examine and uncover diversity across cultures.
ii) identify local cultures, beliefs and practices related to disease transmission and their effects on infectious disease management.
iii) demonstrate the value of family as a primary unit of culture.
iv) demonstrate the value of family in the management of infectious diseases.

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
 5 min			**Introduction to Session 2** *i)* Introduce the session to participants. Inform them that in this session, they shall identify local cultural beliefs and practices and how they interface with human, animal and environmental health. *ii)* Tell them that they first need to understand what family is, then relate

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
			it to culture and to the management of infectious diseases.
5 min			Confirm that participants have read the reading material on cultural diversity and responsiveness that was sent out to them to read before this session: *Cultural responsiveness. Uncovering diversity: race, ethnicity, religion, gender, personality, economic classes, ability (Zion. S., & Kozleski, E. B. (2005).*
60 min	**What is a Family?**		**What is a Family?** i) Brainstorm with the participants to come up with a definition of a "family". Process their views by categorizing family as a: - basic unit of society. - primary agent for personality development. - symbol of cultural identity. - key factor in the management of infectious diseases. ii) Present the slides on family (PPP No.4)
	Definition of culture, responsiveness and diversity		**Definition of Culture, Responsiveness and Diversity** *i)* Review definitions and understanding of the meaning of culture and family. *ii)* Explain to participants that there are several theories and models that explain the meaning of culture and explores the concepts and complexities

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
			of culture. In this course, participants shall be exposed to one such theory and model, known as the "Iceberg Theory" or the "Iceberg Model of Culture". *iii)* Make a presentation on the iceberg model by Edward T. Hall, cultural responsiveness and uncovering cultural diversity. *iv)* Inform participants that culture can be viewed from various levels – including organizational culture, national culture and personal culture. *v)* Examples of other modes which can be found in the resources folder or the website are Geert Hofstede 6-D model which uses six dimensions of culture that society needs to come with in order to organize itself and Fons Trompenaars and Charles Hampden-Turner cultural model that distinguishes seven cultural dimensions to illustrate how cultural differences create a better understanding of reality and how organizations are affected by these differences https://www.toolshero.com/communication-skills/trompenaars-cultural-dimensions/ and his five dimensions of national cultures https://www.grin.com/document/279731
	Understanding Culture	**Group Activity**	**Understanding Culture** i) Divide participants in small groups and

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
			ask them to: - Review the Iceberg model for understanding cultures as they read through the TB case study **Case Study 3: HALI Project on Tuberculosis:** *[Adapted from Compendum of Case Studies by VSF Canada 2010]* - Respond to the following instructions: • Assuming the project was in your community where you come from, identify local knowledge and beliefs that would impact the project objectives negatively and positively. • Discuss cultural practices in this case study and compare with practices in your own communities that would influence the control and prevention of tuberculosis.
 60 min		 **Group Activity**	*i)* Organize the class into their assigned small groups. *ii)* Ask each group to consult the handouts given prior to the session (Zion. S., & Kozleski, E. B., 2005) to answer the following questions. 1. What are the factors that play a significant role in the development of our cultural identity? 2. Is it possible to truly understand a culture outside of your own? Why or why not? 3. In determining the behaviors and

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
			values of a culture, how can we avoid stereotyping? 4. Identify some cultural practices in your communities which relate to human, animal and environmental health. 5. Are there some similarities and differences in your cultural practices? 6. How could you apply these practices and beliefs in the context of human, animal and environmental health? **Group Presentations** *iii)* In plenary ask the different groups to present their findings. Each presentation should build on the other. *iv)* Summarize the main issues arising from these discussions.
90 min	Culture Stereotyping and Diversity		**Culture Stereotyping and Diversity** i) Show "**The danger of a single story**" video [http://everwideningcircles.com/2017/01/15/avoiding-opinions-based-on-a-single-story/] to participants and ask them to look out for issues relating to stereotyping and diversity as they watch. ii) Debrief the activity by asking participants: 1. What they have learnt from the video that relates to stereotyping and cultural diversity. 2. What surprised them? 3. The outstanding cultural issues observed in the video.

Duration	Topic & Sub-topic	Activity Type	Facilitator Instructions
			4. What these issues mean to them as a member of a One Health team that is recruited to assist in managing an infectious disease outbreak like Ebola in West Africa. iii) Summarize the main issues arising from these discussions.
30 min	One Health, Culture and Disease Prevention and Control	**Group Activity**	**One Health, Culture and Disease Prevention and Control** *i)* Divide the class into three groups and provide a flipchart paper and markers to each group. *ii)* Give each group **Case Study 4: Unknown disease outbreak** *iii)* Have each group read the case study, answer the questions at the end of the case and prepare a 10-minute report summarizing the case and conclusions. *iv)* Ask each group to present to the plenary. The second and third group should avoid repetition by presenting to the plenary only what has not been presented by the first group. *v)* Summarize presentations from small group discussions, emphasizing the issues related to the role of culture, beliefs and values on community health and infectious disease control in human, animal and environmental health.
20 min		**Discovery**	**Self-reflection on Your Own Culture** *i)* Ask the class to think about their own

<table>
<tr><th>Duration</th><th>Topic & Sub-topic</th><th>Activity Type</th><th>Facilitator Instructions</th></tr>
<tr><td></td><td></td><td>activity:</td><td>cultures and write down a list of cultural values, beliefs and practices that are related to the transmission of infectious diseases.
ii) Ask then to hand in their lists for reference later on.</td></tr>
<tr><td></td><td></td><td></td><td><h2>End of Day Evaluation</h2>
i) Create the flipchart shown below.
ii) Give the class sticky notes to evaluate the training sessions for the day.
iii) Ask the class: “How did it go today?”
iv) Ask them to answer the question by drawing one of the faces below to represent their answer and adding comments that they would like to bring to your attention.
<table><tr><td>How did today go?

☺😐☹

Comments:</td></tr><tr><td></td></tr></table></td></tr>
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Facilitator Notes for Session 2

Definitions of culture and understanding its meaning

Culture is the customary behavior, beliefs, values and ideals that are passed on through the generations among members of a social group. Culture can be thought of as the total life way of a group encompassing its symbolic beliefs, that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society. *Edward Taylor, 1871*

Dynamic, responsive coherent systems of beliefs, values, and lifestyles that have developed within particular geographic locations, using technology and economic resources; cultures evolve as needed to adapt to changing environmental conditions. *Kagawa-Singer, M. and Kassim-Lakha, S. 2003. Academic Medicine 78:577-587*

"…the capacity for constantly expanding the range and accuracy of one's perception of meanings." *John Dewey, 1916*

"means the whole complex of traditional behavior which has been developed by the human race and is successively learned by each generation. A culture is less precise. It can mean the forms of traditional behavior which are characteristics of a given society, or of a group of societies, or of a certain race, or of a certain area, or of a certain period of time."
Margaret Mead,1973

Cultural Dimensions, Understanding Diversity and Models
Cultural responsiveness/responsivity - refers to the ability to learn from and relate respectfully to people from your own and other cultures. It includes adjusting your behaviors based on things that you learn about other cultures. It requires openness to experiencing and thinking about things from other points of view.

Ethnocentrism - The belief that one's cultural, ethnic, or professional group is superior to that of others.

Stereotyping - Exaggerated beliefs and images that are popularly depicted in the mass media, folklore, and general conversation.

Cultural diversity - Myth of the "melting pot" is being displaced with a sense of identity among various ethnic groups.

