



COVID-19

Global Risk Communication and Community Engagement Strategy

December 2020 — May 2021



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Executive Summary

COVID-19 is more than a health crisis; it is also an information and socio-economic crisis. The pandemic and the associated response are prompting the deepest global recession in nearly a century and pushing an estimated 70-100 million more people into extreme poverty.

Until biomedical tools such as vaccines or treatments are developed and widely available people's behaviours and their willingness to follow public health and social measures remain the most powerful weapons to stop the spread of the virus. Consequently, there is an unprecedented need to elevate the role risk communication and community engagement (RCCE) plays in breaking the chains of transmission and mitigating the impact of the pandemic.

A revised RCCE strategy was needed to reflect this and the learning from the response to-date. The new strategy will cover six months from December 2020 to May 2021.

Analysis of socio-behavioural data shows us some broad trends. In general, people know about COVID-19 and the preventive measures necessary. However, people are becoming complacent and risk perceptions are lowering. In general, people are feeling less confident in what they can do to control the virus. As the pandemic becomes more protracted, pandemic fatigue is increasing. The growing fatigue, the stress caused by uncertainty, lowering risk perceptions and reducing trust in government responses, is taking its toll on the fabric of our communities.

What does the revised strategy focus on?

The shift presented in this strategy is to move from the directive, one-way communication, which characterized the early stages of the COVID-19

response, towards the community engagement and participatory approaches that have been proven to help control and eliminate outbreaks in the past.

OVERARCHING GOAL | That people-centred and community-led approaches are championed widely – resulting in increased trust and social cohesion, and ultimately a reduction in the negative impacts of COVID-19.

To achieve this there are four priority areas of work, outlined in the objectives below.

Objectives	Indicative activities
OBJECTIVE 1 BE COMMUNITY-LED Facilitate community-led responses through the improvement of the quality and consistency of RCCE approaches	Supporting the adoption of RCCE minimum standards Developing strategies on priority issues e.g. stigma Coordinating efforts to manage the infodemic Monitoring and evaluating RCCE activities
OBJECTIVE 2 BE DATA-DRIVEN Generate, analyse and use evidence about community's context, capacities, perceptions, and behaviours	Identifying gaps in existing evidence and how to fill them Enhancing media monitoring, social listening, community feedback systems Using data to advocate on behalf of community priorities
OBJECTIVE 3 REINFORCE CAPACITY AND LOCAL SOLUTIONS Reinforce capacity and local solutions to control the pandemic and mitigate its impacts	Identifying the core RCCE skills and competencies Facilitating participatory capacity needs assessments Developing and implementing capacity building strategies
OBJECTIVE 4 BE COLLABORATIVE Strengthen coordination of RCCE to increase quality, harmonization, optimisation and integration	Identifying the right membership and structures Facilitating joint assessments, planning, monitoring and advocacy Integrating RCCE into all COVID-19 response efforts

What guiding principles that should inform our RCCE work?

There is no one-size-fits-all approach for effective community engagement. Understanding communities and adapting to reflect those insights will look different for every community. However, there are some guiding principles that apply to RCCE in all contexts.



Explore our RCCE **Guiding Principles** in the green box to the right

What can we expect from the next six months?

Lessons from other infectious disease outbreaks, as well as what we have learned responding to COVID-19 so far, can help us anticipate some of the challenges and opportunities that we are likely to face in the coming six months.

These are listed below:

- **Uncertainty** will continue to be one of the defining characteristics of the context.
- **Vaccines** will become available worldwide, with associated RCCE challenges ranging from hesitancy to deliberate anti-vax misinformation.
- **Pandemic fatigue** will likely increase as the crisis becomes increasingly protracted.
- **Trust** will need to be proactively built and maintained.
- **Engaging communities**, both physically and virtually, will help mitigate the increasing politicization of the pandemic response.
- **Investments** in coordinated and proactive community engagement approaches will be crucial to increase demand for testing, treatments and vaccines.
- **Concerted** and coordinated efforts to tackle misinformation and effectively manage the infodemic will be essential to control the virus.
- **Increased** efforts to reduce COVID-19 stigma and discrimination will be crucial to protecting the most vulnerable, including health workers.
- **Increasing** economic pressure will force people to take greater risks.

Risk communication and community engagement should be:



NATIONALLY-LED

by governments supported by civil society and communities



COMMUNITY-CENTRED

working with their knowledge, capacities, and vulnerabilities



PARTICIPATORY

enabling community-led responses



NURTURING TRUST

as the critical component of the COVID-19 response



OPEN AND TRANSPARENT

about knowns/unknowns, uncertainty, and mistakes



INFORMED BY DATA

about the community needs, issues and perceptions



INTEGRATED

as a foundational approach for the entire response



COORDINATED

to avoid duplication and gaps, and increase impact



INCLUSIVE

of all vulnerable and marginalized groups



ACCOUNTABLE

to the affected communities

Exactly how and when this broad and diverse range of opportunities and challenges play out will vary from country to country, and in many cases even within countries. What is certain, however, is that coordinated, adaptive, innovative, localized and participatory approaches to how we engage communities around COVID-19 will be crucial in controlling the virus and mitigating its impacts in the coming six months.

Introduction



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The first COVID-19 global risk communication and community engagement (RCCE) strategy was published in March 2020.¹ Since then, our knowledge about the disease has greatly increased, as has our understanding of how people are affected by and are responding to it. This new RCCE strategy reflects these changes in context and knowledge.

The strategy reflects the experiences and views of a range of partners working on RCCE.² It builds on but replaces the first RCCE global strategy, and is supported by existing RCCE guidance materials.³

The revised strategy focuses on the global strategic direction for RCCE, as well as the relationship between global, regional and national RCCE coordination mechanisms. The document presents some key considerations and recommendations, intended to guide regional and national planning and response efforts.

There is no one-size-fits-all approach for effective RCCE. Understanding communities and adapting to reflect those insights will look different for every community. The global strategy reflects this diversity. It is not meant to be prescriptive; rather, it focuses on supporting regional and national responses to identify the most appropriate and effective community engagement approaches for their contexts.

The strategy is aimed at global, regional and national level audiences such as: governments (including ministries of health, local governments, disaster management authorities and others); the United Nations; local, regional and international health and humanitarian NGOs; National Red Cross and Red Crescent Societies; civil society; and academia.

Given the rapidly changing nature of the pandemic, this RCCE strategy covers a six-month period from December 2020. The next revision is scheduled for May 2021.

Flexibility in evolving this strategy will also be required to deliver the RCCE services necessary to support the now-anticipated global rollout of vaccines in 2021.

Risk communication⁴ and community engagement⁵ are integral to the success of responses to health emergencies⁶. In the case of COVID-19, effective and coordinated RCCE can help break the chains of transmission and mitigate the impacts of the pandemic. Uptake of protective behaviours and adherence to social measures will continue to be critical even with safe and effective vaccines and treatments. Strengthened RCCE

support will be critical to maximize understanding, acceptance and uptake. Consistent participation and empowerment of affected communities is essential to understand local contexts and ensure an informed, people-centred response. Without community engagement, there is a danger that misinformation, confusion, and mistrust can undermine efforts to ensure the uptake of lifesaving tools, services, and information.



For more information, see **Annex 3: Risk Communication and Community Engagement in practice.**

1.1 Context

Since the first strategy was developed in March, the pace of the pandemic has accelerated significantly.⁷ Infection rates fluctuate at regional, national and subnational levels, so both the epidemiological situation and the accompanying public health and social measures⁸ change frequently.

The impact of COVID-19 has overwhelmed some of the most robust healthcare systems⁹ and put unsustainable pressure on healthcare workers. These effects impact the delivery of essential health services: 90% of countries have experienced disruption to health services, with low- and middle-income countries reporting the greatest difficulties.¹⁰

The pandemic is more than a health crisis; the response to the pandemic is also causing a socio-economic crisis. The pandemic and the associated response are prompting the deepest global recession in nearly a century, pushing an estimated 70-100 million more people into extreme poverty.¹¹ The United Nations Emergency Relief Coordinator has warned that without action, 270 million people will face starvation by the end of the year.¹²

The wider impacts of the pandemic are being felt by all parts of society. For example, children and young people are having their educations severely disrupted: as of August 2020, 1.6 billion children and young people in 188 countries have suffered because of countrywide school closures.¹³

The pandemic has impacted the mental health of millions of people through increased levels of fear, stress, anxiety, depression, frustration, uncertainty.¹⁴ And anxiety, uncertainty and fear have often led to increased stigma and discrimination. There have been many reports of healthcare workers around the world being assaulted, because of fears that they would transmit COVID-19 to the people around them.¹⁵

2021 is likely to see a continuation of all these challenges, and additionally a potentially transformational development in the form of COVID-19 vaccines becoming available globally. While a significant biomedical development, the success of the

unprecedented effort to roll out COVID-19 vaccines worldwide will ultimately depend to a large extent on the willingness of individuals to have the injection. To succeed, this vaccine rollout requires an equally huge RCCE campaign in support. Nor is this challenge just about COVID-19: the outcome of this extremely high profile vaccine distribution - positive or negative - carries huge ramifications for adoption levels of all other vaccines for preventable diseases. "Without the appropriate trust and the correct information, diagnostic tests go unused, vaccination rates will be too low, and the virus will continue to thrive."¹⁶

As the situation continues, 'pandemic fatigue' is occurring. This is likely to lead to a decrease in people's motivation to follow recommended preventive behaviours, and create a number of detrimental emotions, experiences and perceptions.¹⁷ Pandemic fatigue can be influenced by a variety of factors depending on the context.

These factors include:

- a decrease in risk perceptions related to the disease;
- an increase in the socio-economic and psychological impact of the crisis and restrictions;
- the urge for self-control and self-determination in a constantly changing and restricting environment;
- and the feeling of getting used to the situation.

A lack of trust and increasing frustration and uncertainty, coupled with the economic impacts of the response to COVID-19, have led to protests against measures to control the virus in some countries. Approximately 20 significant anti-government protests directly linked to COVID-19 recorded between the start of the pandemic and October 2020.¹⁸ The new public health and social measures, such as those put in place to control rapid increases in infection rates, could lead to more protests.

1.2 Socio-behavioural trends: critical perceptions and behaviours

Behaviours drive epidemics and they can also stop them. However, human behaviour is complex. Effective RCCE uses socio-behavioural data to identify ways to reduce risks. This means understanding people's changing perceptions and attitudes, and the barriers and enablers influencing their ability and motivation to adopt and/or sustain positive health behaviors.

In response to the pandemic, multiple efforts are made to collect, analyse and use socio-behavioural evidence.

A meta-analysis was commissioned to draw on different studies and sources of evidence and develop an initial

picture of people's perceptions, understanding and practices in relation to the COVID-19 pandemic.¹⁹ A narrative summary of some of the key findings follows.

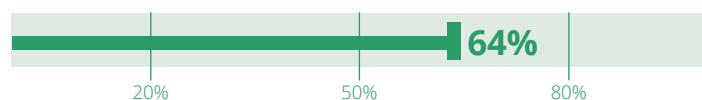
Note that the trends described here are broad observations from international data and do not aim to represent geographic diversity or contextual nuance.²⁰



For more information, see [Annex 4 Summary of global evidence of socio-behavioural trends for COVID-19 prevention and risk reduction](#).

What does the evidence tell us?

KNOWLEDGE OF COVID IS COMMON 64% of people can identify COVID-19 symptoms



Worldwide, basic knowledge of COVID-19 across populations is now common – including knowledge about COVID-19 symptoms. Available global data suggests that 64% of survey participants could correctly describe COVID-19 signs and symptoms.²¹

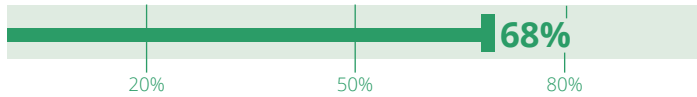
RISK PERCEPTION IS DECLINING

Knowledge about COVID-19 is a critical step for the uptake of preventive behaviours. However, other socio-behavioural factors affect the adoption and maintenance of preventive behaviours. Risk perception is a crucial driver of behaviours, and **there is growing evidence that people's risk perception of COVID-19 infection is declining**. People do recognize COVID-19 is a serious disease, however they often feel COVID-19 is more of a threat to others: their friends and family, their community and country, than to themselves.^{22,23} Also, in many African countries, people reported believing that COVID-19 does not affect young people or Africans, that the disease does not exist, or that the pandemic has already ended.²⁴



INFORMATION SOURCES

68% of people trust information from scientists and doctors



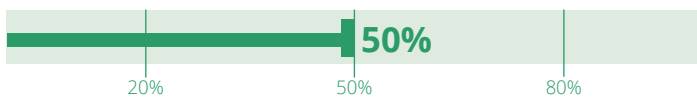
Trust is another vital driver of behaviour, particularly in crises. **Trust in scientific and factual information shared by official sources and credible institutions is often high.** Recent global data suggests that **people tend to have highest levels of trust in information shared by scientists, doctors and health experts (68%), followed by WHO (56%).**²⁵ However, globally there is variation in the extent to which people trust information shared by politicians. Low trust can often be attributed to structural factors such as lack of transparency or historical and cultural factors.²⁶

INFORMATION NEEDS TO BE PROVIDED THROUGH CONTEXTUALLY APPROPRIATE CHANNELS

To communicate evidence-based information effectively, the use of contextually-appropriate information channels is equally important. However, **high level of exposure to a particular information channel does not necessarily correspond to high levels of trust in the information received through this channel.** For example, recent data from Indonesia and Malaysia suggests frequent use of online channels including social media. Nevertheless, these channels tend to be less trusted than WHO, radio and community health workers.²⁷

SELF-EFFICACY

50% of people are not confident in their ability to prevent COVID-19



Self-efficacy is another vital driver of behaviour change. This confidence, or self-efficacy, is the first step towards stronger community participation. However, **the data shows us that globally people's level of confidence in their ability to prevent COVID-19 is usually low (50% or less).** In countries where people feel less confident in their ability to protect themselves, people are also less likely to practise preventive measures.²⁸

COMMUNITY ACTION

People who are included as a part of the decision-making process are more willing to act

To be empowered to act, people also need opportunities to participate in the response to COVID-19, to build ownership and help identify locally appropriate and community-centred solutions. However to date, **there is little evidence to suggest people feel able to influence decision-making about the responses to COVID-19.** This perception can vary by country.

