Risk communication and community engagement readiness and response toolkit

mpox

World Health Organization

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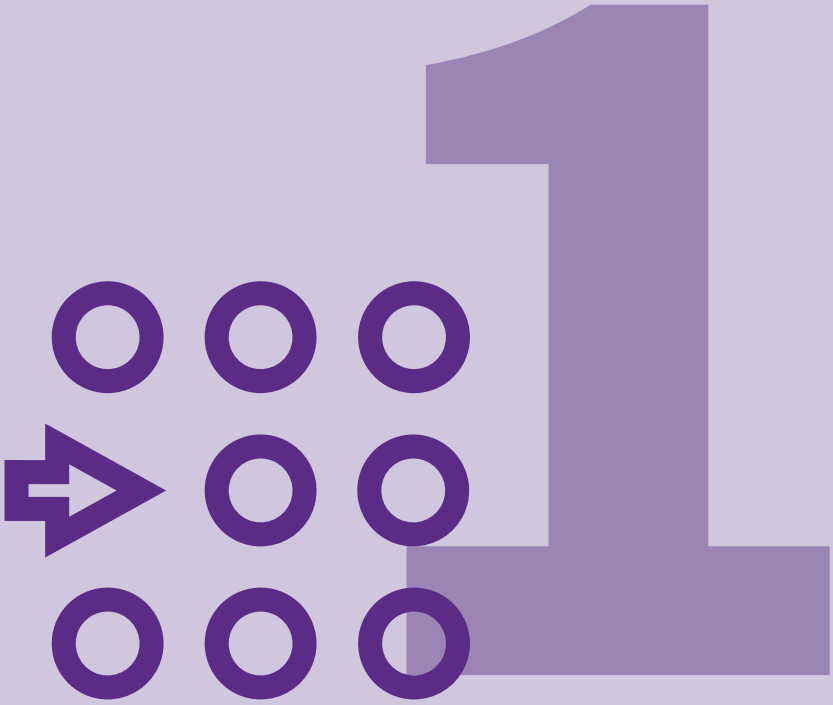
Abbreviations

AIDS	Acquired immunodeficiency syndrome
CSO	Civil society organization
GOARN	Global outbreak alert and response network
HIV	Human immunodeficiency virus
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
IMST	Incident Management Support Team
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex
M&E	Monitoring and evaluation
MEL	Measurement, evaluation, and learning
NGO	Nongovernmental organization
PESTEL	Political, economic, sociological, technological, environmental and legal
PRSEAH	Prevention and reporting of sexual exploitation, abuse and harassment
RCCE	Risk communication and community engagement
SEAH	Sexual exploitation, abuse and harassment
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Glossary

Behavioural insights	Information about variables that influence behaviours at the individual, community, and population level and can improve the design of policies and programmes, communications, and products and services to achieve better health for all.
Behavioural science	Behavioural science is a multidisciplinary scientific approach that deals with human action, its psychological, social and environmental drivers, determinants and influencing factors. It is applied in protecting and improving people's health by informing the development of public health policies, programmes, and interventions.
Community	Refers to a group of people connected by common characteristics, such as geographic location, age, gender, profession, ethnicity, faith, shared vulnerability or risk, or shared interests and values.
Community engagement	The collaborative process that involves people in understanding the risks they face and includes communities in developing health and response practices that are acceptable and workable for them. The goal of community engagement is to empower communities and to develop shared leadership throughout the emergency response cycle.
Collective Service for RCCE	A partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the Global Outbreak Alert and Response Network (GOARN), and as well as key stakeholders from the public health and humanitarian sectors.
Emergency	A situation impacting the lives and well-being of a large group of people or a significant percentage of a population requiring substantial multi-sectoral assistance. For a WHO response, there must be clear public health consequences.
Health emergency management cycle	Spans the prevention, preparedness, readiness, response and recovery phases of health emergencies that all organizations and governments should follow to reduce the impact of disease outbreaks, health emergencies and disasters. Countries and communities may be engaged in different phases for multiple outbreaks and emergencies simultaneously.
Infodemic	An infodemic is overabundance of information, accurate or not, in digital and physical environment, accompanying an acute health event such as an outbreak or epidemic.
Outbreak	Occurrence of cases of a disease in excess of what would normally be expected in a defined community, geographical area, or season.
Partners	International, non-governmental, or community organizations that work in a geographic area or health field.
Readiness	Refers to the ability of countries, communities and organizations to be able to respond quickly and effectively to health emergencies from any hazard. Operational readiness is a critical enabler of resilience in communities and health systems, helping them to withstand crisis. Fast-tracking, activating, testing or preposition specific functional capabilities are all important functions for enhanced readiness.
Response	Phase of a health emergency or outbreak activated once the hazard, risk or threat hits, with the implementation of life-saving public health and health interventions to save lives and protect the most vulnerable.
Risk communication	Real-time exchange of information, advice, and opinions between experts and people who are facing a risk or threat to their health, social or economic wellbeing. The purpose of risk communication is to provide people with accurate and timely information and to support them in making informed decisions to mitigate the effects of a threat or hazard.
Stakeholders	Governments and community leaders that have a vested interest in protecting the health of their own country, region, or community.

Overview of the risk communication and community engagement readiness and response toolkit: mpox



About the toolkit

This toolkit is a comprehensive set of practical tools and resources designed to support country-level risk communication and community engagement (RCCE) practitioners, decision-makers, and partners to plan and implement readiness and response activities for mpox (previously known as monkeypox).

The toolkit contains:

- information about mpox;
- RCCE considerations for how to approach key issues during mpox outbreaks;
- tools for understanding the context in which mpox outbreaks occur;
- methods for collecting data to inform strategy development and bring evidence into planning and implementation of activities;
- case studies; and
- links to existing RCCE tools and training.

It is one of a suite of toolkits on RCCE readiness and response to a range of disease and response areas.

The toolkit has been developed through an iterative and consultative process that has followed several steps to identify, collate and refine the information, tools and best practices it contains. These steps include

Literature Review

- An extensive review was conducted of the scientific literature, research papers, published documents and grey literature related to mpox, risk communication, community engagement, health emergencies and disease outbreak response.
- A structured search of online databases (PubMed, Institutional Repository for Information Sharing (IRIS), ReliefWeb, and Google Scholar) was conducted to identify publications related to mpox, immunization and risk communication and community engagement, specifically within the context of mpox outbreaks.
- Keywords supplied by the technical teams were used as the foundation of the search to identify relevant documents, from which other specific terms and keywords were extracted. Documents were systematically reviewed for content on key thematic areas, methods and definitions relevant to the development of RCCE plans and strategies. This included but was not limited to clinical information on mpox; behavioural science methods related to public health and outbreak response; understanding, preventing and addressing stigma and discrimination; stakeholder engagement and situational analysis; measurement, evaluation and learning frameworks and methodologies; and preventing and responding to sexual exploitation, abuse, and harassment (PRSEAH). Retrieved publications were assessed for relevance, uploaded to a database and logged into a tracking sheet, highlighting them for further consideration.

Iterative consultation

- Following development of the toolkit and integration of relevant publications and sources in close consultation with WHO technical teams, the toolkit was then reviewed and revised by RCCE subject matter experts at country, regional and global levels through an iterative consultation process between March 2023 and December 2023.

Pilot testing

- Draft versions of the toolkits were tested during disease outbreaks and feedback collected on clarity, relevance, and usability of the toolkit.

Peer review

- The toolkit was peer-reviewed by independent experts from a range of disciplines including RCCE, epidemiology, behavioural science.

Readiness and response within the health emergency cycle

In recent years, WHO, Member States and partners have engaged in significant efforts to strengthen the architecture for health emergency prevention, preparedness, readiness, response and recovery. Readiness and response are closely connected. Readiness builds on the preparedness phase and is the interface between preparedness and immediate response to an emergency. For example, the approach of a high-risk season, an outbreak of a contagious disease in a neighbouring country, the hosting of a large international event or the declaration of a public health emergency of international concern (PHEIC) can all trigger operational readiness activities. Experience has shown us that countries that systematically ready their health and emergency systems can respond more quickly, cohesively and equitably to a threat or emergency, shortening their duration, curbing their impact and ultimately saving lives.