Acculturation - The changes of one's cultural patterns to those of the host society (assumed to take 3 generations in the US)

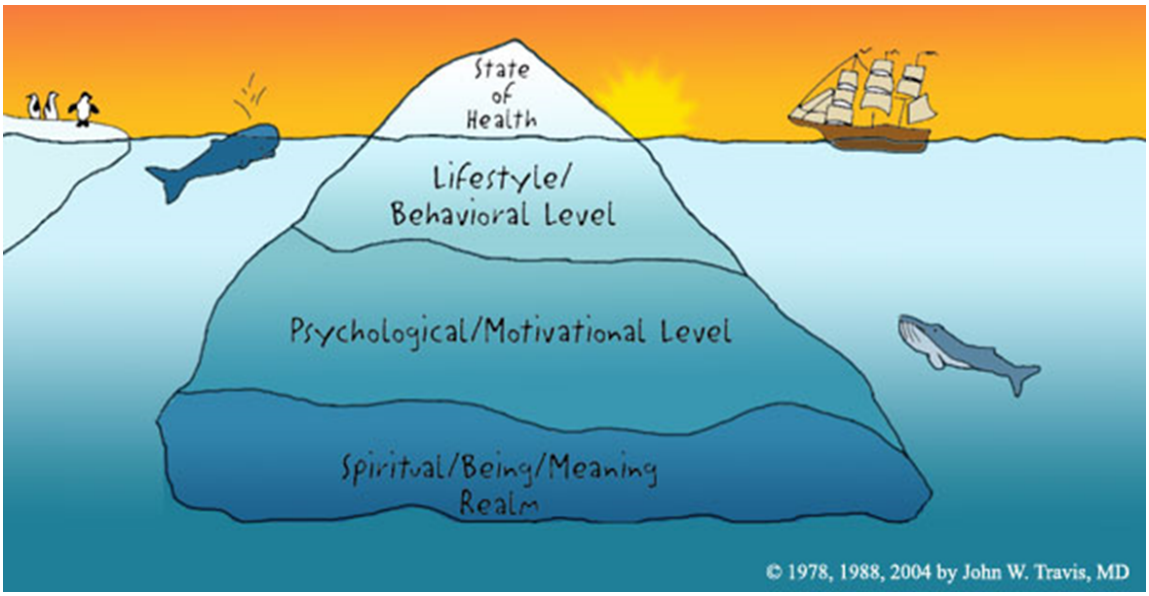
Cultural environment –

- Understanding culture helps in understanding yourself and getting along with others.
- Culture can help you see what all people have in common. It can help you recognize the variety of ways in which people solve the same basic problems.
- Your culture gives you a sense of identity as you take your place in a multicultural world.

Cultural identity – variables include: Ethnicity, race, country of origin, language, gender, age marital status, religious/ spiritual beliefs, SES, education, other identified groups, sexual orientation, migration history, level of acculturation

Iceberg Model – Edward T. Hall
Culture is like an iceberg

- **Surface Culture** - ***Above the surface***: What we can see; Low emotion *[State of Health]*
- **Deep Culture** - ***Just below the surface***: Unspoken rules; Behavior based; High emotion *[Lifestyle/ behavioral level; Psychological/ motivational level]*
- **UNCONSCIOUS RULES** - ***Far below the surface:*** Value based; Intensive emotion *[Spiritual/ being, meaning realm]*
-



Role of Culture, Beliefs and Values on Community Health and Infections Disease Management

Use the two case studies below to get participants to appreciate the role of culture, beliefs and values on community health and infectious disease control in human, animal and environmental health.

Case Study 3: HALI Project on Tuberculosis (Adapted from Compendium of Case studies by VSF Canada, 2010)

The Disease

Rapid land-use change and water scarcity is impacting Tanzania's vast Ruaha landscape, an area of extraordinary conservation significance with an appropriate natural resource base for traditional livestock keeping (pastoralism). In addition to habitat degradation and economic hardship, increasing overlap among human, livestock, and wildlife populations for dwindling water resources may increase transmission of zoonotic diseases like bovine tuberculosis (BTB; Mycobacterium bovis), an emerging zoonotic disease agent in people and a disease of conservation concern for wildlife.

Nearly 40,000 new cases of TB (human, bovine, or atypical strain) are diagnosed per year in Tanzania, with anywhere from 21% to 77% of Tanzanian tuberculosis patients also infected with HIV. The extra pulmonary form of TB in people, often associated with BTB infection from animals, accounts for 20% of the reported cases in Tanzania.

In 2006, the Health for Animals and Livelihood Improvement (HALI; http://haliproject.wordpress.com/) project was initiated to test the feasibility of the One Health approach in rural Tanzania and to find creative solutions to these problems by investigating the impact of zoonotic disease on the health and livelihoods of rural Tanzanians living in the water-limited Ruaha ecosystem. Bovine TB became a focal disease for HALI due to its high livestock prevalence, wildlife data paucity, and the large, susceptible HIV infected human population living in close association with livestock and wildlife. Based on input from local stakeholders, the often neglected zoonotic waterborne diarrheal diseases and the cattle disease, brucellosis, were also assessed.

Animal-Human-Ecosystem Dynamics

Every day thousands of children and adults die from under-diagnosed diseases that have arisen at the human–animal–environment interface, especially diarrheal and respiratory diseases in developing countries. Explosive human population growth and environmental changes have resulted in increased numbers of people living in close contact with wild and domestic animals. Unfortunately, this increased contact together with changes in land use, including livestock grazing and crop production, have altered the inherent ecological balance

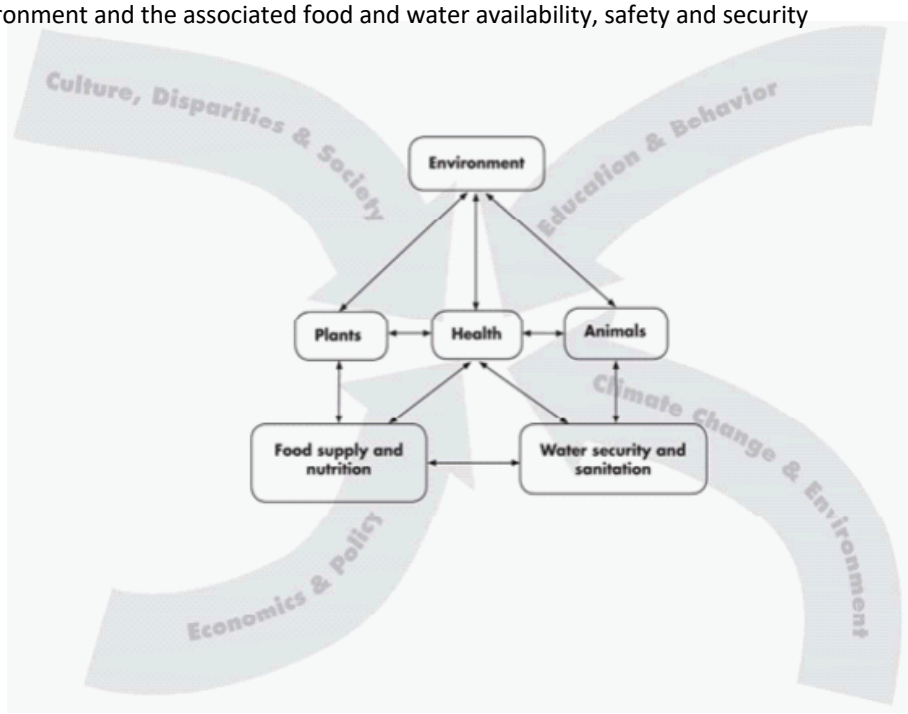
between pathogens and their human and animal hosts. Nowhere in the world are these health impacts more important than in developing countries, where daily workloads are highly dependent on the availability of natural resources. Water resources are perhaps most crucial, as humans and animals depend on safe water for health and survival, and sources of clean water are dwindling due to demands from agriculture and global climate change. As water becomes more scarce animals and people are squeezed into smaller and smaller workable areas. Thus, contact among infected animals and people increases, facilitating disease transmission. Water scarcity also means that people and animals use the same water sources for drinking and bathing, which results in serious contamination of drinking water and increased risk of zoonotic diseases.

Response and Conclusions

HALI is assessing the impact of water limitation and zoonotic disease by simultaneously investigating
the medical, ecological, socioeconomic, and policy issues driving the system (Figure1). This multilevel approach includes: testing of wildlife, livestock, and their water sources for zoonotic pathogens and disease; environmental monitoring of water quality, availability, and use; assessing wildlife population health and demography; evaluating livestock and human disease impacts on livelihoods of pastoralist households; examining land and water use impacts on daily workloads and village economies; introducing new diagnostic techniques for disease detection; training Tanzanians of all education levels about zoonotic diseases; and developing new health and environmental policy interventions to mitigate the impacts of zoonotic diseases.
HALI researchers identified BTB and brucellosis in livestock and wildlife in the Ruaha ecosystem and are using this information to identify geographic areas with varying water availability where risk of transmission may be highest. In addition, Salmonella, Escherichia coli, Cryptosporidium, and Giardia spp. that can cause disease in humans and animals have been isolated from multiple water sources used by people and frequented by livestock and wildlife. These data are being used to examine spatial and temporal associations between landscape factors and disease and to identify risk factors and health impacts that may be mitigated through policy changes and outreach. Preliminary findings also indicate that more than two-thirds of participating pastoral households do not believe that illness in their families can be contracted from livestock, and nearly half believe the same of wildlife. Furthermore, when the HALI project began, 75% of households did not consider sharing water sources with livestock or wildlife a health risk, illustrating the need for effective community education.

In response, the HALI team is raising disease prevention awareness in local communities through outreach events, radio broadcasts, and novel educational materials.