In Africa, for example, people feel more able to influence decision-making at the community level (34%) than decisions made at country level (22%).²⁹

PANDEMIC FATIGUE

Pandemic fatigue is increasing.³⁰ This is due to the stress caused by uncertainty, lower risk perceptions and reduced trust in government responses.



Stress



Uncertainty



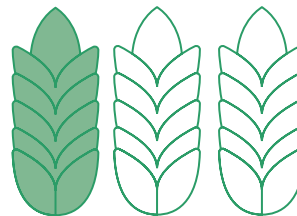
Low risk perception



Reduced trust

INEQUALITIES ARE WIDENING

The pandemic has widened existing inequalities, affecting the world's poorest and most vulnerable. **Evidence suggests that the level of food insecurity and income loss has increased since the pandemic with a disproportionate impact on those already marginalized.**³¹



AROUND 1/3 OF FOOD SYSTEM LIVELIHOODS are at risk due to the pandemic

STIGMA AND DISCRIMINATION REMAIN A THREAT

Other recent studies tell us that **stigma and discrimination remain real threats and are impacting social cohesion in many countries.** Foreign, migrant or minority populations are being blamed for the spread of COVID-19 in some countries, leading to marginalization³².

Social perceptions like those above have consequences. They can hamper efforts to stop or slow the spread of COVID-19 and mitigate its impacts. The collection and use of data on socio-behavioural factors as well as the overall structural environment is critical for sharpening global, regional, and local RCCE and operational strategies. This includes understanding what we do not have – in this case adequate data on how trust, social cohesion, community participation and ownership affect the quality of response efforts. The evidence shows the critical importance of engaging with affected communities so they can lead and deliver local responses where possible.

1.3 A collective response

To meet these challenges, countries around the world have rapidly developed and implemented their own RCCE plans as part of their response efforts. There have been large-scale communication and engagement campaigns to raise awareness of the virus and the preventive measures needed to help control it.

As of 1 October 2020, 90%³³ of countries report having a national RCCE plan. This indicates that the crucial role of RCCE is understood and prioritized by many countries.

Among WHO's 64 priority countries, 73.8%³⁴ report that they have a **coordination mechanism** to work with stakeholders on the design and implementation of their RCCE plans. This indicates that some countries are yet to fully realise the potential benefits of coordinating actions across partners and technical areas.

Additionally, 81.2%³⁵ of WHO's 64 priority countries report that they have established a **feedback mechanism** as part of their response efforts. This indicates that the emphasis has shifted from focusing on providing information to communities to establishing two-way communications, accountability systems and stronger engagement approaches at a country level.

The COVID-19 pandemic has required that coordination efforts be accelerated to scale, to meet the unprecedented challenges of the crisis. RCCE has risen to this challenge by establishing a coordination mechanism to bridge the public health, humanitarian and development responses. This mechanism is known as the **Collective Service**.



For more information about coordination structures see **Annex 5 The Collective Service**. You can learn more about the Collective Service [here](#) and on [the WHO webpage](#).

The successful development and deployment of biomedical tools, testing, treatments and vaccines requires coordinated RCCE approaches. To achieve these goals, investment in community ownership, systems-strengthening and processes must be systematic and consistent.



02

Strategic approach



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Initial RCCE priorities in response to COVID-19 focused on raising knowledge and awareness about COVID-19, and the preventive measures to reduce infection and transmission. In many countries these messages took the form of directives and one-way-communication.

However, community engagement and participation have played a critical role in successful disease control and elimination campaigns in many countries.³⁶ This strategy promotes a move from directives and one-way communications to the community engagement and participatory approaches that have been proven to help control and eliminate outbreaks in the past.^{37,38}

Knowledge about COVID-19 continues to emerge, so while experience of past outbreaks can and must guide RCCE response efforts, we must remain open to innovative solutions.

The RCCE strategy directly supports the [United Nations Comprehensive Response to COVID-19](#) (that includes WHO's [Strategic Preparedness and Response Plan](#)), which focuses on the health, humanitarian and socio-economic responses to the pandemic.

The strategy works towards an overarching goal:

That people-centred and community-led approaches are championed widely – resulting in increased trust and social cohesion, and ultimately a reduction in the negative impacts of COVID-19.

To achieve this goal, governments and partners involved in the public health, humanitarian and development responses to the COVID-19 pandemic need more consistent, systematic and predictable RCCE support. Four strategic objectives will help to implement the overarching goal.

2.1 Four strategic objectives

The four strategic objectives for RCCE are set out below. Some illustrative activities are included under each objective. These activities are intended to be indicative rather than exhaustive.

The responsibility for action at the national level lies with national governments. At the regional level the responsibility lies with the six established regional RCCE coordination platforms.

Those platforms are typically chaired or co-chaired by WHO and other technical agencies. At the global level, the Collective Service is responsible for implementing the actions necessary to deliver the objectives and realize the overarching goal. The Collective Service is also responsible for coordination between the national, regional and global levels, to harmonize and optimize action towards the objectives.



OBJECTIVE 1 | BE COMMUNITY-LED

Facilitate community-led responses through the improvement of the quality and consistency of RCCE approaches.

Communities should assess their own needs and participate in the analysis, planning, design, implementation, monitoring and evaluation of local responses to COVID-19.³⁹

To achieve this objective, country, regional and global actors should:

- **Provide technical guidance and tools for adopting minimum standards**, and document and share community engagement best practices.
- **Support RCCE being adopted as a foundational approach** that enables other pillars and clusters of the response.
- **Develop strategies to prevent and address stigma and discrimination, overcome pandemic fatigue, and build and maintain trust.**
- **Coordinate efforts to manage the infodemic**, build digital and health literacy and mitigate impact.
- **Balance digital engagement with safe and appropriately resourced in-person engagement**, to ensure that vulnerable groups and those who cannot access digital channels are not left behind.
- **Invest in community ownership approaches, processes and systems** to enable community-centred approaches to roll-out testing, treatments and vaccines.
- **Provide formal and informal community health workforce and local actors** with knowledge, engagement and interpersonal communication skills, supplies and tools.
- **Strengthen the availability of relevant and accurate RCCE materials** in a range of accessible and applicable formats and languages.
- **Identify and strengthen the systems needed for sustainable long-term community engagement and empowerment**, to support communities beyond COVID-19.
- **Designing and implementing monitoring and evaluation activities** of RCCE activities.

Examples in practice:

Kenya: Displaced people lead response efforts. In each of Dadaab's three refugee camps, a 12-person committee (with meaningful representation of women) has been established. The committees include camp chairs, community peace and protection teams, young people, religious leaders, and members representing community-based rehabilitation and minority nationalities. Committees monitor the delivery of services, collect feedback from community members, and provide daily updates and reports.⁴⁰

Africa, Sahel region: Religious leaders play a pivotal role in COVID-19 response. Religious leaders are key influencers in the COVID-19 response. Islamic religious leaders in Sahel were involved before the start of Ramadan in discussions about the vision and guidance Islam can provide in times of disease. That included the directions and commands Islam gives about health prevention measures. Culturally appropriate messages on the pandemic were developed using proverbs and religious

references. The early engagement of religious leaders ensured they endorsed messages of healthy living and adhering to medical norms. The leaders play a pivotal role in ensuring that their followers understand public health measures and adhere to social distancing measures to control the spread of COVID-19.⁴¹

Norway: enabling local decision making. National strategies for the reopening of kindergartens in Norway included a degree of flexibility. This way, communities and individual kindergartens could operationalize restrictions and protection measures in ways that were tailored to their context. Kindergarten staff in some places convened to discuss and collectively agree on sustainable local solutions to meet national requirements. Recognizing that people are experts of their own environment, this approach demonstrates the importance of enabling local decision-making, ownership and autonomy in national planning.⁴²

OBJECTIVE 2 | BE DATA-DRIVEN

Generate, analyse and use evidence about community's context, capacities, perceptions, and behaviours.⁴³

Ensure that evidence generated is disaggregated by sex, age and by other potential drivers of vulnerability or exclusion (e.g. ethnicity, language, disability) to improve decisions about the policy and programming responses to COVID-19.

To achieve this objective, country, regional and global actors should:

- **Engage decision-makers across the response** in developing plans to collect and analyse evidence to inform their decisions.
- **Identify existing evidence and gaps** in the data or the tools needed to analyse and use it. Develop protocols and partnerships to conduct secondary analysis of data that already exists.
- **Develop evidence generation plans to fill identified gaps**, including agreed data management and data protection protocols.
- **Adopt and use minimum standard RCCE indicators and create monitoring frameworks to measure the outcomes and impact of RCCE** interventions beyond activities and processes.
- **Ensure data feeds into advocacy and decision-making mechanisms** – triangulate the data generated with epidemiological and sectoral services data.
- **Enhance systems for media monitoring and social listening** as sources of data about perceptions, concerns and understanding.
- **Track trending questions by demographic/location/language/gender/age etc. Map these against available content** to respond to those questions, as a basis for gap and trend analysis, prioritization and monitoring.
- **Create a dashboard to visualise social variables** and integrate it with epidemiological and sectoral services data.
- **Adapt, develop and contextualise common tools, approaches and capacities** to support evidence generation plans.
- **Develop robust systems and processes around knowledge management and the documentation of approaches, lessons and best practices.**

Examples in practice:

Pakistan: RCCE task force uses social data to inform programming. The task force has set up a system to analyze social and behavioural data being collected through surveys and feedback approaches collected via the polio call centre (which also serves as a community feedback channel on COVID-19) and from social and traditional media monitoring. This is developed into an RCCE brief that is discussed with the Ministry of Health and used in the minister's media briefings.⁴⁴

Africa: Community feedback from across the continent. A community feedback subgroup of the regional RCCE coordination platforms collects, analyses and disseminates feedback data across the continent. Twenty agencies

collaborate on that subgroup. The subgroup analyses trends and rumours in country-level data about communities' concerns, questions, beliefs, suggestions and rumours. Every two weeks, the group produces a report compiling the feedback trends and rumours. The report recommends actions to address the feedback or rumours raised. The report is shared through the region and used to support changes in national government responses. In addition, there is an ongoing effort to build the capacity of national organizations through distance coaching and regular webinars. Topics include how to manage, code and analyse feedback to inform social mobilization activities and operational decisions.^{45,46}

OBJECTIVE 3 | REINFORCE CAPACITY AND LOCAL SOLUTIONS

Reinforce capacity and local solutions to control the pandemic and mitigate its impacts through mentoring, technical support and resource sharing with local actors (including media and communication sectors) and national or subnational government, working in the public health, humanitarian and development responses.⁴⁷

Local expertise should be recognized and placed at the centre of RCCE efforts to engage communities. Local institutions and organizations are often best-placed to engage communities, building on existing relationships and established trust, including understanding local community culture, language, knowledge and history.

To achieve this objective, country, regional and global actors should:

- **Identify the skills and competencies needed for RCCE approaches in different contexts and circumstances.** They should base this on the agreed RCCE minimum standards and including participatory approaches, facilitation, coordination and data collection and analysis.
- **Facilitate participatory capacity needs assessments** to identify RCCE partners' priorities for technical support and capacity building.
- **Map existing and planned capacity building** for RCCE and other sectoral or technical training (e.g. contact tracing), into which RCCE approaches could be integrated.
- **Develop, implement and monitor strategies to meet the identified priorities for technical support and capacity building**, to improve the quality of RCCE approaches.
- **Strengthen the capacity of national and local media and communications organizations to communicate accurately about COVID-19** and counter misinformation.
- **Facilitate peer-to-peer learning exchanges at different levels** (e.g. between government institutions, community-based organizations, community mobilizers and community health workforce) to identify the local solutions and share best practices.
- **Develop training resources to build core RCCE skills** that can be adapted for language, delivery format and accessibility.
- **Establish mentoring systems to enable those at national and subnational levels to access technical support** in an accessible and timely manner, helping improve the quality of RCCE approaches.