The role of RCCE for health emergencies and disease outbreaks

Risk communication is the real-time exchange of information between decision-makers, experts and populations exposed to a hazard or imminent threat to their survival, health, or economic or social well-being.

Community engagement is the process of developing trusted relationships and structures that engage communities as important partners in the creation of emergency response solutions that are acceptable and applicable for those they impact.

Informed, engaged and empowered communities are the bedrock of successful readiness and response for outbreaks and emergencies. The principles of RCCE are outlined in the 10 steps to community readiness package, developed by the Collective Service to prepare communities for COVID-19 vaccines, treatments or new test *(1)*.

The desired outcome of effective RCCE is to mitigate the potential negative impact of health hazards before, during and after public health emergencies or unusual events *(2)*. The ultimate goal of RCCE during health emergencies and outbreaks is to reduce morbidity and mortality by empowering communities to confidently participate in leadership, planning, and implementation of activities throughout the health emergency response cycle. This is the reason that risk communication is one of the core technical capacities under the International Health Regulations (IHR) (2005) *(3, 4)* and should be an integral part of all Incident Management Support Teams (IMST) in WHO headquarters and regional offices, as well as Incident Management Teams responding to a graded health emergency at the national or local level.

During infectious disease outbreaks, it is imperative to understand why people behave the way they do and what influences behavioural drivers of disease transmission and risk. Effective RCCE should result in affected communities knowing how to protect themselves and others against the disease, how to seek care, testing, treatment, and vaccines; and to prevent, manage and avoid stigma and discrimination. To achieve this, communities at risk must be included and consulted in developing strategies and plans and in the implementation of readiness and response activities to outbreaks *(5)*.

WHO response to mpox

Mpox is a viral infectious disease. Prior to 2022, most cases were detected in several African countries where zoonotic spillover occurred or was presumed to occur, leading to local or extensive person-to-person transmission. A multi-country outbreak of mpox which began in 2022 has since caused over ninety thousand cases worldwide, primarily affecting men who have sex with men and other key populations. The multi-country outbreak led to the declaration of mpox by the WHO Director-General as a Public Health Emergency of International Concern (PHEIC) from July 2022 to May 2023. Over the same period of 2022 to 2023, the number of cases reported by countries in the African region surged, adding more than twenty thousand cases to the count.

As we enter the control and elimination phase of the global response to mpox and address the still-emerging risk in endemic countries, the WHO Director-

General has issued standing recommendations for mpox that are in effect for all States Parties from 21 August 2023 to 20 August 2024 (5). This includes a recommendation for States Parties to enhance community protection by building capacity for RCCE, adapting public health and social measures (PHSM) to local contexts and continuing to strive for equity and build trust with communities through the following actions, particularly for those most at risk. Actions are recommended to:

- communicate risk, build awareness, engage with affected communities and at-risk groups through health authorities and civil society;
- implement interventions to prevent stigma and discrimination against any individuals or groups that may be affected by mpox.

This toolkit is designed to support the implementation of the standing recommendations for mpox. It is also intended to be useful in the implementation of mpox elimination and control strategies in all contexts in line with WHO recommendations.

Purpose of the toolkit

The purpose of this toolkit is to guide RCCE practitioners, decision-makers, and partners on how to place affected communities at the centre of coordinated efforts to reduce the impact of and end outbreaks of mpox. It provides strategies, best practices, and practical resources to: collect and analyse social and behavioural data; use collected insights to inform strategy and implementation; coordinate activities with partners and stakeholders, support the development and dissemination of accurate information to those at risk; build vaccine confidence and demand; address public concerns; and support the participation of communities as essential partners in mpox readiness and response efforts. These principles are vital for more tailored, equitable and inclusive health emergency programmes.

This toolkit is also designed to support the implementation of the standing recommendations for mpox.

Intended audience

This RCCE readiness toolkit has been designed for use by:

- decision and policy makers;
- national and local health authorities;
- emergency management authorities;
- UN agencies and other international nongovernmental organizations (INGOs);
- Non-governmental organizations (NGOs) and civil society organizations (CSOs), and
- community leaders.

How to use the toolkit

The toolkit supports coordinated, inclusive and tailored RCCE, highlighting approaches that are essential for the successful management of an mpox outbreak. All tools require contextualization based on local epidemiology, social-behavioural data, available partners, capacity, community-specific needs, and the status of outbreak readiness and response activities. The resources in this toolkit should be used at the appropriate emergency management phase, reflecting current conditions.

All those interested in using these tools should coordinate to adapt them for their context using the following three steps:

1. **Review all tools**
   This toolkit contains a range of tools with different aims and objectives. It can be used like a library of resources to meet existing country-level needs, however, not all tools will always be relevant or necessary for all settings. All provided tools should be reviewed and selected for use based on needs and the priorities outlined in the national mpox elimination and control plans.

2. **Adapt the relevant tools**
   This toolkit has been developed at a global level. All provided resources should be adapted to local contexts. This can be done by national decision-makers, RCCE practitioners or partners and in line with communities engaged in the response. Adaptations that may be needed include:

   - **Language and audience:** Translate the tools into local languages and dialects. Considerations should be made to address literacy and accessibility needs.
   - **User:** Adapt and refine the tools according to the needs of those who will be using them. Different stakeholders have different needs and capacities.
   - **Mpox outbreak context:** Adapt the tools based on the current epidemiological situation and what is known about the context and behaviours of affected populations. Future adaptations may be needed as the situation evolves. RCCE activities are cross-cutting and should be conducted in coordination with other outbreak response pillars such as surveillance and case investigation, vaccination, clinical management, infection prevention and control, and others.
   - **Phase of the emergency:** How the tools in the toolkit are adapted and implemented will depend on the current phase of the health emergency cycle in the local context. Tool 5 (the RCCE readiness and response checklist for mpox outbreaks) can be used to identify different priorities within the different phases.
   - **Existing national activities:** Selection and adaptation of tools should be guided by national action plans, strategies and ongoing activities to complement and enhance existing efforts.

3. **Use and monitor**
   Once the tools are tailored to your local context, they can be used to inform strategy and planning and guide the implementation of RCCE activities. The resources within the toolkit provided should guide the work of WHO but are also valuable to other engaged partners and stakeholders, including community leaders, local NGOs, CSOs and other local actors to support their activities. The use of these tools should be monitored and evaluated continuously to inform improvements.

Background information on mpox

This background information is up to date as of February 2024. It is intended to provide RCCE decision-makers, practitioners and partners with the knowledge and understanding needed to effectively respond to mpox outbreaks. Up-to-date information about the local mpox situation should be sought from local mpox outbreak response leads to establish a full understanding of the local setting.

Note: In November 2022, WHO began using "mpox" as the preferred term for monkeypox in the English language. Read more here.

Overview

Mpox was first identified in 1958 in monkeys and identified as a human disease in 1970 in the Democratic Republic of the Congo (DRC) *(6)*. It went on to emerge in other East, Central and West African countries, and outbreaks have occurred in more than one hundred countries in other regions since 2022 *(7)*. These new outbreaks in previously unaffected countries have spread mainly through sexual contact and in communities of gay men, bisexual men and other men who have sex with men. In 2023, a surging epidemic in a central African country involved a complex mix of outbreaks due to transmission via contact (sexual and non-sexual) between people as well as, in some areas, presumed transmission from contact with wild game or meat products *(6)*.

Transmission

Mpox spreads from person-to-person through close contact with someone who is infected. Close contact includes being face-to-face (such as talking or breathing close to someone which can generate droplets or short-range aerosols); skin-to-skin (such as touching or vaginal/anal sex); mouth-to-mouth (such as kissing); or mouth-to-skin contact (such as oral sex or kissing the skin) *(6)*. It is also possible for monkeypox virus (MPXV) to persist for some time on clothing, bedding, towels, objects and surfaces that a person with mpox has touched.

Mpox can also spread to people when they come into physical contact with an infected animal, such as some species of monkeys or rodents (such as the tree squirrel) in certain African contexts where animals may carry the monkeypox virus (MPXV) (6). Physical contact can mean bites or scratches or contact with animals during activities such as hunting, skinning, trapping, or cooking *(6, 7)*. The virus can also be caught by eating infected animals or animal products if the meat is not cooked thoroughly.