Figure 1. Local and global influences involving impacting human health including the interdependence of people, animals plants and environment and the associated food and water availability, safety and security



1. Assuming the project was in your community where you come from; identify local knowledge and beliefs that would impact the project objectives negatively and positively.
2. Discuss cultural practices in this case study and compare with practices in your own communities that would influence the control and prevention of tuberculosis.

Cultural values, beliefs and practices that are related to the transmission of infectious diseases

Case Study 4: Unknown disease outbreak in Uganda

A case of unknown disease outbreak in Uganda

A village in south western part of Uganda where about 1000 people live recently experienced abnormal rains and an unknown disease outbreak. The inhabitants of this village mainly live on Agriculture, Livestock keeping and natural resources. In the recent past they got abnormal rains that led to crop failures and famine. As a result they started mainly relying on hunting game animals, selling livestock and harvesting natural products (leaves roots etc) for food and basic needs. Then came a strange disease that started killing their cattle in big numbers. To make matters worse people who ate dead animal meat also started dying. In efforts to control the situation, the local people visited traditional doctors, pastors, priests, health facilities, animal health workers and local government leaders to seek advice and prayers. Later thru the intervention of Ministry of Health and Animal Health Department of Agriculture, the disease was diagnosed as an animal disease and brought under control thru vaccinations and treatment of animals. People were advised not to eat dead animals and to burry dead animals.

(i) List the different stakeholders affected by this disease
(ii) What cultural practices are commendable in this community and could be promoted to ensure that the same disease can easily be brought under control should it happen again
(iii) What cultural practices are not commendable in this community and could be discouraged to ensure that the same disease can easily be brought under control should it happen again
(iv) Looking at your own communities, what cultural practices are commendable and could be promoted and adapted to ensure that the same disease can easily be prevented or brought under control should it happen in your own community?
(v) Looking at your own communities, what cultural practices are not commendable and should not be promoted and adapted to ensure that the same disease can easily be prevented or brought under control should it happen in your own community?
(vi) What lessons can be learnt from this community
(vii) What message do you have for the stakeholders to promote One Health

Reading Materials

Cultural responsiveness. Uncovering diversity: race, ethnicity, religion, gender, personality, economic classes, ability (Zion. S., & Kozleski, E. B. (2005). The Iceberg Model. Three Models for Understanding

Culture – Hofstede (http://www.geerthofstede.nl/), Trompenaars: (http://hbr.org/web/slideshows/the-50-most-influential-management-gurus/42-trompenaars), Hall http://www.edwardthall.com/. Analysis of local cultures, belief and practices about diseases among human and animal health workers, traditional healers and environmentalists

Culture: Culture, Gender Equality and Development Cooperation" (Johanna Shalkwyk, CIDA)

Ebola's Lasting Legacy by Erika Check Hayden: Nature: volume 519, 5 March 2015

Gender Issues in Human, Animal and Plant Health using an Eco Health perspective by Brigitte Bagnol, Robyn Alders and Robyn Mcconchie: Environmental and Natural Resources Research Vol 5 No1, 2015

Hall http://www.edwardthall.com/. Analysis of local cultures, belief and practices about diseases among human and animal health workers, traditional healers and environmentalists

John DeFrain et al. 2012: Getting connected, Staying Connected: Values, Beliefs, Behaviors and Cultural Differences

What the solution isn't: the parallel of Zika and HIV viruses for Women: Susan T. Fried and Debra J. Liebowitz: The Lancet global health blog; February 2016

Zion. S., & Kozleski, E. B. October2005: **Understanding Culture**. National Institute for Urban School Improvement

SESSION 3: Gender, One Health and Infectious Disease Management

Participants shall look at culture from a gender perspective. Through interactive activities, participants shall examine gender roles and their consequences on disease transmission patterns, explore the strategies for infectious disease prevention and control and the use of a One Health approach using different gender tools.

Session Learning Objectives and Activities

By the end of this session, participants should be able to describe the role of gender in the management of infectious diseases. They will be able to:

i) identify gender practices related to human, animal and environmental health.
ii) explain the role of gender in developing culturally accepted disease management and control activities and in minimizing risks of spread of diseases.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
 5 mins			**Culture from a Gender Perspective** *i)* Select volunteers to remind participants about the gender definitions and concepts which they were introduced to on day one. *ii)* Inform participants that this session shall look at culture from a gender perspective. Specifically, gender roles and their consequences on disease transmission patterns, strategies for infectious disease prevention and control and the use of a One Health approach shall be explored using different gender tools.
	Gender Roles		**Gender Roles**

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
60 min		 **Discovery Activity** **Group Activity**	**Daily Activity Clock for a Household with a Sick Child in a Community that has an Ebola Outbreak** **Part 1: Activities List** *i)* A daily activity clock charts the activities that occur during a 24-hour period, who does them and the time it takes for them to be done. *ii)* In plenary, have participants brainstorm the activities the community will be engaged in when there is an Ebola outbreak and the activities involved in caring for a sick child in a community that has an Ebola outbreak. *iii)* Record responses on a flipchart. *iv)* They should be able to identify activities performed by men only, women only, girls only and boys only as well as communal activities such as cooking for funerals, caring for families that have lost loved ones, attending community training sessions on Ebola prevention. *v)* Refer to notes on what the list should include [Part 1: Activities List] **Activity Clock** *i)* Divide the class into four groups, of mixed gender. *ii)* Give each group a flip chart paper and markers. *iii)* Present to each group an envelope and ask a group member to choose a paper containing one of the four diseases: - Brucellosis - TB - Sleeping Sickness (Trypanosomiasis) - Bilharzia (schistosomiasis)

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			*iv)* Ask each group to spend 20 minutes to read/ reflect about the disease they have been given. Focus on the following: 1. What are the clinical signs? 2. How is the disease transmitted? 3. Is it a zoonotic disease? 4. How is it prevented or treated? 5. Can they identify any gender related risks in disease transmission? 6. Can they identify specific gender related disease prevention mechanisms? *v)* Tell participants that each team shall create an activity clock, following specific instructions. *vi)* Remind them that an activity clock is an exercise which tracks the activities of different groups over a 24-hour period to learn what different people do in a day and to compare the activities. *vii)* Tell them to create a 24-hour "activity clock" for what the men, boys, women and girls are doing in the village or community over a 24-hour period when there is a sick person and animal with their disease in the house. An activity clock is an exercise which tracks the activities of different groups over a 24-hour period to learn what different people do during a day and to compare the activities. *viii)* Show them an example of an activity clock which has been filled in. *ix)* Tell each group to create a 24-hour "activity clock" for what the men, boys, women and girls are doing in the village or community over a 24-hour period when there is a sick person and animal with their assigned disease in the house.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
 20 min			**Class Presentations** *i)* Post all the clocks. *ii)* Have each group present their clock. *iii)* Process the activity: - Start by focusing on "facts", that is, how time was spent. Identify activities including non-caring (e.g., working outside the house, non-paid work that benefits the household, leisure, rest, etc., and the caring activities identified earlier in the session.) - Next focus on "similarities" and "differences" in the activities performed by men and women (e.g., similarities and differences between men and women in "caring" for the child; similarities and differences in non-caring activities). Identify differences related to age, class, education. - Then ask about disease-related activities and impact: o Differences in exposure to the illness. o Difference in contact with people outside the home. *vi)* Debrief the activity by asking the group about: - Areas of agreement/disagreement among team members as they created the activity clock. - What surprised them? - The difference in activities among men, women, boys and girls - What do these differences mean to you as someone involved in managing disease? - Why do these differences exist and why are they maintained?