Examples in practice:

West and Central Africa: Reinforcing national capacity across the region. The regional RCCE coordination platform is implementing a capacity-building strategy for national governments and partner organizations across the region. The platform provides technical advice, coaching and technical training, and shares best practices. It has increased the quality and consistency of RCCE approaches in West and Central Africa. One element of their approach has been the RCCE for COVID-19 e-learning. Available in [English](#) and [French](#), the course takes 60 minutes to complete, and a certificate of achievement is provided. Course participants learn about RCCE principles and best practices, understand how to set up a rumour-tracking mechanism and know where to access resources to design and implement a RCCE plan.

Venezuela: Joining efforts to reinforce local capacity.

Capacity building is one of the main pillars of the RCCE strategy in Venezuela. Strengthening the capacities of partners is the best investment for sustainability and better impact. In 2020, with the support of the Andres Bello Catholic University (UCAB), 37 partners were trained in Behaviour Change Communication. Additional specific workshops were also developed to promote hygiene practices and behaviours, applying theory, practical exercises, communication strategies and creative techniques for promoting hygiene practices. To date 265 people from 22 organizations in the states of Gran Caracas, Zulia, Bolivar and Táchira have been trained over 12 workshops. In September 2020, a pilot project was carried out with the organization Agua Tuya consisting of a further three online workshops focusing on COVID-19 related hygiene practices and behaviour, reaching 546 people from vulnerable communities.

OBJECTIVE 4 | BE COLLABORATIVE

Strengthen coordination at global, regional, and subnational and national levels, to increase quality, harmonization, optimization and integration of RCCE across the different technical areas of the public health, humanitarian and development responses to COVID-19.

Coordination efforts should facilitate partnerships with community-based organizations, INGOs, local governments, private sector and communities themselves to articulate localized community-centred responses.

To achieve this objective, country, regional and global actors should:

- **Convene multi-stakeholder groups** as the primary mechanism to coordinate RCCE and broker partnerships.
- **Identify the right membership, leadership and structures to work across the public health, humanitarian and development responses.** This should include civil society organizations, media development actors and local media (where relevant).
- **Identify institutions or organizations engaging communities,** particularly vulnerable groups, and map any gaps.
- **Facilitate coordination groups to jointly assess, plan, monitor and advocate** on common issues impacting the effectiveness of RCCE (e.g. ministries of health, WHO Incident Management System Team Humanitarian Country Team).
- **Create and/or advocate for mechanisms for civil society and community leadership to participate** in the design and delivery of public health and social measures.
- **Collaborate with existing public health, humanitarian and development coordination mechanisms,** including Accountability to Affected Populations (AAP), Protection from Sexual Exploitation and Abuse (PSEA), Access to COVID-19 Tools (ACT) Accelerator.
- **Integrate RCCE into the design, implementation and monitoring for all COVID-19 response efforts** to avoid duplication and gaps, and to maximize the sharing of RCCE resources, standards, indicators, evidence and expertise.
- **Facilitate multi-sectoral engagement to mitigate the effects of socio-economic-political drivers of COVID-19** and contribute to resilience of families and communities. Work with sectors beyond public health, such as nutrition, WASH, livelihoods, social protection/welfare, local governance, etc.

Examples in practice:

Afghanistan: Coordinating collective approaches to RCCE. COVID-19 has brought new and complex challenges to Afghanistan. Within the broader, ongoing prevalence of insecurity, the Afghan health sector is poorly resourced, overall capacity to provide essential health services is low and access to basic needs, including healthcare, is often limited. In February, the COVID-19 virus was detected in Afghanistan. However, at the time, there was no coordinated strategy to combat the looming crisis that brought humanitarian agencies and the government together with other stakeholders. Many travellers and migrant workers returning to Afghanistan were targeted and blamed for bringing the virus to Afghanistan, which began a trail of harmful and misleading rumours about the virus.

The Afghanistan Health Cluster joined with the Protection Cluster to establish an RCCE coordination mechanism at the start of the COVID-19 outbreak. To formalize the coordinated response, the country RCCE working group developed a national collective approach to RCCE on COVID-19. The approach builds on lessons learned from other health crises around best practices for tackling stigma and misinformation. The working group identifies key channels through which communities commonly discuss specific rumours, questions and fears. The working group then develops guidance and key messages to directly address the questions raised. It does

that with the support of the Afghanistan Ministry of Public Health and WHO. They circulate that content to all actors for incorporation into mass media campaigns and community engagement activities.⁴⁸ The Working Group has been a resourcing and coordinating mechanism and information-sharing platform for humanitarian and development actors since early March. There is a strong focus on providing technical support, skills and information to local field teams who are 'community-facing' and engaging with affected and at-risk people on a daily basis. The working group also wants to ; improve community engagement, beyond 'information provision' to build long-term participation and resilience.

Philippines: Coordination tools to support improved programming. Since 2012, the Philippines has been a pilot country in mainstreaming an integrated and coordinated approach on communication, accountability and community participation within humanitarian responses. This enabled the Philippines to rapidly mobilize support for RCCE efforts in response to COVID-19 and build on existing capacity, systems and platforms. The coordination now includes regular [mapping of RCCE operational presence](#) and sharing of common tools, such as standard [terms of reference for subnational RCCE groups](#), to ensure consistent approaches.

2.2 Guiding principles

The strategic approach to RCCE and the objectives set out above should be informed by core guiding principles that underpin all effective RCCE, regardless of the context. These principles are set out below, applied to the COVID-19 context. They are drawn from learning from past public health responses,⁴⁹ what we know from responding to COVID-19 to date, and minimum quality standards for community engagement.⁵⁰

Risk communication and community engagement guiding principles:



NATIONALLY-LED — The responsibility to implement RCCE lies with national governments. However, they are supported by local, national and international civil society⁵¹ and the communities themselves. Risk communication is a core function that WHO Member States must fulfil, as signatories to the International Health Regulations (2005).⁵²



COMMUNITY-CENTRED — Effective RCCE starts with understanding the knowledge, capacities, concerns, structures and vulnerabilities of different groups in communities – enabling adaptation of approaches, improving outcomes and impact. It is necessary to take a holistic, humanitarian approach that addresses the risk of COVID-19, but also includes other community needs, including protection, water and sanitation, economic stability, mental health and psychosocial support and broader development issues.⁵³



PARTICIPATORY — Communities (with priority given to at-risk or vulnerable groups) should be supported to lead in the analysis, planning, design, implementation, and monitoring and evaluation of RCCE activities.⁵⁴ Where there is no capacity to lead, response partners (including local civil society) can facilitate the process through participatory approaches.⁵⁵



TRUST BUILDING — Community trust in governments and institutions and organizations responding to the pandemic is vital to control an outbreak. Trust in scientific advice and recommended behaviours is also important. Reasons for mistrust are varied and related to structural, historical and cultural factors. Understanding them is key to developing trust-building strategies.



OPEN AND TRANSPARENT, EVEN IN UNCERTAINTY — Timely, audience-tailored, science-based communications, adapted to the local context, language and culture, are critical to mitigating risk and engaging communities. Acknowledging and communicating transparently, about what is known and not known, is critical to allaying the stress and fear of the uncertainty that the pandemic creates.⁵⁶



INFORMED BY DATA — Data should be generated and analysed to enable it to inform RCCE approaches, and the response more broadly. There should be a balance between data about individuals, and data about social and structural factors that drive behaviours e.g. social norms and economic pressures.⁵⁷



INTEGRATED — RCCE should be integrated and harmonized within the public health, humanitarian and development responses to COVID-19. At a programmatic level, RCCE should be mainstreamed across all sectors to ensure participation and to improve effectiveness.⁵⁸



COORDINATED — COVID-19 impacts many aspects of the community beyond health. It also affects, access to food; water, sanitation and hygiene; livelihoods; security; and education. Coordinating RCCE efforts across technical specialties avoids duplication and gaps in coverage, helps ensure consistency in approaches, and maximizes efficiency and impact.⁵⁹



INCLUSIVE — Support should be prioritized to the most vulnerable, marginalized or at-risk groups. RCCE approaches must be accessible, culturally appropriate and gender-sensitive.⁶⁰ The representation of all groups in local decision-making should be prioritized; it will contribute positively to transformative power structures and community dynamics, and will ensure the broadest possible range of community knowledge and skills are represented and drawn upon.⁶¹



ACCOUNTABLE — In responding to COVID-19, public health, humanitarian and development actors must be accountable and transparent to affected communities. RCCE approaches should ensure communities can access information about and participate in decision-making about the response. They should also document and respond to community feedback on the response.

2.3 Engaging the most vulnerable

RCCE efforts will need to be prioritized to reach those who are most vulnerable. Two broad types of vulnerability should be considered:

- **Medical:** those who are at a higher risk to develop severe COVID-19
- **Socio-economic:** those who are more likely to be exposed, be unable to receive or follow recommended advice, or be unable to access services due to their physical, social or economic situation.

The table below lists vulnerable groups and reflects these two types of vulnerability. The first shaded section represents those who are medically vulnerable, and the second section those who are vulnerable due to socio-economic factors.⁶²



Vulnerable population groups vary across country contexts, and individuals may experience multiple vulnerabilities, potentially compounding barriers and impacts.⁶³ These groups could potentially be priority groups to reach with RCCE plans, depending on a context-specific risk assessment. However, even within these groups, different capacities and vulnerabilities should be understood in order to develop effective RCCE approaches.

Groups in the community	Summary of how context can affect vulnerability
Health workers	Doctors, nurses, paramedics, community health workforce and others responding to COVID-19 are at a higher risk of developing the disease due to close personal exposure to COVID-19 patients. ⁶⁴
Older persons	Older persons (that is people over 60 years old) are more likely to develop severe illness as a result of COVID-19. They have a higher fatality rate than other age groups. They may not be able to access health services and information, or the services and information may be inadequate. They may have difficulty caring for themselves and depend on family or caregivers. They may not understand the official public health information. Older persons in assisted-living facilities can find physical distancing difficult.
People with pre-existing medical conditions	Underlying medical conditions (such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer) increase the risk of developing serious illness as a result of COVID-19, especially those with a compromised immune system. These people may not have access to clear information about why they are at higher risk.
Children and young people	Children are particularly vulnerable to the socio-economic impacts and, in some cases, by pandemic mitigation measures e.g. school closures. ⁶⁵ They may not be able to access appropriate information or understand the recommended behaviours and also suffer from the psychosocial impacts of the pandemic. There may also be disruptions in care due to the socio-economic impacts.
Ethnic and/or indigenous minorities	They may not have access to health and other services and may not be able to leave an affected area. They may experience stigma and discrimination in healthcare settings and face difficulties accessing information in their own languages.
GBV survivors	Gender-based violence (GBV) increases during every type of emergency, including disease outbreaks. ⁶⁶ Care and support for GBV survivors may be disrupted, including safety, security and justice services.
People experiencing homelessness	They may live isolated from society and not have a network of family and friends to share information. They may be more focused on surviving and obtaining food than accessing official public health information and may be suspicious or fearful of government services.

People deprived of their liberty	People in prisons or detention centres may have limited options to gather information and ask questions, or not at all. They may not be aware of their right to access healthcare and health information. They may not trust facility staff and the information provided. Those in positions of power may not prioritize the provision of information and health services to these populations.
People living within existing humanitarian crises	There is a high risk of infection if people live in cramped conditions without proper sanitation, e.g. refugee camps. Access to adequate shelter, food, clean water, protective supplies, healthcare, family or community support may be inadequate or disrupted. A lack of access to adequate nutrition and healthcare can lead to weakened immune systems and heightened risk. They may lack access to timely and accurate information due to isolation or language barriers and may feel unable or unwilling to follow advice.
People living in overcrowded spaces	There is a high risk of infection if people live in cramped conditions without proper sanitation, such as in dormitories or slums. Physical distancing may be difficult where overcrowding is common and frequent movement of individuals occurs between dwellings. People living in informal settlements and slums may be more likely to mistrust governments, which can enable rumours and misinformation to spread across communities.
People with existing mental health conditions	People with existing mental health conditions may have difficulty understanding and following information about the situation and preventive measures. Stress and uncertainty about the pandemic may induce or worsen their conditions. Disruptions in mental health services may reduce access to these services for people with existing mental health conditions.
People with disabilities	Even under normal circumstances, people with disabilities are less likely to access health care, education and employment and to participate in the community. They are more likely to live in poverty, experience higher rates of violence, neglect and abuse, and are among the most marginalized in any crisis-affected community. ⁶⁷ They are often excluded from decision-making spaces and have unequal access to information on outbreaks and availability of services, especially those who have specific communication needs.
People working in confined conditions	People working in confined conditions such as factories, abattoirs, and meat-packing plants may not be able to follow physical distancing guidelines, and facilities may be poorly ventilated.
Pregnant women	Services may be disrupted when health services are overburdened. Frequent contact with health facilities can increase the risk of infection, especially in health facilities with inadequate infection control measures.
Refugees and migrants⁶⁸	Legal status, discrimination, and language issues may create additional barriers for refugees and migrants' understanding of official public health information. They may not be included in the national response plans. Refugees and migrants' mobility may make them difficult to reach, including during cross-border movement.
Sexual and gender minorities	These groups face challenges in accessing healthcare systems due to stigma and discrimination, and in contexts where they are criminalized, face threats to their security and lives. LGBTQI ⁶⁹ seniors are more likely to be isolated. LGBTQI families may face barriers to accessing COVID-19 services. ⁷⁰
Women and girls	Women make up the majority of the health workforce and are the primary caregivers to those who are ill. Women and girls are more likely to work in the informal economy. They experience increased risks of gender-based violence. Cultural factors may exclude women from decision-making spaces and combine with limited educational and language learning opportunities to restrict their access to information.
Workers in the informal economy⁷¹	These workers are economically more vulnerable and potentially working in unregulated conditions that do not follow public health recommendations. They may struggle to access official public health information.
Urban poor or slum dwellers	For this group lower education levels, densely-packed living conditions, reduced access to water and sanitation, less access to technology, and lower literacy rates may all be barriers to accessing or understanding official public health information.