Symptoms

Common symptoms include a rash that looks like blisters or sores which may last for two to four weeks. It may start with, or be followed by, fever, headache, muscle aches, back pain, low energy and swollen lymph nodes *(6)*. In most cases, the symptoms go away on their own within a few weeks with supportive care, such as medication for pain or fever. However, infants, children, people who are pregnant and people with underlying immune deficiencies may be at higher risk of serious illness or death *(6)*.

Severe disease due to mpox may include larger, more widespread lesions (especially in the mouth, eyes, and genitals), secondary bacterial infections of the skin or blood, and lung infections. People with severe mpox may require hospitalization, supportive care and antiviral medicines to reduce the severity of lesions and shorten the time to recovery.

Who is at risk

The risk of mpox depends on local epidemiology and drivers of transmission, including some behaviours. Most cases reported since 2022 in the global outbreak have occurred among men who have sex with men who have multiple or new sexual partners (6, 8)). Given that the virus moves from person-to-person in social and sexual networks in many countries, men who have sex with men may be at higher risk of exposure if they have close contact with someone infectious. People who have multiple or new sexual partners are currently most at risk including sex workers. In the central African outbreak, the picture

is complex. In some areas, where mpox has long been known to be endemic, children under the age of fifteen years are most at risk. Conversely, in newly affected areas, men and women are more at risk from newly recognized sexual transmission in this context.

Communities of trans and gender-diverse people linked to the same or related sexual networks are also likely to be disproportionately affected. However, anyone who has close contact to someone with mpox may be at risk.

People who have physical contact with an infected animal or contaminated meat can be at risk of animal-to-human transmission.

Protective behaviours

People can reduce their risk of mpox by knowing the signs and symptoms, how the virus spreads, what to do if they get ill, and what the risk is in their area or community. It is advisable for people who have signs or symptoms associated with mpox to have open conversations with people before coming into close contact. The risk of human-to-human transmission can be reduced by avoiding close contact with someone with mpox, including sexual contact (face-to-face, skin-to-skin, mouth-to-skin and mouth-to- mouth) and avoiding contact with potentially contaminated materials (fomites) such as bedding, clothing or sharps such as needles *(6,7)*.

The risk of people catching mpox from animals can be reduced by avoiding unprotected contact with wild animals, especially those that are sick or dead (including their meat and blood). In countries where animals carry the virus, any foods containing animal parts or meat should be cooked thoroughly before eating *(6)*.

Anyone who thinks they might have mpox can act to protect others by seeking medical advice and isolating until they have been evaluated and tested negative for the virus.

Prevention

Three vaccines have been approved for the prevention of mpox. For most people at risk, mpox vaccines protect against infection and severe disease *(6,7)*. WHO recommends vaccines for people who have been in close contact with someone who has mpox if it can be given quickly, or for people who are at high risk of exposure to mpox. Mass vaccination is not currently recommended. Vaccines are one tool that protects communities against mpox and should be combined with other protective measures.

Treatment

Specific treatments for mpox are limited. An antiviral developed to treat smallpox (tecovirimat) was approved in January 2022 by the European Medicines Agency for the treatment of mpox . Experience with these therapeutics in the context of an outbreak of mpox is growing but still limited. For this reason, their use is usually accompanied by enrolment in a clinical trial or expanded access protocol accompanied by collection of information that will improve knowledge on how best to use them in the future.

WHO has made a small number of tecovirimat treatments available for compassionate use, particularly for those who have severe symptoms or who may be at risk of poor outcomes (such as those with immune suppression and people living with HIV and with advanced HIV disease).

Mpox and HIV

Immunosuppressed people are at higher risk of developing severe mpox or dying. Symptoms of severe mpox include larger, more widespread lesions (especially in the mouth, eyes and genitals), secondary bacterial infections of the skin or blood and lung infections. Data show the most serious symptoms are in people who are severely immunosuppressed *(7)*.

People with advanced HIV disease (with a low CD4 count or immunosuppression) have an elevated risk of death if they develop severe mpox. People living with HIV on antiretroviral treatment and who achieve viral suppression are not at increased risk of severe mpox. In order to minimize cases of severe mpox, WHO advises countries to integrate HIV and mpox prevention and care *(7)*. Integrating mpox messaging with broader messaging on sexual health and well-being may be a useful approach, as they may affect similar communities in many settings.

Tools for mpox outbreaks

3.1: Gathering information and data

The tools in Section 3.1: Gathering information and data are designed to support the collection, analysis and use of social-behavioural data and community insights to inform the development of evidence- based RCCE strategies and plans. The data and insights collected using these tools promotes better decision making and can allow for stronger risk assessments by bringing a community lens to the understanding of risk during an outbreak. By prioritising the collection, analysis and use of social-behavioural data and community insights within and beyond RCCE, it is possible to bring broader response strategies and plans in line with community expectations, needs and priorities.

Tool 1: Conducting a situational analysis: The PESTEL tool

A situational analysis can be conducted in either the readiness or response phase to inform activities during an mpox outbreak. In any of these scenarios, the situational analysis should be regularly updated.

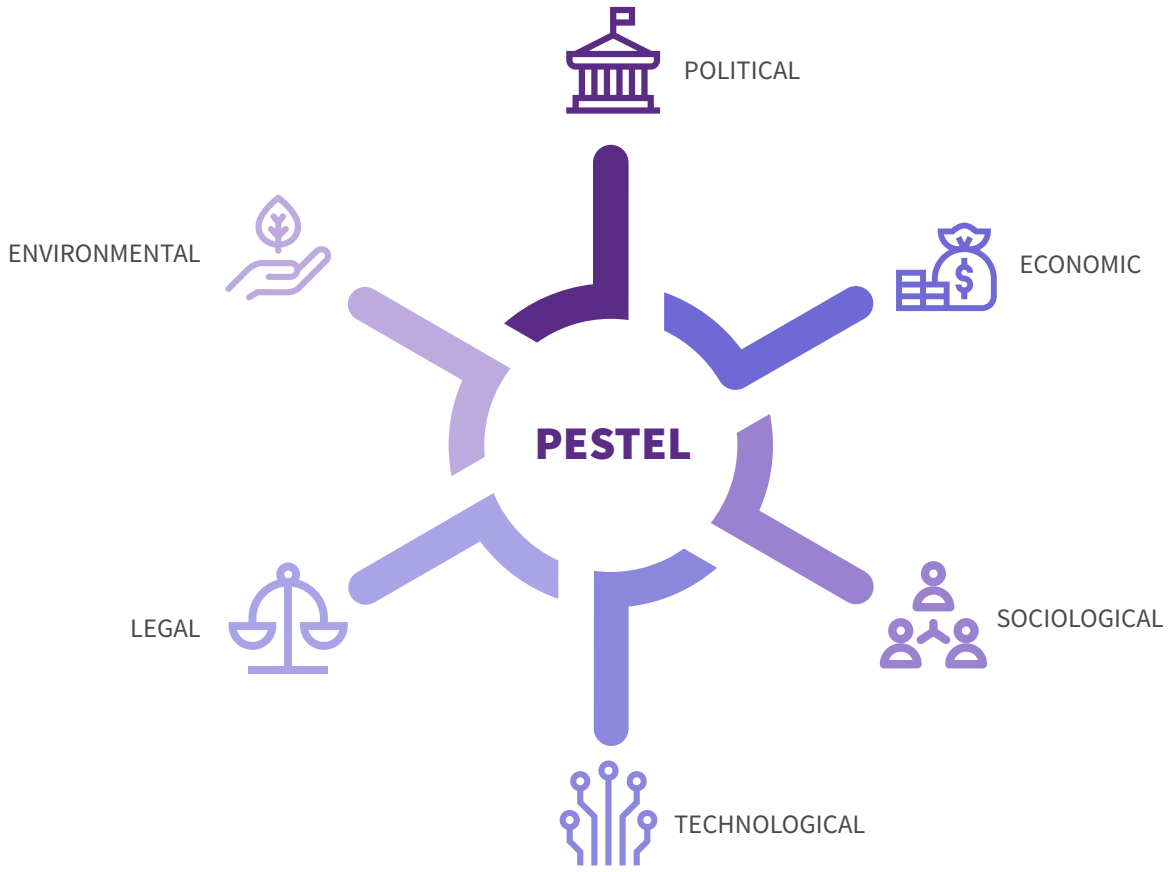
The PESTEL tool is a framework for conducting a situational analysis that helps understand political, economic, sociological, technological, environmental, and legal factors that can influence public health efforts during an emergency, as well as other preventative activities for mpox.