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
20 min	Short Film: Promundo		**Film** i) Gather the group together and show a short film (Promundo): http://promundoglobal.org/resources/mencare-short-rwanda/ **ii)** After watching this film, have the class share similar experiences they know of and the influence this has on their outlook towards men and women and the roles they are expected to play.
15 min 15 min	Consequences of Gender Roles	 **Discovery Activity:**	**Consequences of Gender Roles** *i)* Do a PowerPoint presentation **(PPP No. 1 Slides No 51-59)** for 15 minutes that defines basic terms: gender, sex, reproductive and productive roles, equality, equity and introduce the concept of gender. This should lead into a discussion of the gender tree. **Gender Game** *ii)* After this introduction, have the participants play the gender game to differentiate between sex and gender. **What is the "Gender Tree"?** i) Move into the discussion on the gender tree. ii) Summarize the gender tree exercise. iii) Demonstrate the parts of the tree, using a picture of the tree. iv) To understand the reasons for the differences

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			and the impact of the difference in roles men and women play, use the metaphor of a tree. v) The roots of the tree answer the question why there are gender role differences. Answers should include: culture (stereotypes, myths), religion, legal system, and politics. vi) The trunk of the tree is gender roles differences that you just identified in caring for sick people. vii) Branches of the tree answer the question: What institutions, legislation, policies create and maintain those gender differences? viii) The leaves are the consequences of institutionalized gender differences. The leaves can represent: the spread of disease (sickness, illness), food insecurity, poverty, or lack of education for women.
20 min		**Group Activity**	**Gender Tree Exercise** *i)* Divide the class into three groups. *ii)* Give each group a piece of flip chart paper and markers. Give them three topics to discuss. a) Women in research/workplace at universities (engineering) b) Women in politics c) Male nurses *iii)* Tell them to draw the tree describing in greater detail based on their topic: 1. Why there are role differences between men and women (ROOTS) 2. The different roles men and women play (TRUNK) 3. What institutions and legislation policies create and maintain gender differences (BRANCHES)

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			4. The consequences of institutionalized gender differences (LEAVES) *iv)* Post the trees and do a gallery walk highlighting: – Similarities – Differences – Missing aspects **Note:** Use the tree below to make sure participants have a complete and accurate understanding. When reviewing the tree, provide definitions for gender and sex. Emphasize that culture and as a result gender roles, are not static.
		Debrief	Debrief the session by asking participants to reflect on: 1. Which part of the tree would you target for long-term, systemic intervention in order to manage disease sustainably? 2. And what would you do?
 10 min	**Equity and Equality**	 **Activity**	## Equity and Equality **Gender Shoe Game** i) Ask four participants to come to the front of the room and remove their left shoe and put them all in a pile. ii) Ask each person to select a left shoe that is not their own. Everyone now has a left shoe. But this distribution is not what each person needs, when we take into account other factors by acting equitably, we are inclusive and move towards equality (i.e. you receive a shoe that fits you for your purposes). Equality means "giving everyone the same

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			thing," but that "only works if everyone starts from the same place." Equity means giving everyone "access to the same opportunities. We must ensure equity before we can enjoy equality."
 10 min	**Quick Facts About Gender, One Health and EPT**		**Quick Facts About Gender, One Health and EPT** *i)* Present the PowerPoint **(PPP No.1)** and provide participants with a handout on basic gender terms and definitions. *ii)* Discuss these terms to ensure they understand the different languages used in relation to gender.
 5 min			**Concluding Comments** Understanding the interaction between culture, gender roles, One Health and emerging pandemic threats can lead to important insights into disease transmission patterns, strategies for prevention and control and the use of a multidisciplinary approach to inform policy and practice. Today's focus on gender, One Health and EPT terms and concepts has allowed the participants to critically analyze the convergence of gender, culture and One Health using practical tools such as the 24-hour calendar and the tree metaphor. The four diseases selected for this purpose provide a basis that allows the participants to begin identifying the gender gaps in One Health and EPT, the resources available in the communities, as well as exposure to some tools that can be used in developing a framework for gender analysis.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			How did today go? ☺😐☹ *Comments:*

Facilitator Notes for Session 3

Gender Roles

Discovery Activity: Daily Activity Clock for a household with a sick child in a community that has an Ebola outbreak

Part 1: Activities list

The list of activities should include:

- Taking sick people to hospital
- Paying for transportation
- Preparing funerals/burial
- Attending funerals
- Washing the dead
- Cooking food for funeral attendants
- Having community meetings to plan funerals
- Community outreach programs to prevent Ebola
- Talking to media/doctors, outsiders who have come into the community
- Giving medicine
- Cleaning and bathing
- Assisting with going to the bathroom
- Washing clothing and bedding
- Preparing food
- Feeding
- Calling the doctor or medical care personnel
- Taking to the clinic
- Paying for clinic services
- Checking on the patient
- Talking to/entertaining the patient

Part 2: Refer to the clocks drawn by the different groups

Definition of concepts and tools used in gender analysis

Sex usually defines the biological characteristics differentiating men and women. Sex is also culturally defined as the case of the South African athlete, Caster Semenya, showed. She and her family considered she was a woman while the medical institution and the International Federation of Athletics decided she was a hermaphrodite. Gender is a constitutive element of

social relationships based on perceived differences between the sexes, and gender is a primary way of signifying relationships of Power 1.

Gender is the wide set of characteristics that are seen to distinguish between male and female. As a word, it has more than one valid definition. In all societies men and women play different roles, have different needs, and face different constraints. Gender roles differ from the biological roles of men and women. Gender roles are socially constructed. They demarcate responsibilities between men and women, social and economic activities, access to resources, and decision-making authority. Biological roles are fixed, but gender roles can and do modify with social, economic, and technological changes. Gender roles demarcate responsibilities between men and women, social and economic activities, access to resources and decision making. Social and economic factors underlie and support gender-based disparities:

- Institutional arrangements that create and reinforce gender-based constraints or conversely, foster an environment in which gender disparities can be reduced.
- The formal legal system that reinforces customs and practice giving women inferior legal status.
- Socio-cultural attitudes and ethnic and class-based obligations that determine men and women's roles, responsibilities, and decision-making functions.
- Religious or/and traditional beliefs and practices that limit women's mobility, social contact, access to resources, and the types of activities they can pursue.
- Economic factors that limit women's access, control and benefits over resources, services, activities and knowledge.

Gender analysis

At its simplest, gender analysis is seeing what our eyes have been trained not to see. It is asking about the differences between men and women's activities, roles, and resources to identify their development needs. Assessing these differences makes it possible to determine men and women constraints and opportunities within a sector. Gender analysis can help ensure provision of services that men and women want and that are appropriate to their circumstances. This requires understanding men and women's roles in the sector by analyzing quantitative and qualitative information about their activities, resources and constraints, and benefits and incentives.

Gender planning

Gender planning is a planning that recognizes that because women and men play different roles in society, they often have different needs.

Gender roles

Gender planning recognizes that in most societies, low-income women have a triple role: women undertake reproductive, productive and community managing activities, while men primarily undertake productive and community politics activities.

Reproductive role: Child-bearing/rearing responsibilities, and domestic task done by women, required to guarantee the maintenance and reproduction of the labor force. It includes not only biological reproduction but also the care and maintenance of the workforce (male partner and the working children) and the future workforce (infants and school-going children).

Productive role: Work done by both women and men for pay whether cash or in kind. It includes both market production with an exchange value, and subsistence/home production with actual use-value, and potential exchange-value. For women in agricultural production, this includes work as independent farmers, peasant wives and wage workers.

Community managing role: Activities undertaken primarily by women at the community level, as an extension of their reproductive role, to ensure the provision and maintenance of scarce resources of collective consumption, such as water, health care and education. This is voluntary unpaid work, undertaken in time.

Community politics role: Activities undertaken primarily by men at the community level, organizing at the formal political level, often within the framework of national politics. This is usually paid work, either directly or indirectly, through status and power.

Differential access to, control over resources and benefits: It is important to distinguish between access to resources and control over them when examining how resources (land, labor, credit, income, etc.) are allocated between women and men. How men and women benefit from the resources also should be analyzed.

Access: Gives a person the use of a resource e.g. land to grow crops.

Control: Allows a person to make decisions about who uses the resource or to dispose of the resource e.g. sell land. Baseline data in a complete gender analysis establishes whether there is any differential in men's and women's access to key categories of resources.

Benefit: Allows the person to dispose of the resource in his/her interest.

Condition and position: Development projects generally aim to improve the condition of people's lives. From a gender and development perspective, a distinction is made between the day-today condition of women's lives and their position in society. In addition to the specific conditions which women share with men, differential access means women's position in relation to men must also be assessed when interventions are planned and implemented.

Condition: This refers to the material state in which women and men live, and relates to their responsibilities and work. Improvements in women's and men's condition can be made by providing for example, safe water, credit and seeds (practical gender needs).

Position: Position refers to women's social and economic standing in society relative to men, for example, male/female disparities in wages and employment opportunities, unequal representation in the political process, unequal ownership of land and property, vulnerability to violence (strategic gender needs/interests).

Gender needs: Women have needs that differ from those of men, not only because of their triple role, but also because of their subordinate position in terms of men. It is useful to distinguish between two types: Practical Gender Needs (PGN) - are the needs women identify in their socially accepted roles in society. PGNs do not challenge, although they arise out of gender division of labor and women's subordinate position in society. PGNs are a response to immediate perceived necessity, identified within a specific context. They are practical in nature and often concern inadequacies in living conditions such as water provision, health care and employment.