2.4 Looking at the challenges ahead

Lessons from other infectious disease outbreaks,⁷² as well as what we have learned responding to COVID-19 so far, can help us anticipate some of the challenges and opportunities that we are likely to face in the coming six months.

Exactly how and when this broad and diverse range of opportunities and challenges play out will vary between and within countries. Coordinated, adaptive, innovative, localized and participatory approaches to engage communities around COVID-19 will be crucial in controlling the virus in the coming six months.

UNCERTAINTY

Uncertainty will continue to be one of the defining characteristics of the context,⁷³ and this can lead to fear, panic and a loss of trust.⁷⁴ Clear, consistent and coordinated communications, which acknowledge this uncertainty and outline what is known and unknown (which research has shown does not undermine trust⁷⁵), can help mitigate the impact of uncertainty.



PANDEMIC FATIGUE

Pandemic fatigue⁷⁶ will likely increase as the crisis becomes increasingly protracted. More data and better understanding of people's behaviours in this phase of the pandemic are needed to quantify the impacts of pandemic fatigue. For example, pandemic fatigue may decrease the number of people following recommendations and restrictions. It may also decrease their effort to stay informed about the pandemic and it may decrease their risk perceptions related to COVID-19.⁷⁷ Identifying creative and engaging ways to motivate people by partnering with civil society, community groups, community leaders and influencers is one of the strategies that could increase motivation and likely adherence.⁷⁸



TRUST

Community trust will be vital in ending disease outbreaks.⁷⁹ Understanding the root causes of mistrust, and how the pandemic has impacted the local dynamics of trust, is key to creating strategies to build and maintain trust. Building trust requires deliberate and sustained community engagement. This engagement must be grounded in evidence-based, open communications from trusted sources and be able to react effectively to community feedback.⁸⁰ It requires structures and processes such as participatory governance, accountability systems and mechanisms to design policies and interventions with communities. RCCE actors should therefore advocate for these structural elements, and for increased transparency across health actors, including government, as a cornerstone for building trust.





COMMUNITY ENGAGEMENT

Engaging communities, both physically and virtually, will help mitigate the increasing politicization of the pandemic response. WHO's Director General warned "the politicisation of the pandemic has exacerbated it".⁸¹ Using the pandemic and the associated response as a political opportunity can be expected to increase as the economic impacts of the pandemic increase. Conflicting messages and recommendations from leaders create confusion, which can reduce the uptake of public health recommendations. Engaging communities in order to answer their questions and concerns with scientifically-grounded, politically-neutral information can minimise that impact. Information should be presented in accessible formats, in languages the community understands, via channels they prefer, and using sources they trust.



COORDINATION

Investments in coordinated and proactive community engagement approaches will be crucial to increase demand for testing, treatments and vaccines. As new biomedical tools will progressively hit the market, it will be critical to support their uptake but also fight complacency and continue to promote the full set of solutions available, including behavioural ones (masks, distancing, hand washing, etc.) in order to end the pandemic. The future COVID-19 vaccines will be the centre of attention. Strong RCCE will be needed to accompany their rollout, anticipating rumours and misinformation, but also adjusting to the many factors still unknown when it comes to vaccination priorities, strategies and effects, in different contexts. There is also the potential for anti-vaccination movements to tie any COVID-19 vaccine development to other vaccinations, potentially increasing hesitancy around existing routine immunization. Finally, given the risk of inequitable access to biomedical tools between and within countries, RCCE strategies to support civil society and community participation in policy and strategy design will be paramount, alongside monitoring, feedback and accountability mechanisms.



STIGMA AND DISCRIMINATION

Reducing COVID-19 stigma and discrimination is crucial to protecting the most vulnerable, including health workers. Stigma leads to people hiding symptoms, refusing to get tested or delaying seeking medical care. This inaction potentially contributes to rising infections and deaths. Engaging communities – in person and virtually – is an important way to show that using negative language can further fuel stigma and discrimination. Governments, citizens, media, key influencers and communities have an important role to play in preventing and stopping stigma.⁸³



MISINFORMATION

Concerted and coordinated efforts to tackle misinformation will be essential to control the virus. Misinformation can harm people's physical and mental health, increase stigmatization, threaten precious health gains, and lead to poor observance of public health recommendations. This reduces the effectiveness of those measures and endangers countries' abilities to respond effectively to the pandemic.⁸²



ECONOMIC PRESSURE

Increasing economic pressure will force people to take greater risks. People may be forced to choose between following public health and social measures, and making enough money to survive. RCCE can create opportunities for those who are economically vulnerable to identify locally appropriate responses to COVID-19 risks that reflect their economic and social contexts.

2.5 Global behaviour change framework

The global behaviour change framework with key indicators for RCCE is listed below. It has been developed through a consultative process with RCCE practitioners at global, regional and national levels, and builds on existing best practice. The suggested indicators measure a number of important socio-behavioural variables that have been identified as essential for slowing COVID-19 transmission or measuring the impacts of COVID-19 transmission on communities.

The global behaviour change framework aims to simplify and where possible standardize the collection, analysis and use of social data associated with the COVID-19 pandemic. It is not designed to measure the delivery of activities within the strategy. Rather, it focuses on helping RCCE programme managers, as well as broader operational leadership understand social changes at the population level.

Its main objective is to establish and maintain a set of global, regional and national indicators which support: strategic thinking, operational tracking, real-time evidence-based decision making and advocacy and transparency around RCCE efforts to influence behaviour and increase community empowerment and social cohesion.

The specific objectives of the framework are to:

- **Monitor** changes in human behaviour and help to identify trends and opportunities
- **Help** the prioritization of response activities and inform decision-making amongst all partners;
- **Accelerate** and support transparency and information, knowledge, perceptions, sharing;
- **Support** preparedness and response planning; and
- **Produce** evidence for policy or strategy revision, operational reviews and lessons learned.

The proposed model below helps achieve these objectives. It is grounded within UNICEF's Behavioural Drivers Model and takes into consideration the latest understanding of behavioural theory as well as lessons learnt since the pandemic has begun.⁸⁴



The global behaviour change framework to strengthen RCCE is organized around six dimensions which are considered as most relevant to understand how perceptions, knowledge, practices, social and structural variables are impacting on the uptake of positive health behaviours.



INFORMATION AND COMMUNICATION



KNOWLEDGE AND UNDERSTANDING



PERCEPTIONS



PRACTICES



SOCIAL ENVIRONMENT

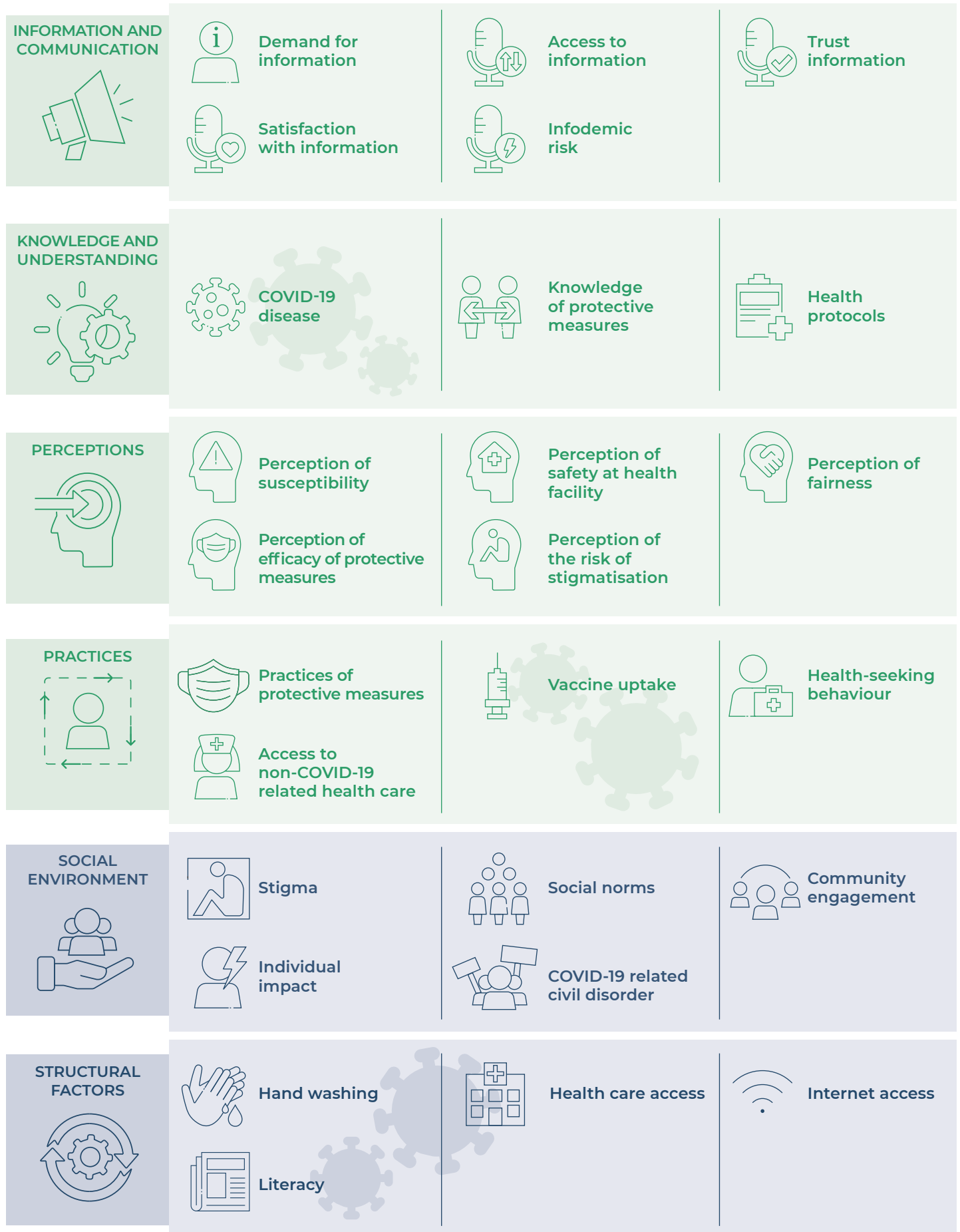


STRUCTURAL FACTORS

Please find [here](#) the questions bank resource. This is a menu of questions related to socio-behavioural factors and COVID-19, based on the finalized framework.

Understanding the extent and impact of these individual and social drivers is critical to understanding why people may or may not be adhering to measures designed to protect them and their families.