Data collected either directly or from existing sources can be used to gather insights into the six categories of the PESTEL analysis. Information can be collected through these and other sources:

- Community surveys, qualitative interviews and focus group discussions, including behavioural science research.
- Tools used under the International Health Regulations *(3)* to evaluate country capacity, including intra-action reviews, after-action reviews, the Health Resources and Services Availability Monitoring System (HeRAMS), joint external evaluation (JEE) reports *(1)*, etc.
- Lessons learned from previous outbreak responses.
- WHO IMST updates, situation reports, Disease Outbreak News *(9)*, and daily reports.
- Peer reviewed journals.
- WHO country profiles.
- News reports from trustworthy sources.
- Government websites and official publications.

The information obtained from a PESTEL analysis should be used with detailed behavioural data from Tool 2 and local epidemiological data on the drivers of transmission.

Figure 1. PESTEL analysis framework



Political considerations:

- government and local policies,
- budgets for mpox readiness and response,
- previous governmental experiences with mpox or other similar infectious disease outbreaks,
- levels of trust in government, partners and other influential voices,
- government and partner public communication activities and style, and
- upcoming elections or potential changes in leadership.

Economic considerations:

- capacity of citizens and communities to participate in economic life,
- access to and supply of health services, including mpox testing, vaccination and treatment, HIV testing and treatment,
- income of citizens, and
- capacity of those being asked to (self-)isolate to do so based on access to economic and social support.

Sociological considerations:

- social and cultural dynamics and demographics,
- behaviours, beliefs and habits,
- religions and traditions,
- literacy, languages and dialects, and
- stigmatizing attitudes and/or discriminatory behaviours, especially towards people with symptoms, people who may be at risk and by health workers.

Technological considerations:

- level of access to information (print, broadcast or online media),
- mobile phone usage and level of penetration,
- social media usage,
- availability of internet access,
- digital literacy, and
- key online communication channels.

- **Environmental considerations:**
- use of forested land for living, hunting or other activities,
- potential dangers and impacts of climate change, such as deforestation and loss of animal habitats,
- natural disasters (floods, earthquakes, droughts, etc.), and
- environmental risk level.

Legal considerations:

- laws, rules and plans — including those related to ethics, such as the prevention of sexual exploitation, abuse and harassment (PSEAH),
- criminalization of identity or activities related to gender or sexual orientation,
- existence of treaties or binding legal instruments,
- multiple levels of governance,
- regulations that impact RCCE in emergency situations, and
- coordination and engagement of CSOs, NGOs and non-State actors.

Tool 2: Behavioural analyses

This tool can be used to identify and understand behaviours relevant to mpox outbreaks or pertaining to vaccine uptake and demand that inform and shape RCCE strategies, tools and tactics. Behaviours do not stay static through an outbreak or health emergency. High-risk behaviours are influenced by barriers and enablers that can be identified through social and behavioural data collection. These should be identified as early as the prevention phase and throughout the readiness and response phases, and regularly monitored to understand norms, trends and changes (10).

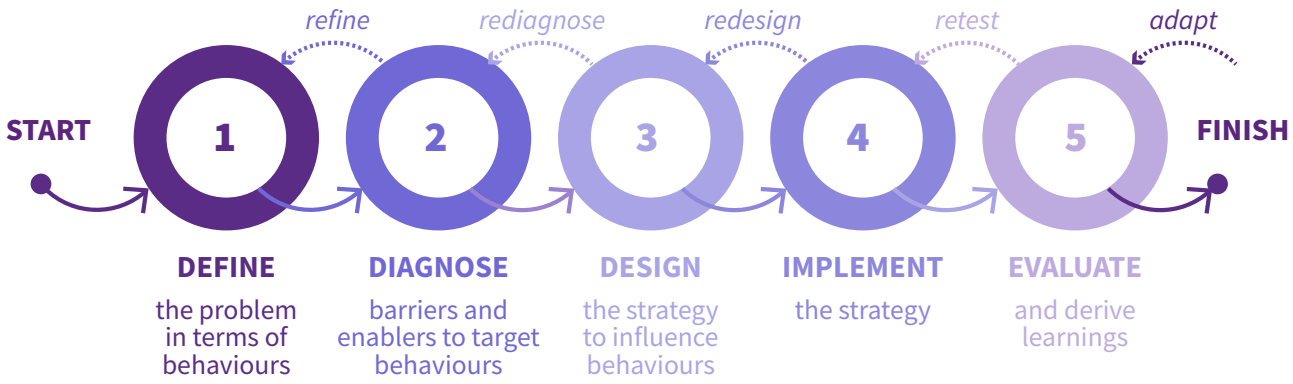
Used together, the findings from the situational and behavioural analyses can help assess how to engage with communities effectively and co-develop plans and strategies that support people to make well-informed decisions to protect themselves. The importance of including behavioural and social sciences in public health interventions was globally recognized by Member States at the seventy sixth World Health Assembly in 2023 *(11)*, where WHO acknowledged the contribution of these disciplines in achieving improved health outcomes and called on the increased use of behavioural science to empower communities in understanding public health problems and designing and evaluating interventions to address them.

Behaviours are one factor that can influence transmission, uptake of protective actions and care-seeking practices in outbreaks and health emergencies. It is important to identify and understand risk-prone and protective behaviours in the current context and to use these to shape RCCE strategy, plans and activities. It is crucial to note that changing behaviour is not the only answer to ending transmission; people need information and opportunities for engagement as well as access to prevention and care to help them make informed decisions that are applicable within the context of their daily lives, and which are practical and accessible.

The behaviours that are relevant to the risk and prevention of mpox transmission will vary depending on the local context (e.g. animal-to-human or human-to-human transmission, availability of vaccines, testing and treatment, forms of stigma and discrimination, laws around same sex relationships etc.). This information should be obtained from a multidisciplinary team including behaviour change experts and epidemiologists working on the response and from your PESTEL analysis.

The Behavioural Insights (BI) checklist included below is designed to guide what data to review to inform RCCE strategy and which include inputs from the communities at risk. It is adapted from the Technical note from the WHO Technical Advisory Group on behavioural insights and science for health *(12)*. This technical note includes additional guidance on behavioural insights including advice on the principles and application of behavioural science. Please refer to the note for additional guidance. The BI checklist is based on the define, diagnose, design, implement and evaluate (DDDIE) steps (Figure 2).

Figure 2. DDDIE steps guide



Step 1: Defining the problem in terms of behaviour: Is the mpox outbreak a problem of behaviours?

Use the data sources available to answer the following questions and complete the table below (e.g. epidemiological data, knowledge from previous outbreaks or other countries, existing social-behavioural data).

1. Does the problem have a behavioural component? Consider factors such as:
    - What is driving transmission?
    - Are people practicing protective behaviours?
    - Are people practicing risk-prone behaviours?
    - Are people seeking/accessing vaccination, if vaccines are available?
2. Which behaviour(s) must be changed to contribute to improving or attaining the desired health outcome(s)?
3. What is the target behaviour you are aiming for? Specify who needs to do what, when, where and how. Try to be as specific as possible about behaviours, whilst recognising that behaviours are interconnected and are likely to be part of a combination or sequence of behaviours from multiple key players, happening in different times and places and all contributing to transmission..

Table 1. Problem and behaviour diagnosis

Step 1: Defining the problem in terms of behaviour	
Does the problem have a behavioural component? If yes, what?	E.g. yes; sexual contact between men who have sex with men who have multiple or new sexual partners is driving transmission of mpox.
Which behaviour(s) must be changed to improve the desired health outcome?	E.g. having new or multiple sexual partners during an mpox outbreak.
What is the target behaviour(s) you are aiming for?	E.g. reducing the number of sex partners while there is risk of mpox; having open and non-judgemental conversations with sexual partners.
Who needs to change their behaviour?	E.g. gay men, bisexual men and other men who have sex with men who have new or multiple sexual partners.
What do they need to do differently?	E.g. reduce their number of sex partners while there is risk of mpox.
When does this behaviour occur?	E.g. until they have been vaccinated against mpox and sufficient time has passed for them to be protected.
Where does this behaviour occur?	E.g. sex-on-premises venues and events.