Strategic Gender Needs (SGN) - are needs women identify because of their subordinate position in society. They vary according to contexts, related to gender divisions of labor, power and control, and may include such issues as legal rights, domestic violence, equal wages, and women's control over their bodies. Meeting SGNs assist women to achieve greater equality and change existing roles, thereby challenging women's subordinate position.

Data disaggregated by sex/gender: This is the information collected by questionnaires, observation or other techniques that reveals the different roles and responsibilities of men and women e.g. a gender analysis matrix chart.

Female/gender headed households: Female headed households, maybe households where no adult males are present (due to divorce, separation, migration, non-marriage, widowhood). They may also be households where the men are present, but do not contribute to the household income (illness, disability, alcoholism).

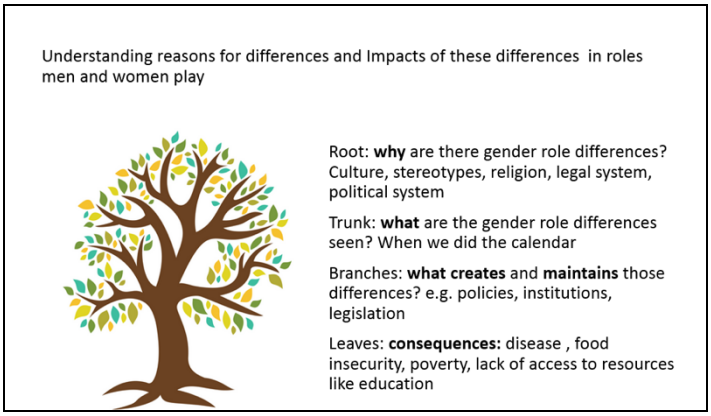
Gender blind: This is a person who does not recognize that gender is an essential determinant of the life choices available to individuals within a society.

Gender sensitive and/or gender responsive: This term is used in reference to projects and planning. Gender sensitivity involves being aware and incorporating into projects activities and considerations about the different needs, priorities and constraints resulting from the different socio-cultural economic groups within the given project environment.

Participation: A process of communication among local people and development agents during which local people take the leading role to analyze the current situation and to plan, implement and evaluate development activities.

Discussions on the Gender Tree

In most societies, women are primarily considered "caring" due to social norms. Consequently, they are often given the responsibility to take care of the sick and the elderly – unpaid work that is valuable in the health of the household. Because women regularly encounter sick people, they are more likely to become infected. Women spend a great deal of their time in the caring activities which involve feeding, cleaning, washing and preparing food. Consequently, often women and young girls are less likely to be involved in political, educational, and professional activities. Because they are less educated and informed, their knowledge about the disease is often less than what men have.



Gender Tree Exercise

i) Why there are role differences between men and women (ROOTS)
ii) The different roles men and women play (TRUNK)
iii) What institutions, legislation policies create and maintain gender differences (BRANCHES)
iv) The consequences of institutionalized gender differences (LEAVES)

Equity and Equality

Equality means "giving everyone the same thing," but that "only works if everyone starts from the same place."
Equity means giving everyone "access to the same opportunities. We must ensure equity before we can enjoy equality."

Reading Materials

"Gender Effects on Health", University of Texas School of Public Health.
Canadian International Development Agency. (2000). Culture: Culture, Gender Equality and Development Cooperation.
CARE International Gender Network. (2012). Good Practices Framework: Gender Analysis.
Ebola's Lasting Legacy by Erika Check Hayden: Nature: volume 519, 5 March 2015
Brigitte Bagnol, Robyn Alders and Robyn Mcconchie (2015). Gender Issues in Human Animal and Plant Health using an Eco Health Perspective. Environmental and Natural Resources Research Vol 5 No1, 2015
What the solution isn't: the parallel of Zika and HIV viruses for Women: Susan T. Fried and Debra J. Liebowitz: The Lancet global health blog; February 2016
Miranda Ramova (2014) The Silent Voices: Domestic Violence against Women in Macedonia, Masters Thesis, Department of Critical Gender Studies, Central European University, Budapest Hungary

SESSION 4: Cultural Competency

Session Overview

This session introduces participants to the term "cultural competency" and equips them with skills to conduct an assessment of cultural competency for an individual and for a One Health team. It enables participants to know and apply culturally competent skills that enable a One Health professional work appropriately in cross-cultural situations.

Session Learning Objectives and Activities

By the end of this session, participants should be able to:

i) assess their personal level of cultural competency.
ii) demonstrate the five essential behavioral elements that a culturally competent person must have to enable effective work in cross-cultural situations.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
 20 min	Cultural Competence		**Cultural Competence** *i)* Inform participants that they are going to be introduced to "cultural competence". *ii)* **Cultural competence** is the potential of a professional/ practitioner to holistically understand and effectively deal with individuals and people across cultural divides. *iii)* Remind them about the Interdisciplinary Theories and inform them that in this session, the concept of self and the significant other is dealt with; it is related to self-consciousness building, while dealing with a culturally sensitive community. *iv)* Tell participants that cultural competency is viewed at different levels including the

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			individual level, organization level and systems level. Refer them to the websites to search for the various levels, if time allows. *v)* We shall also attempt to understand more about developing cultural competence at an individual level. *vi)* **Present (PPP No. 1 Slides 21 to 24) that summarize "Understanding one's own culture"** *vii)*Conduct an exercise on cultural variations within a specific community.
 120 min		 **Group Activity**	**Self-Assessment Tool Development** i) Introduce to participants two self-assessment tools from the following internet link: http://www.lacrosseconsortium.org/uploads/content_files/Awareness_self_assessment.pdf ii) Inform participants that they shall work in groups to develop a self-assessment tool that measures their cultural competency. They shall study the example tools to adapt to their own situations. iii) Divide participants into three groups. iv) Ask them to develop a self-assessment tool that would be able to measure the level of cultural competency of One Health professionals. The tool should employ the One Health approach, make use of the cultural continuum and draw from the provided examples from the Internet links above. v) Exchange the developed tools amongst the groups and ask participants to conduct their own self-assessment using the provided tool. vi) Provide them with sticky notes to write down three ways to improve the provided tool. vii) Ask the three assigned groups to improve their tool basing on the comments received from participants.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
		Group Activity	**Strategy Development** i) Ask participants to work in their three small groups. Assign each group a number according to the task: Group 1: Investigation team Group 2: Prevention team Group 3: Outbreak response team ii) Ask each team to list down five strategies that the team could employ at all levels of their interaction with the community to provide culturally competent services in a community where a disease outbreak has been identified. This means that the team is culturally responsive to the community - to the extent that they respond to the cultural differences that affect identification, assessment, treatment and management of patients and their community. iii) Ask groups to summarize and present the strategies they have identified and mention the three main lessons learned from the importance of cultural competency in relation to infectious disease management. iv) Summarize the presentations.

Reading Materials

American Association for Health Education, http://www.aahperd.org/aahe

Betancourt, J., Green, A. & Carrillo, E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches.* The Commonwealth Fund.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards a culturally competent system of care, volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Lavizzo-Mourey, R. & Mackenzie, E. (1996). "Cultural competence: Essential measurement of quality for managed care organizations." *Annals of Internal Medicine,* 124 919-926.

National Alliance for Hispanic Health (2001). *A Primer for cultural proficiency: Towards quality health care services for Hispanics.* Washington, D.C.

National Medical Association, National Medical Association Cultural Competence Primer

Tervalon, M. & Murray-Garcia, J. (1998). "Cultural humility versus cultural competence: A Critical discussion in defining physician training outcomes in multicultural education." *Journal of Health Care for the Poor and Underserved,* 9 (2) 117-125.

Facilitator Notes for Session 4

Definition of cultural competence

There are several definitions of cultural competence. We shall use the definition by Cross (**Cross et al, 1989):** Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.

Cultural Competence

i) Involves understanding and appropriately responding to the unique combination of cultural variables that the professional and population/community bring to interactions. These variables include ability, age, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status.
ii) Happens at different levels - individual, organization, system or program.
iii) Is a dynamic, ongoing, developmental process that evolves over an extended period and requires a long-term commitment.
iv) Is portrayed along a cultural competence continuum. The continuum indicates the various levels of awareness, knowledge and skills of an individual, organization or system.

Why: Cultural competence in service delivery is increasingly important to:

i) improve the quality of services and health outcomes.
ii) eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
iii) meet legislative, regulatory, and accreditation mandates.
iv) eliminate inappropriate infectious disease management interventions/ culturally insensitive interventions.
v) increases the success rate and eliminates trial and error.
vi) minimizes resource wastage.