COVID-19 RCCE Framework



3.6 Global RCCE Indicators



INFORMATION AND COMMUNICATION




Variable	Indicators	Definition of key terms	Numerator	Denominator
 Demand for information	Percentage of individuals who seek information about COVID-19 on a weekly basis	Individuals who seek information about different aspects of COVID-19 at least once a week using channels they have access to (health care workers, family, friends, community leaders, newspapers, radio, TV, online sources including social media and messaging apps)	Total of respondents who report seeking information on COVID-19 on a weekly basis	Total of respondents aged 15 and above
 Access to information	Percentage of individuals who have access to appropriate information on COVID-19	Accurate and factual information in the local language which facilitates / helps people to identify local level solutions and adopt (and sustain) key preventive measures	Total of respondents who report accessing to appropriate information on COVID-19	Total of respondents aged 15 and above who report seeking information on COVID-19 on a weekly basis
 Satisfaction with information	Percentage of individuals who are satisfied with the information content they receive on COVID-19	Satisfaction with information content received regardless of format or channel or information source	Total of respondents who express satisfaction with the information content they received	Total of respondents aged 15 and above who report seeking information on COVID-19 on a weekly basis
 Trust information	Percentage of individuals who receive information through a communication channel they trust	Individual's perception of the trustworthiness of the communication channel through which they receive information on COVID-19. Channels may include health care workers, family, friends, community leaders, newspapers, radio, TV, online sources including social media and messaging apps	Total of respondents who report trusting the communication channel through which they receive COVID-19 related information	Total of respondents aged 15 and above who report seeking information on COVID-19 on a weekly basis
 Infodemic risk	Proportion of unreliable content vs all content online in a specific geography and population	Potentially unreliable content is referring to false, untrustworthy news or unsupported claims. Content measured at geographical or population level - Geographical or population risk can be a proxy for individual risk	Total of unreliable public posts on Twitter related to COVID-19 during the past month	Total of public posts on Twitter related to COVID-19 during the past month

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems)

Additional sources: HBS Global Behaviours and Perceptions Study; YouGov Surveys; Imperial College Behavioural Tracker; GeoPoll SSA Perceptions; GTS Perception Survey; UNICEF U-Report; HHI Global COVID-19 survey



KNOWLEDGE AND UNDERSTANDING

Variable	Indicators	Definition of key terms	Numerator	Denominator
 Covid-19 disease	Percentage of individuals who know correct symptoms of COVID-19	Symptoms as defined in current WHO guidance	Total of respondents who know correct symptoms of COVID-19	Total of respondents aged 15 and above
	Percentage of individuals who know correct transmission routes of COVID-19	Transmission routes as defined in current WHO guidance	Total of respondents who know correct transmission routes of COVID-19	Total of respondents aged 15 and above
 Knowledge of protective measures	Percentage of individuals who know how to protect themselves from COVID-19	Knowledge about personal protective measures such as hand washing / physical distancing / limiting social gatherings to reduce individual's infection risk of COVID-19	Total of respondents who know how to protect themselves from COVID-19	Total of respondents aged 15 and above
	Percentage of individuals who know how to stop COVID-19 transmission in their community	Knowledge about measures (limit community movements, suspend participation in community events / social gatherings, cancelling of non-essential travels etc.) which are critical to stop COVID-19 transmission in a given geographical area	Total of respondents who know how to stop COVID-19 transmission at community level	Total of respondents aged 15 and above
 Health protocols	Percentage of individuals who know what measures should be taken if they have been in contact with someone who has COVID-19	Triggers for different actions such as self-isolation, testing, agreement to contact tracing will vary across contexts and depend on public health's laboratory testing capacity and / or public health capacity to take care of people	Total of respondents who know about appropriate measures to be taken if in contact with someone who has COVID-19	Total of respondents aged 15 and above

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems)

Additional sources: Facebook-MIT-WHO; EPI-WN; HHI Global COVID-19 survey; OSF COVIDiSTRESS Global Survey



PERCEPTIONS





Variable	Indicators	Definition of key terms	Numerator	Denominator
 Perception of susceptibility	Percentage of individuals who believe they are at risk of contracting COVID-19	Individual's subjective approximation of the probability of personally contracting COVID-19	Total of respondents who report being at risk of contracting COVID-19	Total of respondents aged 15 and above
 Perception of efficacy of protective measures	Percentage of individuals who believe following recommended measures will protect them from COVID-19	Individual's perception that by following recommended measures they will protect themselves from COVID-19	Total of respondents who report that following recommended measures will protect them from COVID-19	Total of respondents aged 15 and above who know how to protect themselves from COVID-19
	Percentage of individuals who believe following recommended measures will help stop COVID-19 transmission in their community.	Individual's perception that by following recommended measures they will help to contain the spread of COVID-19 in their community	Total of respondents who report that by following recommended measures will contain the spread of COVID-19 at community level	Total of respondents who know how to stop COVID-19 transmission at community level
 Perception of safety at health facility	Percentage of individuals who believe that their health facility is currently safe to go to	Individual's perception that the health facility they normally go to provides medical care (for non-COVID-19 related health issues) without exposing medical personnel, patients and their families to COVID-19 infection risks	Total of respondents who report that their health facility is currently safe to go to	Total of respondents aged 15 and above who have access to health facility
 Perception of the risk of stigmatization	Percentage of individuals who think falling ill with COVID-19 leads to stigma	Individual's perception of stigmatization by immediate environment or wider community, that is associated with individuals that have contracted COVID-19	Total of respondents to report that falling ill with COVID-19 leads to stigma	Total of respondents aged 15 and above
 Perception of public health measures fairness	Percentage of individuals who think locally recommended measures for COVID-19 are fair	Perception of inequity drives frustration that can negatively affect social cohesion and reduce public trust in recommended measures	Total of respondents who report locally recommended measures for COVID-19 are fair	Total of respondents aged 15 and above who know how to protect themselves and to stop COVID-19 transmission at community level

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems)

Additional sources: HBS Global Behaviours and Perceptions Study; YouGov Surveys; Imperial College Behavioural Tracker; GeoPoll SSA Perceptions; OSF COVIDiSTRESS Global Survey



PRACTICES




Variable	Indicators	Definition of key terms	Numerator	Denominator
 Protective measures	Percentage of individuals who report practising recommended measures to protect themselves from COVID-19	Recommended measures will depend on national and local public health guidelines and local context - which aim to reduce an individual's risk of contracting COVID-19	Total of respondents who report practising recommended measures to protect themselves from COVID-19	Total of respondents aged 15 and above who know how to protect themselves from COVID-19
	Percentage of individuals who report practising recommended measures to stop COVID-19 transmission in their community	Recommended measures will depend on national and local public health guidelines and local context - which aim to contain the spread of COVID-19 in a given geographical area	Total of respondents who report practising recommended measures to stop COVID-19 transmission at community level	Total of respondents who know how to stop COVID-19 transmission at community level
 Vaccine uptake	Percentage of individuals who would get vaccinated once a vaccine is available and recommended	Intended behaviour which will be particularly relevant for targeted groups	Total of respondents who report that they will seek vaccination once a vaccine is available and recommended	Total of respondents aged 15 and above
 Health-seeking behaviour	Percentage of individuals who would immediately seek medical care if they had COVID-19 symptoms	Self-reported measure of health-seeking behaviour triggered by COVID-19 symptoms. This can include calling a specific and dedicated hotline, consultation of medical staff, seeking testing or seeking treatment	Total number of respondents who report that they would immediately seek medical care if they had COVID-19 symptoms	Total of respondents aged 15 and above who have access to health facility
	Percentage of individuals who would self-medicate if they had COVID-19 symptoms	Self-reported measure of health-seeking behaviour triggered by COVID-19. Individuals do not seek any formal health care advice or service and self-medicate	Total of respondents who report to self-medicate if they have COVID-19 symptoms	Total of respondents aged 15 and above who have access to health facility
 Access to non-COVID-19 related health care	Percentage of individuals who have difficulty in accessing healthcare for non-COVID-19 related treatment	Measures only access and not the actual demand. Difficulty is defined as having skipped or delayed health care visits due to the suspension or interruption of non-essential health services (e.g. sexual and reproductive health, immunization, cancer treatment etc.) as response to the pressure of COVID-19 on the national and local health system	Total of respondents who have difficulty in accessing healthcare for non-COVID-19 related treatment	Total of all respondents who require non-COVID-19 related treatment for themselves or their children and normally have access to health facility

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems)

Additional sources: YouGov Surveys; Imperial College Behavioural Tracker; GeoPoll SSA Perceptions; U-Report



SOCIAL ENVIRONMENT



Variable	Indicators	Definition of key terms	Numerator	Denominator
 Stigma	Percentage of individuals who have observed people in their community stigmatized because of COVID-19	'Stigma' is defined as individuals and/or groups sharing specific characteristics (gender, ethnical identity, culture etc.) and experiencing disapproval or discrimination. This might be expressed by verbal, physical and/or emotional abuse; or denial of access to services and infrastructure (housing, jobs, education); being shunned in or excluded from social situations; because they are COVID-19 patients or are associated with bringing the disease to the community	Total of respondents who report to have observed people in their community stigmatized because of COVID-19	Total of respondents aged 15 and above
 Social norms	Percentage of individuals who believe that their friends or family would want them to self-isolate if they have been in contact with someone who has COVID-19	Individual's perception that self-isolation is a social norm and expected by their immediate environment which will shape the uptake of the measure	Total of respondents who report that their friends or family would want them to self-isolate if they have been in contact with someone who has COVID-19	Total of respondents aged 15 and above
 Community engagement	Percentage of individuals who report that authorities involve the local population to inform public health measures	Authorities (national, local and subnational government entities) work directly with the local population to inform decision-making processes concerning public health measures	Total of respondents who report that authorities involve the local population to inform public health measures	Total of respondents aged 15 and above
	Percentage of individuals who report collaborating in decisions about community actions	Individual's ability to participate in collective decision-making processes affecting the community i.e. participation in local and community planning or other meeting for COVID-19	Total of respondents who report collaborating in decisions about community actions	Total of respondents aged 15 and above
	Percentage of individuals who know how to provide feedback about decision-making processes which affect them	Individual's knowledge about mechanisms to provide feedback and complaints concerning the way they are or were asked to express their viewpoints or opinion and input in decision-making processes which affect their lives	Total of respondents who report to know how to provide feedback about decision-making processes which affect them	Total of respondents aged 15 and above
	Percentage of individuals who trust authorities and partners leading the COVID-19 response	Increase of trust due to community engagement efforts undertaken by authorities (national, local and subnational government entities) and partners (e.g. local or international NGOs)	Total of respondents who report to trust authorities and partners leading the COVID-19 response	Total of respondents aged 15 and above

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems)

Additional sources: HBS Global Behaviours and Perceptions Study; YouGov Surveys; Imperial College Behavioural Tracker; GeoPoll SSA Perceptions; OSF COVIDISTRESS Global Survey



SOCIAL ENVIRONMENT (cont.)





Variable	Indicators	Definition of key terms	Numerator	Denominator
 COVID-19 individual impact	Percentage of individuals who report COVID-19 has had a negative economic impact on their life	Concerns about economic impact may include for example loss of income, loss of job, difficulty purchasing food for themselves and their families	Total of respondents who report COVID-19 has had a negative economic impact on their life	Total of respondents aged 15 and above
	Percentage of individuals who report that COVID-19 has had a negative psycho-social impact on their life	Psycho-social impact may include, feelings of anxiety or fear of the future; pervasive feelings of hopelessness or desperation; frustration; depression; insomnia caused or reinforced by the direct and indirect impact of COVID-19	Total of respondents who report that COVID-19 has had a negative psycho-social impact on their life	Total of respondents aged 15 and above
 COVID-19 related civil disorder	Number of COVID-19 related civil disorder events reported in the last three months	The 'number of COVID-19 related civil disorder events' is defined by all events directly linked to the pandemic. These events include recorded protest against government measures made in response to COVID-19, demonstration of conspiracy belief, violent attacks linked to COVID-19 transmission, including violence against healthcare workers responding to the coronavirus. Indirect protest or demonstration such economic shocks or complex social demonstrations are not captured with this indicator	Total number of COVID-19 related civil disorder events	Past 30 days

Data sources: Country data collection (KAP survey, Community Rapid Assessment, Community feedback systems); ACLED

Additional sources: Carnegie; OSF COVIDiSTRESS Global Survey; GeoPoll SSA Perceptions; HBS Global Behaviours and Perceptions Study



STRUCTURAL FACTORS

Variable	Indicators	Definition of key terms	Numerator	Denominator
 <p>Handwashing</p>	Percentage of individuals who have at least basic hand washing facilities with soap and water	Basic handwashing facilities are defined by WHO as a sink with tap water, and can also include other devices that contain, transport or regulate the flow of water. Buckets with taps, tippy-taps and portable basins are all examples of handwashing facilities. Bar soap, liquid soap, powder detergent and soapy water all count as soap for monitoring purposes. Depending on the context people may have also access to alcohol based hand wash rub	Total of repondents who report to have access to a basic hand washing facility with soap and water	Total of respondents aged 15 and above
 <p>Health care access</p>	Proportion of physicians and nurses per 1,000 people	Key indicator to monitor the availability of health workers. It can serve as a proxy to monitor equity in the allocation of resources by humanitarian actors across different groups within the humanitarian case load and/or crisis affected population versus local populations. No consensus about optimal level of health workers for a population. It can be broken down according to the type of health worker to present the workforce mix	Total of physicians and nurses in the country	Total of population
 <p>Internet access</p>	Percentage of individuals using the internet	Individuals using the internet are defined by the World Bank as individuals who have used the Internet (from any location) in the last three months. The internet can be used via a computer, mobile phone, personal digital assistant, games machine, digital TV etc. It might be relevant to disaggregate by gender as possible	Total of individuals who report to use the internet	Total of individuals aged 16 to 74
 <p>Literacy rate of adults</p>	Percentage of individuals aged 15 and above who can both read and write with understanding a short simple statement about their everyday life	The literacy rate is defined by UNESCO as the percentage of the population of a given age group that can read and write. The adult literacy rate corresponds to ages 15 and above. It is typically measured according to the ability to comprehend a short simple statement on everyday life. The definition of literacy could be adapted by country, check this link for more information	Total of respondents who can both read and write according to the in-country definition of adult literacy	Total of respondents aged 15 and above

Data sources: Household survey; WHO

Additional sources: UNESCO; MICS; World Bank; UNICEF; WASH Cluster

03

Annexes



Annex 1

Methodology

This strategy was developed between June to October 2020 and included a series of consultations with global and regional stakeholders.