Step 2: Diagnose the barriers to and enablers of target behaviours

A barrier is an obstacle or challenge that impedes the uptake or adherence to mpox interventions. Enablers are factors that facilitate or support the successful implementation of mpox preventive measures and RCCE interventions. Barriers and enablers of behaviours can be cognitive, psychological, social, cultural, environmental, religious, and linked to perceptions of self-efficacy, risk, and efficacy of interventions, as well as other factors.

Identifying and understanding the barriers and enablers of your desired target behaviour is essential to design interventions that are effective, practical, and culturally acceptable. Use social-behavioural science evidence to prioritize and determine what barriers and enablers will be explored further to inform the design of interventions.

It can also be useful to consider whether barriers and enablers are: 1) cognitive/psychological; 2) social/ cultural; 3) environmental/ structural.

Examples of barriers include:

- Lack of awareness or knowledge about mpox symptoms, transmission and/or preventive measures (cognitive/psychological).
- Cultural beliefs and practices that contradict guidance or discourage people from adopting the desired behaviours (social/cultural).
- Limited access to health care resources, information or services required to follow the desired behaviours (environmental/structural).
- Fear or stigma associated with mpox, making people reluctant to report symptoms or seek care (cognitive/psychological).

Examples of enablers include:

- Strong community inclusion, support, and engagement in promoting interventions (social/ cultural).
- Accurate RCCE interventions that provide information about mpox and the importance of infection control or immunization (environmental/structural).

- Positive social norms that encourage and support people to adopt desired and avoid risky behaviours (social/cultural).
- Engaging positive role models, such as community leaders and influencers, to advocate for and model the desired behaviours (social/cultural).
- Involvement of private sector to ensure that at-risk workforce is protected (environmental/structural).
- Accessible and reliable health services to support the adoption of the desired behaviours (environmental/structural).

Table 2. Behaviour barriers and enablers

Step 2: Diagnosing barriers and enablers		
Risky behaviour	**Enablers**	**Barriers**
E.g. having new or multiple sexual partners during an mpox outbreak.	E.g. not wanting to be perceived as spreading mpox by others. E.g. the anticipated regret of knowing how they will feel in case they transmit the disease to others E.g. feeling able to have open, non-judgmental conversations with household members or sexual partners. E.g. the fear of possible serious/long term consequences or changes to physical appearance such as scarring.	E.g. not knowing for how long to reduce number of partners. E.g. not considering the benefit of reducing number of partners to be worth the effort. E.g. self-efficacy: not believing that they are capable of changing behaviour, not remembering to do so, or not knowing how to do so without causing embarrassment or offence or without feeling embarrassment.

Steps 3, 4 and 5: Design, implement and evaluate interventions to address barriers and encourage enablers of behaviours

Steps 1 and 2 provide insights and data that can then be used in steps 3 (design of evidence based RCCE approaches and interventions aimed at addressing the barriers identified), 4 (implementation of interventions aimed at addressing the barriers identified) and 5 (evaluation) to support mpox readiness and response efforts.

Design and implementation of interventions should be done in collaboration with behavioural scientists, health experts, communication specialists and, crucially, with affected communities and stakeholders, ensuring the design of effective and culturally sensitive interventions. Tools to support implementation are included in this toolkit.

Evaluation of interventions and of behaviour change is important to drive future learnings about the effectiveness of RCCE strategies. It is possible to measure the impact of interventions on behavioural outcomes using epidemiological data or direct observations of behaviours. If these data are not available, use self-reported information, such as adherence to preventive measures or uptake of vaccination (when available). It can also be useful to include process evaluation indicators to understand how context, implementation and mechanisms of impact may have influenced outcomes.

Tool 3: Mapping and understanding communities

This tool can be used to identify and record key information about communities affected by mpox and who should be included in outbreak response activities. This information should be used to inform RCCE strategy and action plans for the priority communities at risk of mpox infection.

In order to have inclusive RCCE plans and strategies, it is imperative to involve communities in co-designing solutions and interventions aimed at protecting their health and wellbeing from an imminent threat. Individuals and communities experience outbreaks of mpox differently. Anything from where they live and work, to their varying levels of knowledge, awareness, perceptions of risk, or specific local contexts in which mpox outbreaks occur, can significantly impact their likelihood of falling sick. Understanding these differences helps identify who is most at risk of the disease and who in the community is best placed to support engagement efforts.

The tool below helps to collect and organize information about key communities at risk and in combination with tools 1 and 2, provides a broader context to help tailor RCCE activities to the needs of the specific population. Priorities for RCCE strategy, plans and activities should be based on levels of risk and ability to inform and drive behaviour change particularly for those at high-risk.

Table 3. Community assessment matrix

	Priority community 1: e.g. participants in sexual networks such as sex workers or men who have sex with men	**Priority community 2:** e.g. health workers	**Priority community 3:** e.g. young people who hunt wildlife for food
Demographic information – age range, gender, languages spoken, literacy levels, education, occupations			
Risk level – based on epidemiology and findings from situational and behavioural research			
Perceived risk level – based on level of knowledge about mpox, immunization status, perception of personal and community risk, self and intervention efficacy			
Trusted information channels – note that this may differ from frequently accessed channels			
Community leaders – advocacy groups, religious leaders, etc.			
Influential voices – HIV and LGBTQI+ advocates, celebrities, thought leaders, health workers, social media accounts, etc.			
Access to key interventions – vaccination, testing, treatment, etc.			
Rumours and misinformation			
Other			

Tool 4: Stakeholder analysis

This tool looks at the various people and groups identified as important in mpox readiness and response activities or impacted by the outbreak. It helps to bracket and group their potential roles, capacities, and anticipated engagement to support collective efforts to prevent or respond to mpox outbreaks.

A stakeholder analysis goes into more detail and builds on the findings of the PESTEL, behavioural analysis and community mapping. It should be adapted to the local context to provide a precise overview of different stakeholder roles, motivations, anticipated involvement, and key milestones to maximize the impact of RCCE activities. There are four main categories into which stakeholders fall and an associated strategy for interacting with them.

Table 4. Stakeholder categories

	Stakeholder category	Strategy
Champion	Champions support your activities and do so actively and visibly. These groups/ people agree with the proposed actions and goals and are already taking action on their own to support them i.e. other UN agencies.	With champions, continue engaging them in planning and implementation of activities, provide them with updates and information to ensure they are up to date, appreciate and acknowledge their contributions and support, and let them champion the cause.
Silent booster	Silent boosters support the planned or proposed activities and goals but do so privately, with little to no public support. These stakeholders need additional motivation to become more active and supportive of the proposed actions.	With this group, the strategy is to educate, enable, inform and motivate. Energize these stakeholders by involving partners and champions they respect and normally engage with to help advocate for the planned activities and goals.
Avoider	Avoiders don't necessarily support your cause but aren't vocal or visible about their lack of support. They silently oppose aspects of planned activities and passively disagree.	Inform or ignore. With avoiders, it is helpful to engage groups from the Champions category to help influence them to support activities.
Blocker	Blockers are groups who are visibly, publicly opposed to the planned activities and take action to encourage others to disagree as well. They pose an obstacle to the implementation of activities, depending on their influence.	Blockers pose a greater challenge if they are influential. If they are, the best approach is to counteract their action by continuing to enlist champions to advocate for your cause and provide facts. If they are not influential, the best strategy is to ignore this group. Regardless, keep track of who they are and who they are influencing.

Table 5. Stakeholder matrix

Responsible officer: **Date:** **Version:**											
Name of organization or individual	**Area of work**	**Stakeholder type**	**Anticipated involvement or support**	**Anticipated challenges**	**Motivation, drivers**	**Expectations of exchange**	**Milestones**	**Activities**	**Responsible party**	**Date due**	**Status**
		(Champion, blocker, silent booster, avoider)	*What level of involvement is expected and what type of support can this stakeholder contribute?*	*Known or potential issues, lack of capacities, etc.*	*Why is the stakeholder invested in the proposed activities?*	*What is the stakeholder's predicted input?*	*At what point of the response or planned activities is this stakeholder's involvement required?*	*What activities directly involve or impact the stakeholder?*	*Team member(s) responsible for engagement with the stakeholder*	*Task/ involvement needs to be met by:*	*Have all the agreed activities been implemented in the foreseen time frame?*

3.2: Strategy and planning

The tools in Section 3.2: Strategy and planning are designed to support the development of evidence- based RCCE strategies and plans drawing on social-behavioural data, community insights, epidemiological data and priorities identified by other areas of the outbreak response or in support of immunization campaigns. Strong strategies and plans promote more effective implementation of activities in the long run and provide an opportunity to consider how to work with communities as core partners in all RCCE activities.