Continuum of Cultural Competence

Cultural competence is portrayed along a cultural competence continuum. The continuum indicates the various levels of awareness, knowledge and skills of an individual, organization or system. The continuum of cultural competence includes six stages ***(Re: Kohnert, 2008)***.

- **Cultural Destructiveness**—in which "attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture" are exhibited.
- **Cultural Incapacity**—in which individuals and agencies do not seek to be "culturally destructive, but lack the capacity to help …"
- **Cultural Blindness**—in which "the system and its agencies provide services with the expressed philosophy of being unbiased … and function with the belief that color or culture make no difference and that all people are the same"
- **Cultural Pre-competence**—in which there is awareness and an attempt to "improve some aspect of services to a specific population" and clinicians are aware of perceptions, values, and other elements of their own culture and of cultures different from their own.
- **Cultural Competency**—a stage of "acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models". At this stage, clinicians are able to effectively use their cultural knowledge during interviewing, assessment, and treatment.
- **Cultural Proficiency**—in which agencies hold "culture in high esteem … and seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects". In this stage, clinicians champion cultural competence in practice by training others in cultural competence, recruiting personnel from diverse cultures, and conducting research that adds to the knowledge base.

How?

- One Health professionals are culturally competent to the extent that they practice in a manner that considers the impact of cultural variables on the health challenges that they are dealing with. This will affect the nature of the service that they are delivering.

- Developing cultural competence is a dynamic and complex process which evolves over time and requires:
  - understanding one's own culture [self-assessment]
  - interactions with individuals from various cultures [ethnographic interviews …]
  - continuous expansion of one's cultural knowledge [training/capacity building]
- It may require an attitude shift in which professionals recognize what they do not know about the relevant cultures of the individuals, families, and communities they serve and seek to gain culture-specific knowledge and experience in these areas.

Essential Behavioral Elements of a Culturally Competent Person

There are five essential behavioral elements that a culturally competent person/ organization/ system must have to enable effective work in cross-cultural situations. These are:

i) Valuing diversity
ii) Conducting self-assessment
iii) Managing the dynamics of difference
iv) Acquiring and institutionalizing cultural knowledge
v) Adapting to diversity and the cultural contexts of communities that are being served

In the next section, we shall attempt to understand more about developing cultural competence at an individual level. We shall also conduct an exercise on self-assessment. For activities on self and other assessment, you could use self-reflection/ self-imaging, Johari window or any exercise on ethnocentrism.

Summarize "Understanding one's own culture"

At the individual level: It involves:

i) examining one's own attitude and values, beliefs, biases and professional personal history.
ii) assessing the manner in which these factors might influence perceptions.
iii) understanding how personal perceptions might influence interactions and service delivery to a community /variety of clients.
iv) acquiring values, knowledge, skills and attributes that will allow an individual to work appropriately in cross cultural situations.

When using the continuum of cultural assessment, self-assessment may reveal where a professional is along the continuum of cultural competence. Specific steps in the development of cultural competence are identified based on a professional's location along the cultural competence continuum, the essential characteristics of the culturally competent professional, and a reflection on individual needs.

Exercise on cultural variations within a specific community

Summarize "Interactions with individuals from various cultures"

Interactions with Individuals from Various Cultures

i) A community reflects a wide array of differences as well as similarities across cultural variables.
ii) Competence requires that One Health professionals practice in a manner that considers each individual's cultural characteristics and unique values so that the most effective services can be provided.
iii) An approach that is appropriate for one individual may not be appropriate for another.
iv) It is important to recognize that the unique influence of an individual's cultural background may change over time and according to circumstance (e.g., interactions in the

workplace, with authority figures, within a social context), necessitating adjustments in approaches to services delivery.

Continuous expansion of one's cultural knowledge

These are examples of strategies that enable a One Health professional to continuously expand his/her own cultural knowledge:

i) Identifying and acknowledging limitations in knowledge and responses to cultural difference and seeking funding, human and other resources to address these limitations.
ii) Engaging in capacity building programs on cultural competence e.g. short training, ongoing professional development of cultural competence throughout one's career, community interactions.
iii) Collaborating with professionals across disciplines and with various organizations to gain more knowledge on culture and its influence on health.

Group exercise

List down five strategies a One Health team could employ to provide culturally competent services in a community health center during all clinical interaction. This means that the team is culturally responsive to patients and their caregivers - to the extent that they respond to the cultural differences that affect identification, assessment, treatment and management of a patient.

Summarize Possible Strategies

i) Assessing/treating each patient as an individual and responding to his/her unique needs, as opposed to anticipating cultural variables based on assumptions
ii) Completing self-assessment tool to consider the influence of one's own biases and beliefs and the potential impact on service delivery.
iii) Identifying and acknowledging limitations in knowledge and responses to cultural difference and seeking funding, human and other resources to address these limitations.
iv) Engaging in capacity building programs on cultural competence e.g. short training, ongoing professional development of cultural competence throughout one's career, community interactions.
v) Demonstrating respect for an individual's race, ethnicity, gender, age, religion, nation origin and/or ability.
vi) Integrating clients' traditions, customs, values, and beliefs in service delivery.
vii) Identifying the impact of assimilation and acculturation on behavioral patterns during identification, assessment, treatment and management of a health condition.

viii) Identifying appropriate intervention and assessment strategies and materials that do not violate the patient's unique values and/or create profound differences between the clinician and patient and his/her community.

ix) Using culturally appropriate communication with patients, caregivers and family so that information presented during service delivery is provided in a health literate format consistent with patients' cultural values.

x) Referring to/consulting with other service providers with appropriate cultural proficiency.

xi) Upholding ethical responsibilities during the provision of clinically appropriate services.

xii) Collaborating with professionals across disciplines and with local and national organizations to gain knowledge of, develop and disseminate educational, health and medical information pertinent to particular communities.

xiii) Providing appropriate and culturally relevant consumer information and marketing materials/tools for outreach, service provision and education, with consideration of the health, literacy, values, and preferences of communities taken into consideration.

xiv) Identifying and educating communities regarding the impact of local and national legislation on service delivery.

Applying Ethical Values and Principles during One Health Interventions

Introduction to Personal Values and Ethical Code of Conduct

This section shall focus on enabling participants to appreciate the concepts of values and ethics. It brings out various values at the personal, societal and organizational level. Participants shall appreciate their personal values through a self-assessment exercise and reflect on how their personal values affect the manner that they relate with other professions and in communities.

Section Learning Objectives

By the end of this section, participants will be able to:

i) explain personal values and professional code of conduct.

ii) apply professionalism in order to build trust in a community during One Health interventions.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			Inform the class that the next section shall focus on the "value" concept using group work, a PowerPoint presentation **(PPP No. 6)** and self-assessment of personal values. **Group Activity** *i)* Divide the class into groups based on professions. *ii)* Give each group a piece of flipchart paper and markers. *iii)* Ask them to brainstorm and provide answers to the following two questions on a flipchart: 1. Do you have a professional code of conduct? If yes, what does it stipulate? 2. How does your professional code of conduct facilitate or hinder you from dealing with other professions?
			Presentations on values and professionals *v)* Ask groups to present to the plenary their group work. *vi)* Summarize presentations from small group discussions. *vii)*Discuss professionalism in One Health activities. *viii)* Try to match the values, ethics and professional codes of conduct of the different professionals.
			Discovery Activity *i)* Introduce the values self-assessment exercise to the class *ii)* Handout the "value assessment exercise to participants. *iii)* Process the activity. *iv)* Hand out sticky notes to the class. *v)* Present the slide on a set of values and ask participants to select the ten they think are important to them.

<table>
<tr><th>Duration</th><th>Topic & Subtopic</th><th>Activity Type</th><th>Facilitator Instructions</th></tr>
<tr><td></td><td></td><td></td><td>vi) From the ten they have selected, ask them to select 5 they think are most important.
vii) Narrow the final list down to the three values that are core to them.
viii) Have them display their sticky notes on the wall and get them to read the displayed sticky notes and summarize with them the lessons that they learn from this exercise and implications on working in a One Health team.</td></tr>
<tr><td>  10 min</td><td>Quick Facts about Values and Ethics</td><td></td><td>Present the PowerPoint (PPP No. 5) on “Working with Other People: Ethical Conduct” to summarize the two activities that participants have completed. Clarify any concerns from the presentation and activities.</td></tr>
<tr><td>  </td><td></td><td>  </td><td>End of Day Evaluation

i) Create the flipchart shown below.
ii) Give the class sticky notes to evaluate the training sessions for the day.
iii) Ask the class: “How did it go today?”
iv) Ask them to answer the question by drawing one of the faces below to represent their answer and adding comments that they would like to bring to your attention.