The first phase involved a series of key informant interviews with 30 public health and humanitarian experts, working on RCCE in the COVID-19 response. A full list of key informants can be found in the Acknowledgements section.

In addition, 20 people took part in an online survey to provide their input. The survey participants represented a range of partners, including donors, governments, NGOs, UN agencies, and WHO staff.

In the key informant interviews discussions focused on: identifying the changes in the context since the initial strategy was developed; the challenges and lessons learned implementing the original strategy; and what the key considerations should be for the next six months of RCCE work.

The online form supplemented this information with a focus on the new strategy. The surveys aimed to identify: areas of focus, key considerations, and how to work across the public health and humanitarian responses to COVID-19.

The initial phase of the consultations fed into the first draft of the strategy. The first draft was shared for peer review with a broad and diverse range of partners. These included:

- 50 key informants who took part in the consultations or the online survey
- GOARN's [COVID-19 Risk Communication and Community Engagement Coordination Platform](#)
- [Health Cluster Strategic Advisory Group](#)
- [Inter-Agency Standing Committee \(IASC\) Results Group 2 on Accountability and Inclusion](#) – including dedicated feedback sessions with technical expert groups on Accountability (AAP), Inclusion, and Protection from Sexual Exploitation and Abuse (PSEA)
- The [Communication Initiative Network](#), Reference Group
- The [Communicating with Disaster Affected Communities \(CDAC\) Network](#) membership and expert pool
- The [RCCE Collective Service](#) Core Team, including technical specialists from WHO, IFRC and UNICEF.

The feedback generated fed into the second draft, which was shared with the same peer groups listed above for review and feedback.

The document was revised to reflect this feedback into the third draft, which was reviewed by the internal sign-off mechanisms within WHO, UNICEF and IFRC.

Annex 2

Supporting RCCE guidance documents

Please find below a linked list of supporting guidance documents, that have been produced as part of the RCCE response to COVID-19, or are key documents to help guide the implementation of this strategy.

[Risk Communication and Community Engagement \(RCCE\) Action Plan Guidance COVID-19 Preparedness and Response](#) (IFRC, UNICEF, WHO, March 2020)

[Risk communication and community engagement readiness and response to coronavirus disease \(COVID-19\) – interim guidance](#) (WHO, March 2020)

[Minimum quality standards and indicators in community engagement](#) (UNICEF, August 2019)

[Pandemic Fatigue Reinvigorating the public to prevent COVID-19](#) (WHO, September 2020)

[Building Trust Within and Across Communities for Health Emergency Preparedness](#) (IFRC, UNICEF, July 2020)

[Critical preparedness, readiness and response actions for COVID-19](#) including RCCE actions for each transmission scenario (WHO, November 2020)

[COVID-19 Planning Guide for Adapting Risk Communication and Community Engagement as Public Health and Social Measures Shift: With Safety Tips for Conducting Community Meetings](#) (IFRC, Save the Children, Johns Hopkins Centre for Communication Programs)

[FINDING COMMUNITY-LED SOLUTIONS TO COVID-19: An interagency guidance note on working with communities in high density settings to plan local approaches to preventing and managing COVID-19](#) (IFRC, UNICEF and WHO)

[COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement](#) (IFRC, UNICEF, WHO)

[COVID-19: How Can Risk Communication and Community Engagement \(RCCE\) Include Marginalized and Vulnerable People in the Eastern Mediterranean Region](#) (EMPHNET, Global Health Development, IFRC, IOM, UNFPA, UNICEF, UN WOMEN, WHO)

[A guide to preventing and addressing social stigma](#) (IFRC, UNICEF, WHO, February 2020)

[Factsheet to address stigma and discrimination](#) of people who have been affected by COVID-19 (IFRC, WHO and UNICEF)

[Factsheet on mistrust, disbelief and denial of COVID-19 in Africa](#) (IFRC, WHO and UNICEF)

[Factsheet on treatments and vaccine trials for COVID-19](#) (IFRC, WHO and UNICEF)

[PRACTICAL GUIDANCE FOR RISK COMMUNICATION AND COMMUNITY ENGAGEMENT \(RCCE\) for Refugees, Internally Displaced Persons \(IDPs\), Migrants, and Host Communities Particularly Vulnerable to COVID-19 Pandemic](#) (IFRC, IOM, Johns Hopkins Center for Communication Programs, UNHCR, UNICEF, UNODC, WHO)

[Risk Communication and Community Engagement for COVID-19- Engaging with Children and Adults with Disabilities](#) (UNICEF)

[Tips for Engaging Communities during COVID-19 in Low-Resource Settings, Remotely and In-Person](#) (GOARN, IFRC, UNICEF, WHO)

[COVID-19: Key tips and discussion points for field staff, community workers, volunteers and community networks](#) (IFRC, UNICEF, WHO)

[Social science support for COVID-19: working in humanitarian context](#) - what social sciences researchers working in humanitarian contexts (Sub-Saharan Africa) should be asking in COVID-19 and why

[Social science support for COVID-19: gender inclusiveness in COVID-19 response operations](#)

[Social science support for COVID-19: humanitarian programme recommendations](#) - humanitarian programme recommendations for COVID-19 based on social sciences evidence from the Democratic Republic of Congo (DRC) Ebola outbreak response.

[Social science support for COVID-19: barriers to healthcare seeking](#)

Annex 3

Risk Communication and Community Engagement in practice

Risk Communication and Community Engagement in practice focuses on:

- **Acknowledging the questions** and concerns of individuals and communities, and providing answers and opportunities for dialogue;
- **Assessing behavioural** and social drivers, and adapting approaches to enable and encourage behaviour change accordingly;
- **Translating science**, data and evidence-based information into audience-tailored, timely, relevant and actionable lifesaving messages;
- **Increasing opportunities** for communities to participate in the design of public health measures and other response interventions, ensuring they meet the communities' needs;
- **Enhancing risk** assessments and improving decision-making, by providing evidence from social listening, perception studies, social science research and dialogue with communities;
- **Advocating for communities'** priorities and concerns, and making sure their voices are heard in decision-making forums they cannot access on their own;
- **Encouraging health-seeking behaviours**, and strengthening the understanding, acceptability and uptake of bio-medical tools (e.g. testing, treatment, vaccines) and non-medical solutions (e.g. public health and social measures⁸⁵) to control the outbreak; and
- **Ensuring the accountability** of those implementing the response (e.g. governments, organizations, institutions).

RCCE is a technical pillar of any structured public health emergency response. It is a foundational way of working, which enables other technical pillars to achieve their goals by better understanding the needs and capacities of communities, increasing efficiency and impact.

Annex 4

Summary of global evidence of socio-behavioural trends for COVID-19

This is a narrative summary of key socio-behavioural trends emerging about COVID-19 Public Health and Social Measures (PHSMs). It synthesizes emerging factors that may be relevant to behaviours that reduce and/or slow down COVID-19 transmission.

The synthesis draws on findings from the global perception analysis undertaken by Dalberg (on behalf of the RCCE Collective

Service) which undertook a meta-analysis of nine datasets relevant to COVID-19 and was complemented by additional data sources, to capture broader representation and geographical coverage. Key resources are summarized in Table 1. The trends described here are those found broadly across international data and cannot aim to represent geographic diversity or contextual nuance; some illustrative examples (in italic font) are included to demonstrate variation.

Table 1. Key sources consulted in this review

Source	Details
Global Risk Perception Study, Dalberg Ref.: Dalberg (2020): COVID-19 Global Risk Perception Study	Nine datasets (seven respondent level datasets and two country level datasets), most of them collected between February and August 2020
KAP COVID-19 survey, Johns Hopkins Ref.: Johns Hopkins Center for Communication Programs in collaboration with WHO, GOARN, MIT and Facebook: Exploring knowledge, attitudes and practices for COVID-19 prevention (KAP COVID-19)	67 countries, July 2020
Phase 3 Global COVID-19 Survey, HHI Ref.: Harvard Humanitarian Initiative, Brigham and Women's Hospital: Global COVID-19 Survey, Phase 3, launched in May 2020	8,822 respondents, 102 countries, May 2020
COVID-19 briefs by the Social Science in Humanitarian Action Platform⁸⁶	Operational social science briefs March-September 2020
IFRC community feedback Ref.: IFRC COVID-19: Community Feedback Report #21 – Africa Region	Africa region
Partnership of Evidence Based COVID-19 Response Ref. PERC (September 2020): Responding to COVID-19 in Africa: using data to find a balance, part 2	Surveyed 24,041 adults in 18 Sub-Saharan African countries August, 2020
UNICEF MENA Literature Analysis Ref.: Anthrologica (2020): Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region	Norms and behaviours related to transmission

Limitations: This overview attempts to present headline trends drawing on a variety of sources which in themselves have some limitations. Socio-behavioural analyses are most valuable if there are comparable data from mixed methods of qualitative and quantitative methods. Many of the sources presented

here are from digital channels which can limit representation for groups with lower access to digital technology and low literacy. The global datasets used have limitations in terms of their geographical coverage and respondent level data is also self-reported which may be subject to personal biases.



KNOWLEDGE OF COVID-19

Worldwide, basic knowledge of COVID-19 across populations is now common – including knowledge about COVID-19 symptoms.

| Available global data suggests that 64% of survey participants could correctly describe COVID-19 signs and symptoms.⁸⁷

The level of understanding of specific aspects of the disease is variable between countries and influenced by a combination of socio-behavioural determinants such as age, educational background and/or the environment in which people live (e.g. urban or rural).

| According to recent data, 28% of survey respondents in Vietnam correctly identified those at most risk of infection, compared to 59% in Ghana and 70% in Venezuela.

| In South Africa, 56% of those living in rural areas could identify those most at risk of infection, compared to 62% living in urban areas.

| In Uganda, 43% of survey respondents with secondary school education or below knew about those most at risk compared to 58% with a college degree or higher.⁸⁸

Despite adequate existing knowledge about COVID-19 in many settings, there is increasing evidence of a decline in people's perceptions of infection risk

| In several African countries people reported to believe that COVID-19 does not affect young people or Africans, that the disease does not exist or that the pandemic has already ended.⁸⁹



INFORMATION AND COMMUNICATION

Scientific knowledge about COVID-19 constantly generates new evidence, this affects the level of trust that people have in the information they receive, and whom they trust to deliver that information. Using trusted information sources and channels to timely communicate accurate and evidence-based information is critical.⁹⁰

Trust in scientific and factual information shared by official sources and credible institutions is often high.

| Recent global data suggests that people tend to have highest levels of trust in information shared by scientists, doctors and health experts (68%), followed by WHO (56%).⁹¹

However, trust and exposure to traditional media channels is very variable between countries and while the level of exposure to information might be high this does not necessarily correspond with high level of trust in the information from those channels.

| Data from Myanmar suggests that radio is considered as one of the most trusted media channels but only 20% of the local population is exposed to information broadcasted by radio channels.⁹²

| In Colombia, a majority of survey respondents (88%) reported to receive COVID-19 related information through television while only one third (32%) trust in this channel.⁹³

Health workers and traditional media channels are well-trusted information channels in many countries.

| Global data found that 50% of the general population trust health workers, 44 % television, 38% radio and newspaper.⁹⁴

Public figures, and particularly religious leaders can play a vital role in encouraging people to adhere to COVID-19 related public health and social measures (PHSMs).⁹⁵

Globally there is variation in the extent to which that people trust information shared by politicians, low trust can often be attributed to structural factors such as lack of transparency or historical public-state mistrust.⁹⁶

While exposure to online information sources is increasing there is evidence to suggest that trust in those channels is generally low.⁹⁷



ADHERENCE TO PUBLIC HEALTH AND SOCIAL MEASURES (PHSMs)

In the global data, self-reported adherence to personal measures such as hand washing, mask wearing or keeping distance tends to be generally high – which is likely to be influenced by local COVID-19 disease trends and the extent to which PHSMs are enforced.

In African countries with stringent PHSMs (such as Uganda) and / or high incidence of COVID-19 (e.g. South Africa) a large proportion of the respondents reported to adhere to PHSMs.⁹⁸

Compliance with measures that restrict economic activities is likely to be lower.

Recent data suggests that the risk of food insecurity and income loss can influence people's compliance with PHSMs.⁹⁹

Adherence to measures that limit public gatherings are often poor. This is influenced by socio-cultural norms, traditions and the need for social interaction.

In Iran, Libya and Sudan there were reports of gatherings for weddings and mourning ceremonies and public religious events (Eid al-Fitr) despite the advice not to do so.¹⁰⁰

Lower levels of knowledge about COVID-19 decreases the level of compliance with PHSMs; socio-behavioural determinants relating to levels of knowledge are variable across regions and between countries.