Tool 5: Readiness and response checklist

This tool is designed to assist RCCE professionals and responders to update or develop mpox readiness and response plans. Drawing on the tools provided here it provides a comprehensive list of activities that should be considered during the readiness and response phases of an outbreak. Links to additional tools are found in section 3. If action planning and implementation begins during the response phase, items listed under readiness should also be referred to.

This checklist is adapted from the following documents: International Health Regulations (2005) – Third edition (who.int) *(3)*, COVID-19 Global Risk Communication and Community Engagement Strategy – interim guidance (who.int) *(13)*, Readiness and initial response for nCoV. Interim guidance *(14)*, RCCE 10 steps to community readiness *(1)*, HEPR (Health Emergency Preparedness Response) framework *(15)* and Joint External Evaluation tool, Third Edition *(2)*.

Table 6. RCCE readiness and response checklist[1]

Area of work	Steps	Activities
Systems and coordination	**Readiness**	❒ Establish or strengthen RCCE coordination mechanisms, including establishing an inter-agency task force or crisis communication centre, technical working groups for key areas of work, and ensure content clearance and information sharing protocols are approved. ❒ Review and update existing RCCE strategies and plans using intelligence from local surveillance, epidemiological and social-behavioural data (see tools 1 and 2). Ensure these are linked to broader emergency preparedness and response plans (EPRP) and national mpox elimination and control plans. ❒ Set up or strengthen an RCCE team, define members' roles and responsibilities and how the team will link to other response pillars. ❒ Map RCCE expertise at all levels, with specific focal points within the Ministries of Health and local health authorities, including topics such as immunization. ❒ Conduct or update PESTEL situational analysis and stakeholder analysis ❒ Develop a budget, with funding options and a human resource plan, including plans for surge support if needed.
	Response	❒ Convene and coordinate the RCCE response with government, stakeholders, partners and across technical areas/pillars. ❒ Activate the inter-agency task force or crisis communication centre and ensure content clearance and information sharing protocols are followed. ❒ Revise and update RCCE strategies and plan according to need and current surveillance, epidemiological and social-behavioural data (see tools and 2), new evidence or learnings and community insights. ❒ Implement approved operational budget and human resource plan, including deployment of surge staff.
Community data for action	**Readiness**	❒ Conduct a review of social-behavioural data (see tools 1 and 2) and identify vulnerable populations (see tool 3), risk factors, priority behaviours and potential barriers and enablers for an effective response and/or immunization campaign (see tool 2). Use this knowledge to inform decision-making at all levels. ❒ Ensure mechanisms for community listening are established (both online and offline) and respond to rumours and misinformation proactively (see tool 6 to support tracking of rumours and misinformation). ❒ Analyse gaps in available social data. A mix of quantitative and qualitative data is best - including community feedback, social listening, polling, situational and behavioural analyses, PRSEAH and survey data to understand community knowledge gaps, perceptions, and behaviours. Commission appropriate research to fill in the identified gaps. ❒ Set up a framework for measurement, evaluation and learning to track the efficacy of RCCE activities and impact made. Use findings to tailor and adjust the RCCE strategy and plans accordingly.
	Response	❒ Continuously conduct data collection among at-risk and affected populations to track changes in knowledge, attitudes, perceptions, behaviours, and other social-behavioural variables. ❒ Regularly conduct community listening (see tool 7). Use the findings to develop, adjust and implement RCCE interventions that address concerns, misconceptions, rumours, and barriers to uptake of protective behaviours or vaccines. Address any unacceptable behaviours, including sexual misconduct. Include affected communities throughout this process. ❒ Continue to monitor the impact of response activities on communities (see tool 7). Ensure plans are in place to manage potential or unexpected impacts (changes to health seeking behaviours, impact on job and food security, other economic or social impacts) and update accordingly. ❒ Share data back to communities and update local response activities as new social, behavioural, and anthropological data becomes available

[1] RCCE: risk communication and community engagement; PESTEL: political, economic, sociological, technological, environmental, and legal factors; PRSEAH: preventing sexual abuse and harassment; LGBTQI+: lesbian, gay, bisexual, transgender, intersex or queer; CSO: civil society organization; MEL: measurement, evaluation, and learning.

Area of work	Steps	Activities
Risk communication	**Readiness**	❒ Ensure that the highest levels of government are ready to release information to protect the public's health in a rapid, transparent, and accessible manner. ❒ Create or review a repository of existing RCCE materials such as message banks, tools, products, and templates. ❒ Map and prioritize trusted and commonly used communication channels and platforms. Assess these for accessibility to people in remote areas, without digital skills or access, those with low literacy skills or who may not speak the dominant language, etc. ❒ Identify alternative communication channels to reach all pockets of society, such as street radio, mobile announcers, voice messages for health centres, dating applications and other social media, etc, and partners who can potentially support dissemination of key messages through these methods. ❒ Identify focal points and media spokespeople for all key partners at all levels; list their areas of expertise in relation to the disease or health emergency threat; if necessary, train them. ❒ Coordinate communication activities and use standard operating procedures (SOPs) for clearance and sharing.
	Response	❒ In collaboration with affected communities, continuously develop, adapt, and test messages based on the perception of risk and as the situation evolves. ❒ Update interventions and messaging, based on MEL framework, feedback from communities, and/or the effectiveness of the immunization campaign. ❒ Continue to build and deliver high-quality information to raise knowledge and manage risk perceptions related to the specific topic of interest, using trusted and commonly used channels. ❒ Engage regularly with and provide risk communication content to government, media and other partners to ensure public information is adapted and consistent with the latest science and current context. ❒ Activate spokesperson and influential individuals, including those from other agencies and stakeholders, to align messaging and to broaden the reach of RCCE activities. ❒ Provide guidance to media outlets on how to access reliable information, manage misconceptions and avoid stigma.
Community engagement	**Readiness**	❒ Hold discussions with communities to understand sociocultural contexts and power dynamics of key audiences. ❒ Identify what type of engagement is safe, feasible and acceptable for different communities. ❒ Identify existing platforms (community leaders, CSOs, and key influencers, particularly those accessed by people at risk) and engage communities in decision-making processes. This may include organizations working with LGBTQI+ communities, people living with HIV, leaders in communities whose livelihood involves contact with animals in forested settings etc. ❒ Establish or strengthen community feedback systems to ensure community beliefs, questions, concerns and suggestions are heard. ❒ Co-develop priority actions with affected groups to strengthen readiness and build trust and encourage uptake of protective behaviours and vaccines (risk and needs assessments, strategies, plans, guidance, messaging, etc.). ❒ Design and co-implement interventions and strategies with communities. ❒ Train community engagement teams including volunteers and establish surge capacity mechanisms. ❒ Ensure translation capacities are available to tailor all RCCE materials into local languages and dialects. ❒ Anticipate special information and engagement needs for people who are disabled, illiterate or marginalised.
	Response	❒ Update and co-implement RCCE interventions and strategies with communities. ❒ Ensure continuity of community feedback systems and close information gaps. ❒ Launch or strengthen an "alliance" of influencers and stakeholders who can listen, advocate, inform, address rumours and misinformation and promote health literacy using evidence and data. ❒ Ensure representation of civil society and vulnerable groups. Work closely with other committees and advisory groups. ❒ Engage relevant sectors (government, social and private sector) to manage service and supply needs, assess barriers and strengthen referral systems such as for mental health, gender-based violence, and PRSEAH. Ensure affected communities are linked to referral systems.