How did go today?
☺😐☹
Comments:</td></tr>
</table>

Facilitator Notes for Section 4

Ethical Values

Exercise: Values Self-Assessment

A Self-Assessment by A. Bronwyn Llewellyn with Robin Holt, M.A

Clarifying your personal values is a critical step toward understanding your own definition of success, finding new career options, evaluating specific organizations to work in, and understanding how to change your current work situation to make it more meaningful and fulfilling. The process gives you a deeper sense of what makes your life meaningful and helps you see how certain career decisions affect your life. Knowing your values makes you resilient. Just like that storm-lashed tree with deep roots, a person with strong core values does not bend every way the workplace wind blows.

This test is designed to help you identify your core values. Values are highly individual; therefore, there are purposely no definitions given for the words following. Each word means something different to different people. Reflect on what each value word means to you. Think about how these values might influence how you adapt to living and working in a culture that is new to you. Present a set of values and ask participants to:

- Select the ten they think are important to them.
- Then from the ten, they select five which they think are most important.
- Then, narrow the final list down to the three values that are core to them.

Ask the participants to post their values on a flipchart.

Have them display their sticky notes on the wall and get them to read the displayed sticky notes and summarize with them the lessons that they learn from this exercise and implications on working in a One Health team.

List of Values

Accomplishment	Curiosity	Justice	Self-Discipline
Adventure	Diversity	Knowledge	Self-restraint
Affiliation	Duty	Leadership	Spirituality
Authority	Family	Love	Stability

Autonomy	Friendship	Loyalty	Structure
Balance	Fun	Meaning	Status
Beauty	Harmony	Moderation	Teamwork
Challenge	Health	Nature	Time Freedom
Community	Helpfulness	Obligation	Trust
Competence	High Earnings	Pleasure	Variety
Competition	Honesty	Predictability	Wisdom
Contribution	Humility	Recognition	
Control	Independence	Respect	
Cooperation	Influence	Responsibility	
Creativity	Integrity	Risk-Taking	

Section 3: Overview of Ethical Values and Animal Welfare during One Health Activities

This section will cover ethical considerations for both human and animal research when carrying out One Health activities. It is important to ensure protection of human and animal subjects in a culturally sensitive setting or in a society.

Section Learning Objectives and Activities

By the end of this section, participants should be able to:

i) know ethical issues in human subjects and animal welfare.
ii) identify which bodies are responsible for overseeing ethics.

Duration	Topic & Activity	Detailed Facilitator Instructions

	 **Pre-work Assignment**	**Pre-work** *i)* Ask the participants to read the history of the development of ethics in human subjects' research, specifically the Nuremberg Code, Declaration of Helsinki, Beecher article, the Belmont report and the Tuskegee Syphilis project. *ii)* As part of pre-work, ask participants to do the CITI ethics research certification. It is free and available on line.
 15 min		*i)* Research with human subjects has a long and troubled history around the world. Most egregious and well known examples of unethical biomedical research abuse such as experiments conducted by Nazi doctors and scientists on concentration camp prisoners during World War 2, and the US Public Health Tuskegee study of untreated syphilis in the negro males. It is therefore important to understand ethical considerations in One Health and which bodies are responsible. *ii)* Begin this session by watching the following two videos: https://www.youtube.com/watch?v=9pCfq5QH_v4 https://www.youtube.com/watch?v=Zbi7nIbAuMQ *iii)* After watching the videos: discuss what research ethics is and the three key ethical principles for conducting research with human subjects. Participants should provide examples of each principle. *iv)* Have the participants focus on the occurrences in both the Nuremberg and the Tuskegee scenarios and highlight the ethical violation in each situation. *v)* In small groups, have them discuss the following: • Importance of research ethics • The core principles which must be considered by researchers • How these principles must be addressed into the research proposal and research implementing • Benefits and risks in research and balancing between the two • Progress and drivers of establishment of ethical regulations in human research

30 min		• Vulnerable populations and their protection
		• Violations of ethical regulations
		• Applying research ethics:
		  ○ Principle of respect of persons
		  ○ Principle of beneficence
		  ○ Principle of justice
		vi) Review the following three cases and discuss if they, in any way, violated the rights of the patients, and which one of the three principles.
		
		Case study 1
		
		In Laud Humphreys' study, detailed in his book *Tearoom Trade: Impersonal Sex in Public Places*, the researcher observed men meeting other men for casual sexual encounters in public restrooms. Humphreys, then a sociology graduate student, gained the confidence of the men by pretending to be a participant and acting as a lookout. While Humphreys eventually revealed himself as a researcher to some of the men and was able to interview them openly, he withheld his identity from many others, recording the license plate numbers of a subset of 100 other tearoom regulars in order to contact them for interviews at a later date.
		
		A year after completing the observational part of the study, Humphreys followed up with these subjects, including them in a separate social health study that enabled him to conduct in-home surveys and gather data about their family relationships and religious background. In a 1970 article taken from his book, Humphreys maintained that the researcher's obligation to protect respondents from harm was a critical ethical assumption. To avoid being recognized by the interview subjects, Humphreys changed his appearance and the kind of car he drove.
		
		"I already knew that many of my respondents were married and that all were in a highly discreditable position and fearful of discovery. How could I approach these covert deviants for interviews? By passing as deviant, I had observed their sexual behavior without disturbing it. Now, I was faced with interviewing these men (often in the presence of their wives)

		without destroying them" (Humphreys 1970). **Answer:** *Although the resulting book, based on Humphreys' dissertation, may have been beneficial in dispelling some stereotypes, the research violated the autonomy of the individuals who became part of Humphreys' study without their knowledge. Subjects were not informed about the study and did not choose to participate.* **Case study 2:** A more recent example of research that obtained personal information about individuals without their knowledge is the "Tastes, Ties, and Time (T3)" study (2006-2009). Sociologists gleaned voluminous and detailed personal information from the Facebook profiles of an entire class of undergraduates and followed those students over four years. The research team created an extensive data set that included students' gender, home state, major, political and group affiliations, friend networks, photographs, and tastes in music, books, and film. In 2008, the researchers made the data publicly available through the Dataverse Network Project. Although no students were identified by name, some data were specific enough to allow for re-identification of students by an outside researcher (Zimmer 2010; Parry 2011). *In this study the ethical concerns are invasion of privacy, lack of informed consent, and a failure to protect against deductive disclosure of identity. The Harvard study violated subjects' autonomy and privacy. Subjects did not agree to participate in the research and subjects were able to be identified (failure of researchers to protect subjects from deductive disclosure).* **Case study 3:** The Stanford Prison Experiment," Philip Zimbardo's 1971 landmark psychological study of the human response to captivity, specifically prison life, Zimbardo assigned roles to male student volunteers to create groups of "prisoners" and

		"guards." The simulation became so intense that physical and psychological abuse of "prisoners" by "guards" escalated and several of the subjects experienced distress less than 36 hours after the study began. Zimbardo's study, like Humphreys' study, occurred in a different regulatory environment, before the advent of the *Belmont Report*. Zimbardo did submit his research plan to an ethics board, but the consent process contained no provisions allowing subjects to withdraw at will, and no risks of harm beyond loss of privacy were addressed. According to Zimbardo (2012), the consent form signed by the subjects only allowed them "to be released from participation for reasons of health deemed adequate by the medical advisers to the research project or for other reasons deemed appropriate by Dr Philip Zimbardo." Zimbardo did not stop the experiment until six days had passed. *The Stanford experiment exposed subjects to psychological and to physical risks of harm.* In educational research testing (such as a new curriculum or teaching method), subjects in the treatment group may derive benefits from the intervention while subjects in the control group do not have access to that intervention. If the program being tested is specific to that age group, the control group participants would not have the opportunity to benefit from that intervention in the future. To fulfill the Belmont principle of justice, the control group must receive standard instruction.
 20 min	 Group Activity	Divide participants into groups of two. Each group should then do a review and identify other unethical researches that have been done around the world. They should present these to the plenary. Did any of these happen in Africa? Which principles were violated?
 45 min	**Reviewing the Roles of Institutional Review Boards and IACUC**	**Reviewing the Roles of Institutional Review Boards and IACUC**

20 min	Group Activity	**Cultural Traditions in Research** i) Discuss briefly how cultural beliefs, myths and local norms could affect research or interventions and how participants can deal with such issues. For example, in Nepal, they believe that they cannot take any form of life be it human or animal. This means that they cannot euthanize any stray dogs or cats. The streets are full of stray dogs that therefore increase the numbers of rabies cases in the country: how would participants deal with this situation? ii) Can participants come up with similar examples from their own experiences or other peoples' experiences? iii) Discuss the following as well in that context: ○ Gender – inequality, productivity and poverty ○ Behavioral changes Sum up the whole discussion on ethics by stressing that ethics are important and there are rules and regulations that govern this.