Data from the Middle East and Northern Africa (MENA) region suggests that lower level of knowledge about COVID-19 is primarily associated to personal characteristics such as male gender, lower education, lower income, rural location and older age.¹⁰¹ Emerging global evidence suggests on the other hand that especially young people seem to adhere less to PHSMs including personal measures such as keeping physical distance.¹⁰²

Adherence to PHSMs is influenced by personal characteristics and meta-norms including gender ideologies, moral norms, power dynamics.

In the MENA region, distancing and quarantine were less frequently found among men due to their usual social and professional or labour activities. Compared to their male counterparts, women in the MENA region are also more likely to stay at home when movements have been restricted.¹⁰³



RISK PERCEPTIONS

It is common for people, worldwide, to recognize COVID-19 is a serious disease, however they often feel COVID-19 is more of a threat to others: their friends and family, their community and country, than to themselves.^{104,105}

Globally people's level of confidence in their ability to prevent COVID-19 is usually low (50% or less). In countries where people feel less confident in their ability to protect themselves, it also seems people are also less likely to practise preventive measures.¹⁰⁶

There is little evidence to suggest people feel able to influence collective decision-making aiming to control COVID-19.

In Africa perceived ability tends to be however higher for influencing decisions at community level (34%) than decisions made at country level (22%).¹⁰⁷



PHYSICAL DISTANCING

Self-reported adherence to keep physical distance tends to be high, although lower compared to other personal measures such as hand washing or mask wearing.

Recent data from Sudan suggests lower level adherence to maintain physical distance (47%) than to hand washing (75%).

Adoption of physical distancing is likely to be influenced by structural factors such as social and environmental context, personal circumstances – including displacement and migration – and individuals' access to space.¹⁰⁸

Population and housing density in slums and inner-city settlements, often concentrate large populations of the urban poor in Low and Middle-Income Countries, which increases the likelihood of social mixing.

Adherence appears to be also determined by personal characteristics such as socio-economic status and gender.

Emerging evidence from the MENA suggests that men tend to leave the house more frequently and socialize more often than women.¹⁰⁹ While in several African countries it was found that risk behaviours are more common among those with least economic resources carrying out informal sector work.¹¹⁰

Perceived norms can become an important enabler to maintain physical distance but are different between countries and populations.

Recent data from South Africa revealed that among 85% of survey respondents reporting to maintain physical distance, nearly half of them thought that distancing was the norm in their community.¹¹¹

Caretaking responsibilities can negatively influence people's ability to adhere to physical distancing.

Global data indicated that almost half of survey respondents (43%) were not able to keep physical distance because they needed to care for others outside of their homes.¹¹²



MASK WEARING

Globally, use of face coverings has increased worldwide in response to the pandemic, but perceptions and adoption shift over time as attitudes and perceptions of risk change.¹¹² Adherence is also influenced by factors such as perceived norms¹¹⁴, face mask mandates, and clear guidance on mask wearing from official sources.

Data from African countries revealed that many people perceive face covering as necessary however but self-reported adherence to it is lower.¹¹⁵

In several African countries people report wearing face masks out of the fear of being fined.¹¹⁶

Adoption of face coverings can also be subject to personal factors as well affordability.

Respiratory problems when wearing masks are frequently reported.¹¹⁷ And, in the DRC, as the cost of masks increased, feedback data revealed that people requested free distribution of face masks.^{118 119}



SELF-ISOLATION

Globally, adherence to self-isolation is lower compared to other personal measures.

Across the Middle East and Northern Africa (MENA) region, people seem to approve the isolation of people showing symptoms of COVID-19 although structural factors and the fear of stigma or the perception of being punished can influence the acceptability of self-isolation.¹²⁰

There is confusion about the meaning of the different concepts that involve isolation.

There is emerging evidence found that the concept of and terminology around isolation of infected people; quarantine of contacts; shielding of most vulnerable needs, to be made clearer.¹²¹

Informal mechanisms play a predominant role in supporting vulnerable people who need to be shielded.

In Low and Middle Income Countries that have tested shielding, families and households are primarily responsible to care for the vulnerable and are supplemented by extended kinship networks and mutual aid groups in the community.

Mandatory shielding policies seem to be less effective than voluntary approaches.

Emerging social science evidence highlights that household shielding is usually a preferred option compared to communal, block or camp level green zones.

Concerns about the overall economic impact on the household (e.g. loss of livelihood for those shielded, potential unpaid caregiving by family members) can be a barrier to shield most vulnerable from COVID-19 infection risks.¹²²



SUPPORT FOR PUBLIC HEALTH AND SOCIAL MEASURES

Overall, the acceptability of PHSMs appears to be high, with measures restricting economic activities being generally less accepted.¹²³

Survey respondents across 18 African Countries reported different levels of support for different types of measures: hand washing (86% stated it is absolutely necessary) versus staying home or reducing trips to markets or stores (68% stated it was absolutely necessary).¹²⁴

The uptake and acceptability of PHSMs is also likely to be influenced by the extent to which public authorities adhere to them.

In several African countries, people shared irritations about public authorities not adhering to personal measures themselves which in turn had negative implications on individual's acceptability of PHSMs.¹²⁵

The feeling of pandemic fatigue can become a barrier to be supportive of PHSMs. The level of confidence in complying with PHSMs is likely to decrease if they last over a longer period of time although coping capacity with the current situation tends to exist.^{126,127}

Data from African countries reported, decreasing levels of interest and motivation in discussing COVID-19 and participating in related awareness and promotional activities.¹²⁸

Global data collected in May 2020 revealed that more than half of the survey respondents felt confident (51%) or totally confident (14%) to cope with the situation, but although there was still support expressed for PHSMs for as long as needed (69%), that support diminished over time.¹²⁹

Low level of acceptability and trust in government responses to COVID-19 can result in protests and anti-government movements.

Globally, approximately 20 anti-government protests have been recorded since the start of the pandemic.¹³⁰



HEALTHCARE-SEEKING BEHAVIOUR

Healthcare-seeking behaviours, like protective behaviours are influenced by a number of variables including structural factors, low levels of awareness of signs and symptoms of COVID-19, fear of stigma, misinformation and affordability.

In Jordan the fear of being stigmatized after seeking treatment seemed to be an important barrier to seeking health care; in Yemen people reported the fear of becoming infected with COVID-19 in hospital and reported rumours that doctors killed COVID-19 patients in hospital. In both, Iraq and Yemen the cost of treatment also affected care-seeking behaviour.¹³¹

Depending on the context, religion can become a barrier and an enabler to seek healthcare.

Emerging evidence suggests that in MENA religion can encourage people to perform religious rites instead of getting formally treated or promoting the belief that COVID-19 is a punishment which can be cured by prayers.¹³²

Changes in service provision do not necessarily affect people's healthcare choices.¹³³

Knowledge of COVID-19 symptoms is crucial to trigger appropriate health-seeking behaviour however does not necessarily lead to testing.

Global data collected in May 2020 revealed that 93% of survey respondents didn't attempt to get tested while showing COVID-19 symptoms or having been exposed to someone who might have tested positive with COVID-19 (95%). Among those who sought to get tested over the past four weeks prior to the survey, a large majority were not able to get tested (98%).¹³⁴



VACCINE ACCEPTABILITY

Acceptability of a potential vaccine is variable across regions and between and within countries.

Recent global data suggests that people in the Western Pacific tend to be more inclined to use a potential COVID-19 vaccine once it becomes available (>60%). Within the Western Pacific region, there are fewer people in the Philippines (61%) who are willing to accept a potential vaccine compared to people in South Korea (84%). Vaccine acceptability seems to be particularly lower across specific countries in the European region (e.g. Azerbaijan, Kazakhstan, Ukraine) and the African region (e.g. Cameroon, Senegal and Cote d'Ivoire).¹³⁵

Barriers to vaccine uptake are likely to be influenced by a large range of factors.

Emerging evidence from MENA highlighted that Syrian refugees in Jordan reported the lack of a UNHCR ID card as major barrier to register their children for vaccination. In Morocco, in the past, historical and political factors have resulted into low rates of vaccine uptake. In Iran affordability has been a problem, and in Qatar and Morocco fear of injections was more commonly expressed.¹³⁶

Misinformation and rumours can negatively impact on vaccine confidence.

In several African countries scepticism toward vaccine was common and people reported to believe in foreigners discrediting African medicines or 'that foreigners testing vaccines on Africans'.¹³⁷

Health care professionals play a vital role in promoting vaccine uptake among their patients and/or communities.

Recent data revealed that in Libya and Morocco, the lack of awareness and knowledge among medical students and health workers put significant barriers to vaccine uptake in the past.¹³⁸



SECONDARY HEALTH IMPACTS OF COVID-19

The pandemic puts pressure on existing health services and makes already vulnerable groups more susceptible to preventable diseases such as measles, malaria and cholera.¹³⁹

In several African countries people reported to have delayed or skipped health care visits (44%) and / or experienced difficulties in obtaining medication (47%).¹⁴⁰

Difficulties in accessing timely health care for non-COVID-19 related health issues are influenced by structural and financial constraints and the fear of becoming infected with COVID-19 at the health facility.

Recent data from Africa revealed that the fear of COVID-19 infection (26%) and cost of services (17%) were the most common barriers to access care. Differences among urban and rural population's health-seeking behaviour equally exists and are likely attributed to more stringent PHSMs in urban areas.¹⁴¹

Annex 5

The RCCE Collective Service

The RCCE Collective Service is a collaborative partnership between RCCE practitioners, convened by IFRC, WHO and UNICEF, with support from the Global Outbreak Alert and Response Network (GOARN), and key stakeholders from the public health and humanitarian sectors. The three agencies have a long history of effective collaboration to bolster coordinated community-centred approaches across a broad range of emergencies, contexts, and geographies. The Collective Service aims to ensure that the strengths of each partner are leveraged to deliver the greatest impact, reduce duplication, and increase effectiveness of localized action.

The Collective Service aims to deliver the structures and mechanisms required for coordinated, community-centred approaches embedded throughout public health, humanitarian, and development responses.

Globally, the Collective Service team facilitates a coordination platform for RCCE, which supports RCCE within the global COVID-19 public health response. The Collective Service collaborates closely with humanitarian response actors, through the [IASC Results Group Two on Accountability and Inclusion](#).

Regionally, support for national RCCE efforts is available through six established regional RCCE coordination platforms. The regional platforms are all set up to coordinate regional efforts, as well as provide technical support to the countries in their region.

You can learn more about the Collective Service [here](#) and on [the WHO webpage](#).

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Jon Bugge (*author*)
Independent consultant

References

- ¹ [COVID-19 Global Response Risk Communication and Community Engagement \(RCCE\) Strategy](#) (IFRC, WHO, UNICEF, March 2020)
- ² For additional information, please [see Annex 1: Methodology](#)
- ³ For additional information, please [see Annex 2: Supporting RCCE guidance documents](#)
- ⁴ Risk communication refers to: ‘...the real-time exchange of information, advice and opinions between experts, community leaders, or officials and the people who are at risk...Effective risk communication allows people most at risk to understand and adopt protective behaviours. It allows authorities and experts to listen to and address people’s concerns and needs so that the advice they provide is relevant, trusted and acceptable.’ [Communicating risk in public health emergencies](#) (WHO, 2017)
- ⁵ Community engagement refers to ‘...working with traditional, community, civil society, government, and opinion groups and leaders; and expanding collective or group roles in addressing the issues that affect their lives. Community engagement empowers social groups and social networks, builds upon local strengths and capacities, and improves local participation, ownership, adaptation and communication...’ [Minimum quality standards and indicators in community engagement](#) (UNICEF, August 2019)
- ⁶ [Risk communication and community engagement readiness and response to coronavirus disease \(COVID-19\) – interim guidance](#) (WHO, March 2020)
- ⁷ For the latest statistics please see [WHO COVID-19 Dashboard](#)
- ⁸ Public health and social measures are: ‘...actions by individuals, institutions, communities, local and national governments, and international bodies, to suppress or stop community spread of COVID-19’ – these include hand hygiene, movement restrictions, physical distancing, adaptations in the workplace and in educational institutions, avoiding high risk settings, as well as use of masks and other strategies. [Overview of Public Health and Social Measures in the context of COVID-19](#) (WHO, May 2020)
- ⁹ Reconfiguring health systems vital to tackling COVID-19 (WHO, April 2020)
- ¹⁰ [In WHO global pulse survey, 90% of countries report disruptions to essential health services since COVID-19 pandemic](#) (WHO, August 2020)
- ¹¹ [United Nations Comprehensive Response to COVID-19](#) (United Nations, September 2020)
- ¹² [Global Humanitarian Response Plan COVID-19 – July Update](#) (UN OCHA, July 2020)
- ¹³ COVID-19 and children (UNICEF, August 2020)
- ¹⁴ [The psychological impact of COVID-19 on the mental health in the general population](#) (QJM, August, 2020)
- ¹⁵ [Social stigma in the time of Coronavirus](#) (European Respiratory Journal, June 2020)
- ¹⁶ [Managing the COVID-19 infodemic: Promoting healthy behaviours and mitigating the harm from misinformation and disinformation](#) (WHO, UN, UNICEF, UNDP, UNESCO, UNAIDS, ITU, UN Global Pulse, IFRC, September 2020)
- ¹⁷ [Pandemic Fatigue Reinvigorating the public to prevent COVID-19](#) (WHO, September 2020)
- ¹⁸ [Global Protest Tracker](#) (Carnegie Endowment for International Peace, accessed 12 October, 2020)
- ¹⁹ The synthesis draws on findings from the global perception analysis undertaken by Dalberg (on behalf of the RCCE Collective Service) which undertook a meta-analysis of nine datasets relevant to COVID-19 and was complemented by additional data sources, to capture broader representation and geographical coverage.
- ²⁰ This overview attempts to present headline trends drawing on a variety of sources, which in themselves have some limitations. Socio-behavioural analyses are most valuable if there are comparable data from mixed methods of qualitative and quantitative methods. Many of the sources presented here are from digital channels which can limit representation for groups with lower access to digital technology and low literacy. The global datasets used have limitations in terms of their geographical coverage and respondent’s level data is also self-reported which may be subject to personal biases.
- ²¹ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ²² [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ²³ [COVID-19 Global Risk Perception Study](#) (Dalberg, August 2020)
- ²⁴ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ²⁵ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)