Area of work	Steps	Activities
Capacity building	**Readiness**	❒ Conduct a rapid needs assessment, which includes mapping of existing RCCE human resource capacities and capabilities. ❒ Develop a capacity plan with stakeholders based on the result of the needs assessment. ❒ Build the capacity of RCCE teams and other key stakeholders based on the plan developed. ❒ Create SOPs to drive consistency and quality across RCCE interventions and collaboration with partners. ❒ Initiate a continuous peer-to-peer support system for community mobilizers, responders, and networks.
	Response	❒ Adapt capacity building tools as needed. ❒ Identify and train emergency RCCE staff and potential surge staff on plans and procedures. ❒ Provide refresher or on-the-job training for RCCE responders and spokespersons as interventions and strategies change. ❒ Continue to provide orientation to media professionals and communication networks as the response evolves.
Measurement, evaluation and learning (MEL)	**Readiness**	❒ Develop/review the MEL framework including M&E indicators based on the developed RCCE strategy, planned activities, and expected outcomes (see tool 8). ❒ Develop/strengthen a real-time monitoring system using existing/adapted tools such as mobile and manual data collection methods, interactive dashboards, and automated data analysis. ❒ Train the RCCE team on the use of relevant tools. ❒ Promote community participation in developing the measurement, evaluation, and learning process. ❒ Develop a system to effectively store, manage and share information and key data sets.
	Response	❒ Continuously revise the MEL framework to ensure it is capturing the data needed to measure results and impact (see tool 9). ❒ Use established real-time and participatory monitoring and evaluations systems where possible such as mobile or application-based reporting. ❒ Generate evidence and data that allows regular assessment of strategy implementation and impact. ❒ Include CSOs in monitoring, reporting and joint accountability efforts to increase the likelihood of broad community uptake and responsibility for new interventions. ❒ Maintain and strengthen systems to effectively manage and share information, document lessons learned and gather best practices. Disseminate lessons and best practices widely.

Tool 6: Activities tracker

This tool is designed to assist RCCE decision-makers, practitioners, and partners to track activities once identified using the readiness and response checklist (tool 5).

Table 7. Activities tracker

Area of work	Task/ activity	Organization and individual responsible	Budget / resources	Links	Deadline	Status
E.g. Community engagement	Review suitability of existing community feedback system for mpox	E.g. Ministry of Health; name, email, phone number		E.g. to any working documents		E.g. complete, in progress, incomplete

3.3: Implementation

The tools in Section 3.3: Implementation are designed to support activities conducted as part of evidence- based RCCE strategies and plans. While the projects and activities that need to be implemented will vary in each context based on needs and strategy, these tools offer ways to approach some key components of most RCCE plans. Communities should be considered key implementing partners for RCCE activities during mpox outbreaks or vaccination campaigns.

Tool 7: Community listening and feedback systems for mpox outbreaks

This tool is designed to provide support for collecting and using community listening data including social listening and community feedback for mpox outbreaks.

Community listening encompasses various approaches to collecting data to identify current narratives, questions, rumours, misinformation, levels of trust and other relevant factors from at-risk populations. It can help to track and monitor trends, changing attitudes towards health authorities and interventions, and identify newly emerging concerns.

On- and offline sources should be used for community listening. Offline sources of data can include community feedback systems, qualitative interviews, focus group discussions, findings from social-behavioural research, television and radio. Online sources can include social media, websites, chatrooms, etc. All community listening sources have advantages, biases and limitations which should be documented when reporting data.

To collect community feedback for mpox, identify community representatives that are closely involved with readiness, response, and immunization activities or who are from or represent affected communities. CSOs that are already involved in related health advocacy or service provision (for example those catering to affected communities such as gay and bisexual men, sex workers or young people involved in sexual health issues) are good sources of community feedback as these groups can provide targeted input and help reach specific demographics more effectively.

Research conducted during the global mpox outbreak by WHO highlighted the central role of geospatial networking applications in reaching and engaging communities. Close collaboration with these applications is key for readiness and response to emerging infections transmitted in these sexual networks *(16)*.

Many countries have country coordinating mechanisms under the Global Fund to Fight AIDS, Tuberculosis and Malaria or community advisory boards for HIV/AIDS that can be activated for an mpox response as sources of data for community listening.

If resources are available, look for public health advice on mpox or community outreach at community or facility-based services (such as LGBTQI+ housing, harm reduction services, and gender-affirming care, and popular local venues like parties, bars, and nightclubs), which can serve as influential platforms for disseminating health information and gathering feedback.

To effectively use community listening in managing an outbreak of mpox, health authorities and all involved partners should use the full range of on and offline tools to collect, monitor and analyse public narrative and conversations related to mpox. These tools may vary significantly from context to context and based on specific community needs, access and norms. Particular attention should be given to key populations and themes of misinformation, while also identifying information voids such as the sudden increase in searches for "mpox symptoms" or "how do you catch mpox?".

Setting up a dedicated online social listening system involves defining objectives, selecting relevant social media platforms, identifying mpox-related keywords

and hashtags, setting up a taxonomy, monitoring these keywords using tools like Google Trends, conducting data analysis, and reporting the findings to stakeholders. The system should be regularly reviewed and adjusted based on the findings, such as adding new keywords, hashtags or identifying new platforms of concern.

The data sourced through both social listening and community feedback systems can be triangulated with epidemiological data, research and programme data to gain additional insights to inform strategy and planning.

The development of community listening and community feedback systems for mpox readiness and response will depend on existing platforms and resources but should be considered an essential part of any RCCE planning. The following resources can be used to inform these activities, as can the matrix below.

- Community Engagement in Humanitarian Action Toolkit (CHAT) *(17)*
- IFRC Community Feedback Kit *(18)*
- WHO/UNICEF How to build an infodemic insights report in 6 steps *(19)*
- WHO Infodemic management training 101 (OpenWHO) *(20)*
- Infodemic Management: Defining a taxonomy for social listening (OpenWHO) *(21)*

Table 8. Rumours, misinformation, and event tracker

Issue / event / Date	**Country of origin**	**Platform** (print, web, social media, official statement, etc)	**Level of risk** (low or high)	**Facts** (what really happened, scientific explanations, etc)	**Respond YES/NO**	**Initial response (IF YES) of WHO** (key messages)	**Cleared by:**
							Date:
							Date:
							Date:

Negative messages about mpox vaccine or their safety may emerge and can include distorted, false, or misleading opinions, mis- and disinformation and expressions of anti-vaccine sentiment. However, not all messages warrant a response, but it is important to set clear protocols to determine the relevance and impact as well as appropriate response of the Ministry of Health, WHO, or other partners if needed. You may wish to refer to the matrix above to standardize protocol of reporting rumours and misinformation and respond accordingly.

Tool 8: Developing key messages and content

This tool is designed to guide the development of key messages based on data collected, social-behavioural insights, epidemiological surveillance, and best practices. Key messages are the main points of information you want to convey to the audience so that they will understand and remember the risk of contracting mpox and reduce the risk of transmission.

These should be clear and concise statements that explain key concepts and factual information in lay language. Key messages should also support your desired communication outcomes- the change we want to see in the behaviour of the affected population.

Key messages for mpox outbreaks should focus on key areas related to vector control, reducing risk of transmission, and immunization, including:

- signs and symptoms;
- how it is spreading in the area/community;
- who is at risk (both of catching it and of more serious symptoms);
- how to protect yourself and others;
- prevention and treatment; and
- what to do if you get ill;

Key messages need to be adapted based on the local context (see Tool 1: Situational analyses: PESTEL), epidemiological surveillance, what is known about key audiences (see Tool 3: Mapping and understanding communities), enablers and barriers of key behaviours (see Tool 2: Behavioural analyses) and what is being learnt through community listening (see Tool 7: Community listening and feedback systems). Below, you will find a checklist with key considerations when developing messages for your audience. Additional information on how to test your messages can be found here (22).

Table 9. Mpox key messages template

Process for developing key messages
❒ Identify and target key behaviours and influences. ✓ Identify specific behaviours to target so there is a clear call-to-action for the public. ✓ Draw on situational analysis (PESTEL), social-behavioural insights and other research to determine the key influences (cognitive, social, and environmental) on those target behaviours. ✓ The messages should aim to utilize or address these key influences. ❒ Test messages (key and supporting) with the public before releasing. ✓ If possible, conduct quantitative testing of messages to identify best performers before mass roll-out. ✓ If time is limited, undertake rapid qualitative testing to optimize content and presentation and minimize risk of backfire.
Language and content of key messages
❒ Include a clear action that directly conveys what people should or should not do. ✓ This action should be prominent, so the reader knows what to do after a quick glance. ✓ Use a "rule of thumb" or do's and don'ts. ❒ Make content easy for the public to understand. ✓ Use clear and simple words. ✓ It is best to use as few words as possible, while still conveying the importance of the matter. ❒ Draw on positive social framing, where appropriate. ✓ Use framing that encourages people to undertake a behaviour for the benefit of others. ❒ Include a reason why people should do the desired behaviour. ✓ Provide a brief explanation or reason why a behaviour should be performed. ❒ Translate materials into multiple languages, where appropriate. ✓ Provide multiple versions of messages in different languages that are spoken in the target population.