Make a presentation on:

i) introduction on existing laws, regulating bodies, regulations, guidelines
ii) roles of institutional review boards

Reading Materials

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Zion. S., & Kozleski, E. B. (2005). Understanding culture. Uncovering diversity, Denver, CO: National Institute for Urban School Improvement

SESSION 5: Community Assessment and Management of Infectious Diseases Using the One Health Approach

Session Overview

In this session, participants are equipped with skills to assess cultural issues associated with infectious disease transmission and management at a community level and to develop culturally sensitive strategies for infectious disease management using the One Health approach. The session enables participants to appreciate the importance of factoring in the role and impact of culture in disease transmission and control when designing response interventions. Participants are introduced to two of the numerous participatory methodologies namely, in-depth interviews and focus group discussions, that enable the One Health professionals to identify and respond to cultural issues that impact infectious disease transmission and control.

Session Learning Objectives and Activities

By the end of this session, participants should be able to:

i) relate with the importance of cultural competence among health professionals in disease transmission and management.
ii) apply participatory methodologies to identify and respond to cultural issues that affect infectious disease transmission, prevention and response in a specific community.
iii) apply the One Health approach to develop culturally sensitive strategies to prevent and respond to infectious diseases in a community.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
 5 min			*i)* Inform participants that today they shall apply what they have learnt from the previous sessions through a field activity. *ii)* Participants shall be assigned to work within teams to conduct an assessment of the association between cultural beliefs, practices and value systems within the assigned community on the one hand and infectious disease transmission, prevention and control, on the

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
			other. *iii)* Participants shall be introduced to two participatory tools that they shall use to elicit information from their assigned communities.
			**Field Preparation** *(Done prior to field visit day)* *i)* Identify the field site. *ii)* Organize field logistics and inform participants about the necessary logistical arrangements. *iii)* Divide participants into three groups. These groups shall be maintained throughout the field assignment. *iv)* Assign a field supervisor (academic and field) to a group. *v)* Facilitate the supervisors to take the groups of participants to their assigned sites. *vi)* Ask participants to find out about their assigned community from available sources including the internet, reports, etc.
 15 min			**Introduction to the Field Activity** Make a presentation on: – Introduction of the field activity – Objectives of the field activity – Group activity
			Objectives of the Field Activity *i)* Identify an infectious disease that has challenged the community in the past or currently. *ii)* Identify the cultural beliefs and practices in the community that are associated with the identified infectious disease transmission and management. *iii)* Assess with the community the extent that culturally sensitive strategies have been employed in the previous management of the identified infectious disease. *iv)* Apply the One Health approach to develop culturally sensitive strategies to combat the identified infectious disease.

Duration	Topic & Subtopic	Activity Type	Facilitator Instructions
90 min			**Group Activity 12: Checklist Development** i) Explain that each group shall do the following: ○ develop a checklist of questions from the provided objectives to guide the field activity in the next session. The questions should be both culturally and gender sensitive and should be written down on a flip chart. ○ On a flip chart, to document issues relating to community entry, stay, exit and return that they must consider when they are going to engage a particular community. ○ Describe how they shall conduct a focus group discussion and in-depth interview *iv)* Ask each group to report back to the plenary
60 min			i) Present PowerPoint **(PPP No. 5, 6 and 8)** to summarize process issues of: ○ Teamwork ○ Community entry, stay, exit and return ○ Community engagement ○ Cultural assessment (*In Resources Folder)* ○ Participatory methodologies – Focus Group Discussion and In-depth interviews ○ Reporting of the field activity ii) Summarize content issues that should be captured in the checklists which the groups have developed. iii) Ask participants to refine their checklists basing on the plenary discussions and presentations.
			Field Assignment Provide each group with the assignment.
			Feedback from the Field

<table>
<tr><th>Duration</th><th>Topic & Subtopic</th><th>Activity Type</th><th>Facilitator Instructions</th></tr>
<tr><td>60 min</td><td></td><td></td><td>i) Inform participants that this session shall involve group presentations on their field experience, plenary discussions and final documentation of the field experience.
ii) Invite each group to present their findings from the field.
iii) Conduct a discussion with participants about their field experience using the following questions:
1. What can we conclude about the communities visited?
2. What do they have in common?
3. How are they different?
4. If teams selected the same group/community to observe, how were the observations similar?
5. How were the observations different?
6. What could cause groups to see the same community differently?
7. What advice would you give to a One Health practitioner to be effective in preventing disease in the community(ies) visited, for purposes of promoting human, animal and ecological wellness?</td></tr>
<tr><td></td><td></td><td></td><td><h2>End of Day Evaluation</h2>
i) Create the flipchart shown below.
ii) Give the class sticky notes to evaluate the training sessions for the day.
iii) Ask the class: “How did it go today?”
iv) Ask them to answer the question by drawing one of the faces below to represent their answer and adding comments that they would like to bring to your attention.
<table><tr><td>How did it go today?
☺😐☹
Comments:</td></tr><tr><td></td></tr></table></td></tr>
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Facilitator Notes for Session 5

Sample Checklist

Examples of questions for the checklist

1. What are the most common infectious diseases in this community?
2. What cultural beliefs foster the spread of these diseases?
3. What cultural beliefs enhance the prevention and spread of these diseases?
4. What are the major cultural barriers to controlling/ managing these diseases?
5. How do men support the prevention and control of these diseases?
6. How do women support the prevention and control of these diseases?

When preventing or controlling the spread of these diseases:

1. How do men and women interact? How do men interact with men? How do women interact with women? Does there appear to be a hierarchy?
2. How do men and women interact with domestic animals? Is it the same or is it different?
3. How do men and women interact with wildlife? Is it the same or different?
4. How do women and men interact with their environment? Is it the same or different?
5. Who provides health care/animal care leadership?
6. What are the roles of the health care provider, traditional healers, veterinarians and community or government leaders?
7. How are decisions made about healthcare and wellness?
8. How do people see the relationship between health/illness and the environment?
9. How might the community be culturally vulnerable to emerging pandemic diseases?
10. What aspects might increase risk of coming into contact with a pandemic disease?
11. What aspects might make disease prevention, disease transmission or treatment of illness difficult?
12. What strategies would you recommend to overcome the cultural barriers to disease prevention and control?

Reading Materials

"Other Voices, Other Ways, Better Practices: Bridging Local and Professional Environmental Knowledge" (Kim M. Wilkinson, Susan G. Clark and William R. Burch)

OHCEA EVENT EVALUATION – CULTURE AND ETHICS SHORT COURSE

Facilitators:

_____

Dates: _____

OHCEA supported you to attend the **Culture and Ethics Short Course**_event. Please take a few minutes to fill out the following confidential questionnaire. Your responses will help us better understand the value of this event and improve future programs. Thank you!

Please circle your response to each of the following:

1. This event met my expectations.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

2. This event was relevant to my personal interests.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

3. This event was relevant to my professional interests.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

4. The information presented was new to me.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

5. The amount of information provided was:
   a) Not enough

b) About right

c) Too much

6. This event helped clarify my understanding of "One Health."
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know
7. The pre-event logistics were well organized.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

8. The event itself was well organized.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

9. Overall, I found this event to be worthwhile.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree
   e) Don't know

10. I intend to take actions in my work as a result of what I learned at this event.
    a) Strongly disagree
    b) Disagree
    c) Agree
    d) Strongly agree
    e) Don't know

11. Describe what, if any, actions you will take in your work as a result of this event.

12. What were the strengths of this event?

13. What can be done to improve this event?

14. What single most important lesson did you learn from this event?

15. Please write any additional comments you may have about this event.

16. Did you present at this event?

a) Yes

b) No

16a. If yes, what was the topic of your presentation?

17. What is your *primary* area of work?

a) Nursing

b) Human Medicine

c) Veterinary medicine

d) Wildlife Medicine

e) Public Human Health

f) Public Veterinary Health

g) Other (please specify): _____

18. Which sector do you represent?
    a) Government
    b) Private sector
    c) Education
    d) Non-governmental organization (NGO)
    e) Research
    f) Other (please specify): _____

19. What is your sex?
    a) Male
    b) Female

20. Nationality: _____