- ²⁶ Ibid.
- ²⁷ [COVID-19: Community Insights from the Asia Pacific Region - Indonesia, Malaysia, Myanmar, and Pakistan](#) (IFRC, UNICEF, WHO, September 2020)
- ²⁸ Ibid.
- ²⁹ [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ³⁰ [Pandemic fatigue Reinvigorating the public to prevent COVID-19](#) (WHO, September 2020)
- ³¹ [COVID-19: Community Insights from the Asia Pacific Region - Indonesia, Malaysia, Myanmar, and Pakistan](#) (IFRC, UNICEF, WHO, September 2020)
- ³² Ibid.
- ³³ COVID-19 Strategic Preparedness and Response Plan Monitoring (WHO, October 2020)
- ³⁴ COVID-19 Strategic Preparedness and Response Plan Monitoring (WHO, October 2020)
- ³⁵ COVID-19 Strategic Preparedness and Response Plan Monitoring (WHO, October 2020)
- ³⁶ [The architecture and effect of participation: a systematic review of community participation for communicable disease control and elimination](#) (Malaria Journal, August 2011)
- ³⁷ [Community engagement for COVID-19 prevention and control: a rapid evidence synthesis](#) (BMJ Global Health, October 2020)
- ³⁸ [Community engagement in outbreak response: lessons from the 2014–2016 Ebola outbreak in Sierra Leone](#) (BMJ Global Health, August 2020)
- ³⁹ Adapted from Standard 1 in [Minimum Quality Standards and Indicators for Community Engagement](#) (UNICEF, August 2019)
- ⁴⁰ [FINDING COMMUNITY-LED SOLUTIONS TO COVID-19](#) (IFRC, UNICEF, WHO, July 2020)
- ⁴¹ [FINDING COMMUNITY-LED SOLUTIONS TO COVID-19](#) (IFRC, UNICEF, WHO, July 2020)
- ⁴² [Pandemic fatigue - Reinvigorating the public to prevent COVID-19, September 2020](#) (WHO Europe)
- ⁴³ Examples of evidence regularly needed to shape an effective response include: data about the social, political, historical and economic context; local knowledge, attitudes, beliefs and behaviours; pathways of care and local transmission of the virus; and key community stakeholder mapping, including existing local structures and decision-making processes. This background information must be supplemented by real-time insights and feedback to ensure adaption as necessary.
- ⁴⁴ [COVID-19 Risk Communications and Community Engagement Stories from the Field](#) (UNICEF, 2020)
- ⁴⁵ [COVID-19 Pandemic 6-month Update](#) (IFRC, 2020)
- ⁴⁶ [COVID-19 Risk Communication and Community Engagement Stories from the Field - ESARO](#) (UNICEF, 2020)
- ⁴⁷ These could include government departments, local NGOs, and community-based organizations such as women's groups, youth groups, persons with disabilities organizations, parent teacher associations, community health workforces, traditional healer organizations, birth attendants' groups, and local radio/media.
- ⁴⁸ [Coordinated community engagement in Afghanistan](#) (WHO, August 2020)
- ⁴⁹ [FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies](#) Global Preparedness Monitoring Board (GPMB) 2019 Background paper (IFRC, September 2019)
- ⁵⁰ [Minimum Quality Standards and Indicators for Community Engagement](#) (UNICEF, August 2019)
- ⁵¹ For examples of quality criteria and actions please see: Standard 11 Government Leadership, in [Minimum Quality Standards and Indicators for Community Engagement](#) (UNICEF, August 2019)
- ⁵² [WHO guidance on emergency risk communication](#) (WHO, 2015)
- ⁵³ For examples of quality criteria and actions please see: Standard 5 Adaptability and localization and Standard 6 Building on local capacity, in [Minimum Quality Standards and Indicators for Community Engagement](#) (UNICEF, August 2019)
- ⁵⁴ For examples of quality criteria and actions please see: Standard 1 Participation, Ibid.
- ⁵⁵ [FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies](#) Global Preparedness Monitoring Board (GPMB) 2019 Background paper (IFRC, September 2019)
- ⁵⁶ For examples of quality criteria and actions please see: Standard 4 Two-way communication, in [Minimum Quality Standards and Indicators for Community Engagement](#) (UNICEF, August 2019)
- ⁵⁷ For examples of quality criteria and actions please see: Standard 15 Data Management, Ibid.
- ⁵⁸ For examples of quality criteria and actions please see: Standard 13 Integration, Ibid.
- ⁵⁹ For examples of quality criteria and actions please see: Standard 12 Partner coordination, Ibid.
- ⁶⁰ For examples of quality criteria and actions please see: Standard 3 Inclusion, Ibid.
- ⁶¹ [FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies](#) Global Preparedness Monitoring Board (GPMB) 2019 Background paper (IFRC, September 2019)
- ⁶² Adapted from the above, and [Update #1 COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement](#) (IFRC, OCHA, WHO, April 2020)

- ⁶³ [Actions for consideration in the care and protection of vulnerable population groups from COVID-19](#) (WHO, May 2020)
- ⁶⁴ [Risk of COVID-19 among front-line health-care workers and the general community](#) (The Lancet, July 2020)
- ⁶⁵ [COVID-19 and children](#) (UNICEF, October 2020)
- ⁶⁶ [Gender-based violence and COVID-19](#) (UNDP, May 2020)
- ⁶⁷ [COVID-19: Considerations for Children and Adults with Disabilities](#) (UNICEF, April 2020)
- ⁶⁸ "...including migrant workers and their families; irregular migrants; cross-border populations. While legally distinct, refugees and migrants are jointly addressed here as both groups could face similar challenges as non-nationals and a mobile or potentially mobile population" [Update #1 COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement](#) (IFRC, OCHA, WHO, April 2020)
- ⁶⁹ Lesbian, gay, bisexual, transgender, queer, and intersex [Health and sexual diversity](#) (WHO, June 2016)
- ⁷⁰ [Stigma is not quarantined: The impact of COVID-19 on the LGBTI community](#) (World Bank feature story, May 2020)
- ⁷¹ The 'informal economy' is the part of any economy that is neither taxed, regulated nor monitored by any form of government
- ⁷² [FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies](#) Global Preparedness Monitoring Board (GPMB) 2019 Background paper (IFRC, September 2019); [Community engagement for successful COVID-19 pandemic response: 10 lessons from Ebola outbreak responses in Africa](#) (BMJ Global Health, August 2020)
- ⁷³ [Ten considerations for effectively managing the COVID-19 transition](#) (Nature, June 2020)
- ⁷⁴ [Communicating and Managing Uncertainty in the COVID-19 Pandemic: A quick guide](#) (WHO, May 2020)
- ⁷⁵ [Ten considerations for effectively managing the COVID-19 transition](#) (Nature, June 2020)
- ⁷⁶ Defined as "demotivation to follow recommended protective behaviours, emerging gradually over time and affected by a number of emotions, experiences and perceptions" [Pandemic Fatigue Reinvigorating the public to prevent COVID-19](#) (WHO, September 2020)
- ⁷⁷ Ibid.
- ⁷⁸ Ibid.
- ⁷⁹ [FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies](#) Global Preparedness Monitoring Board (GPMB) 2019 Background paper (IFRC, September 2019)
- ⁸⁰ [Building Trust Within and Across Communities for Health Emergency Preparedness](#) (IFRC, UNICEF, July 2020)
- ⁸¹ [World Government Summit](#) (WHO, 22 June 2020)
- ⁸² [Managing the COVID-19 infodemic: Promoting healthy behaviours and mitigating the harm from misinformation and disinformation](#) (WHO, UN, UNICEF, UNDP, UNESCO, UNAIDS, ITU, UN Global Pulse, IFRC, September 2020)
- ⁸³ [A guide to preventing and addressing social stigma](#) (IFRC, UNICEF, WHO, February 2020)
- ⁸⁴ [The Behavioural Drivers Model](#) (UNICEF, September 2019)
- ⁸⁵ Public health and social measures are: "actions by individuals, institutions, communities, local and national governments, and international bodies, to suppress or stop community spread of COVID-19" – these include hand hygiene, movement restrictions, physical distancing, adaptations in the workplace and in educational institutions, avoiding high risk settings, as well as use of masks and other strategies. [Overview of Public Health and Social Measures in the context of COVID-19](#) (WHO, May 2020)
- ⁸⁶ For more information please see [Social Science in Humanitarian Action Platform](#)
- ⁸⁷ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ⁸⁸ Ibid.
- ⁸⁹ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ⁹⁰ [Key considerations: online information, mis- and disinformation in the context of COVID-19](#) (Anthrologica, March 2020)
- ⁹¹ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ⁹² Ibid.
- ⁹³ Ibid.
- ⁹⁴ Ibid.
- ⁹⁵ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ⁹⁶ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ⁹⁷ Ibid.
- ⁹⁸ [Responding to COVID-19 in Africa: using data to find a balance Part II](#) (PERC, September 2020)
- ⁹⁹ Ibid.
- ¹⁰⁰ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹⁰¹ Ibid.

- ¹⁰² *COVID-19 Global Risk Perception Study* (Dalberg, August 2020)
- ¹⁹³ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹⁰⁴ *COVID-19 Global Risk Perception Study* (Dalberg, August 2020)
- ¹⁰⁵ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ¹⁰⁶ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ¹⁰⁷ [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ¹⁰⁸ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹⁰⁹ Ibid.
- ¹¹⁰ [Compliance with Physical Distancing Measures for COVID-19 and Implications for RCCE in Eastern and Southern Africa](#) (Anthrologica, September 2020)
- ¹¹¹ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ¹¹² [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ¹¹³ Ibid.
- ¹¹⁴ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ¹¹⁵ [Responding to COVID-19 in Africa: using data to find a balance Part II](#) (PERC, September 2020)
- ¹¹⁶ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ¹¹⁷ Ibid.
- ¹¹⁸ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹¹⁹ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ¹²⁰ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹²¹ [Emerging evidence on shielding vulnerable groups during COVID-19](#) (SSHAP, 2020)
- ¹²² [Emerging evidence on shielding vulnerable groups during COVID-19](#) (SSHAP, 2020)
- ¹²³ [Responding to COVID-19 in Africa: using data to find a balance Part II](#) (PERC, September 2020)
- ¹²⁴ Ibid.
- ¹²⁵ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ¹²⁶ [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ¹²⁷ Ibid.
- ¹²⁸ COVID-19: Community Feedback Report #21 – Africa Region (IFRC, October 2020) forthcoming report
- ¹²⁹ [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ¹³⁰ [Global Protest Tracker](#) (Carnegie Endowment for International Peace, accessed 12 October, 2020)
- ¹³¹ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹³² Ibid.
- ¹³³ [What questions we should be asking about COVID-19 in humanitarian settings: perspectives from the Social Sciences Analysis Cell in the Democratic Republic of the Congo](#) (BMJ, September 2020)
- ¹³⁴ [Global COVID-19 Survey, Phase 3](#) (Harvard Humanitarian Initiative, May 2020)
- ¹³⁵ [KAP COVID-19 Exploring knowledge, attitudes and practices for COVID-19 prevention](#) (Johns Hopkins University, WHO, GOARN, Facebook, MIT, 2020)
- ¹³⁶ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹³⁷ [Responding to COVID-19 in Africa: using data to find a balance Part II](#) (PERC, September 2020)
- ¹³⁸ *Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region* (Anthrologica, September 2020)
- ¹³⁹ [Broader health impacts of vertical responses to COVID-19 in low- and middle-income countries \(LMICs\)](#) (SSHAP, 2020)
- ¹⁴⁰ [Responding to COVID-19 in Africa: using data to find a balance Part II](#) (PERC, September 2020)
- ¹⁴¹ Ibid.