The section below provides an additional template to support development of messages that stick with your audience by preparing the main message and three supporting messages/evidence to back up the point you are making.

Table 10. Mpox key messages and supporting messages template

Key message	If you are at high risk of contracting mpox - get vaccinated. It takes three weeks after being vaccinated to develop immunity.
Target behaviour	Vaccine uptake
Supporting message 1	Know the signs and symptoms of mpox and check yourself regularly. If you think you might have mpox, get advice from a health worker and get tested, if possible.
Supporting message 2	If you think you have been exposed to mpox, post-exposure vaccination is recommended, ideally within 4 days from possible exposure. You may be offered two doses.
Supporting message 3	Mpox is preventable and vaccination is an important part of stopping the spread of the disease.

Tool 9: Measurement, evaluation, and learning (MEL)

This tool will help enhance the accountability and effectiveness of RCCE through measuring, evaluating activities and constantly learning from your audiences how to improve or adapt interventions to achieve expected health outcomes.

A measurement, evaluation, and learning (MEL) framework recognizes the importance of *(1)* measurement to collect evidence, *(2)* evaluation and systematic analysis of results and *(3)* learning to gain insights and new knowledge that can be applied in future planning and strategy. MEL should be used throughout all phases of the emergency management cycle and should include community participation to support sustainability, joint-accountability and ultimately increase the effectiveness of RCCE strategies, plans and interventions *(23)*.

Once you have determined if the problem you are tacking is of a behavioural nature or if it is another type of barrier, such as environmental or structural, it is possible to design interventions. There are many different models that can help design and structure MEL framework, based on priorities or targeted behaviours. Within the MEL manual, WHO proposes the "Theory of Change" and "Program Logic Models." For more detailed information on these tools, and others, access "The MEL Manual" *(23)* here.

The Theory of Change and Program Logic Models help logically explain how the intervention is expected to lead to the desired behaviour change and how to measure it along the way. The theory of change involves two key steps:

- (1) identification of all the possible interventions and/or stimuli that can lead to a change in a particular context; and
- (2) examination of the evidence and assumptions that support such beliefs.

The program logic model helps demonstrate the theory of change by linking activities with outputs, short-term and longer-term outcomes (See Table 11). The next step is to develop specific, measurable, achievable, realistic, and time-bound (SMART) objectives and indicators to measure the progress and impact of the intervention. Indicators should be identified and collected at each stage of RCCE activities and aligned with national mpox elimination and control plans to reflect priority actions and desired outcomes. The tools and examples provided below can be used to inform the identification of such indicators that are fit for the local context.

Below is a helpful template for structuring and planning your MEL framework.

The Mpox Strategic Preparedness, Readiness, and Response Plan: Global Monitoring and Evaluation Framework *(24)* may also be a useful resource. The WHO Strategic framework for the enhancing control and achieving elimination of human-to-human transmission of mpox (2023- 2027) also outlines the monitoring and evaluation framework for this initiative.

Table 11. MEL framework template

The theory of change (programme logic model)						
e.g.: Affected communities are unaware that there is a vaccine available for mpox	e.g.: Affected communities are informed about key benefits or receiving the mpox vaccine	e.g.: Affected communities form an opinion about the vaccine and feel empowered to get immunized	e.g.: Affected communities are engaged in online and offline conversation about mpox vaccine	e.g.: Affected communities acknowledge the value of immuniza-tion	e.g.: Affected communities support im-munization against mpox	e.g.: Affected communi-ties have received the mpox vaccine

What do you need to complete MEL (ex.)	When and how should you report on findings
1. Situational analysis (PESTEL) 2. Behavioural analysis 3. Community listening 4. Stakeholder analysis 5. Community feedback mechanisms 6. Social listening reports 7. Access to Google analytics or other analytic tools related to social media	Here you should briefly outline your reporting plan, including reporting intervals, format, general content and more.

What will you track		
Inputs	**Metrics and indicators**	**Methods**
Data and insights collected through various proposed research can qualify as inputs		
Activities	**Metrics and indicators**	**Methods**
Producing and distributing RCCE products based on the collected data and insights		
Outputs	**Metrics and indicators**	**Methods**
Reaching and engaging audiences		
(e.g.) Mpox vaccination campaign launched	# of IEC materials developed	Log of materials in circulation (quantitative)
	# of announcements released	Log of radio and tv announcements (quantitative)
	# of posts on social media	Content analysis and social media reports (qualitative)
Short-term outcomes	**Metrics and indicators**	**Methods**
Assessing audiences' initial reactions, response to RCCE activities		
(e.g.) Affected communities form an opinion about the vaccine and feel empowered to get immunized		
Long-term outcomes	**Metrics and indicators**	**Methods**
Evaluating what sustainable effects RCCE activities had on audiences		
(e.g.) Affected communities acknowledge the value of immunization against mpox		
Impact	**Metrics and indicators**	**Methods**
Evaluating the results achieved, in full or in part, by RCCE activities		
(e.g.) Affected communities have received the mpox vaccine		

The Collective Service has developed the Risk Communication and Community Engagement Indicator Guidance for COVID-19 *(25)*, which provides useful support that can be applied to other disease areas, including mpox.

Tool 10: Checklist for preventing and responding to sexual exploitation, abuse and harassment

This tool is designed to assist RCCE decision-makers, practitioners and partners identify and include key activities for preventing and responding to sexual exploitation, abuse and harassment (PRSEAH) into planning and implementation. This tool should be used together with the principles for managing PRSEAH in Annex 1.

Sexual misconduct such as sexual exploitation, abuse and harassment (SEAH) and sexual violence violate the rights and well-being of the people we serve and the people with whom we serve. Such behaviours are directly in opposition to WHO's values and our abiding responsibility to do no harm. To the WHO workforce and collaborators, these acts are prohibited, and therefore lead to disciplinary action.

WHO has zero tolerance for any form of sexual misconduct, for inaction and for retaliation against those who raise complaints or bear witness. Our work prioritizes the rights and needs of victims and survivors.

Sexual misconduct can occur in all communities. In the context of an outbreak of mpox, victims of sexual misconduct can face the additional threat of exposure to HIV or any other infectious disease or condition.

Please note that it is your obligation to report any wrongdoing you become aware of or witness directly through established complaints mechanisms. Do not conduct the investigation yourself; only investigators are mandated and trained to do so.

If you work for WHO, please write directly to investigation@who.int or access the integrity hotline.

Table 12. PRSEAH checklist

For best results, RCCE practitioners should identify and coordinate with the PRSEAH focal point on the following activities:
1. Contribute proactively to the SEAH risk assessment and implementation of the risk mitigation plan.
2. Identify trusted networks within communities to engage them in becoming more aware of and addressing sexual misconduct concerns.
3. Contribute to the development and dissemination of clear and consistent PRSEAH messages adapted to local contexts and preferences. These must include: i) aid, including medical interventions and services is free and must not be exchanged for anything; ii) what to expect from development and aid workers, including health providers; iii) how to safely report any wrongdoing; and iv) how victims can access services.
4. Support the dissemination of PRSEAH materials during RCCE interventions with and through CBOs, CSOs and public information stakeholders.
5. Ensure sure prevention and response to sexual misconduct components are included in training curricula and other key materials.

RCCE principles and considerations for mpox outbreaks

This section contains additional considerations for RCCE strategy, planning and implementation during mpox outbreaks. More on RCCE principles can be found in the 10 steps to community readiness package (1) from the Collective Service.

Addressing uncertainty and maintaining trust

Managing uncertainty is an important function of RCCE during outbreaks and health emergencies. The readiness phase of an mpox outbreak is an opportunity to gather data to understand how people who may be at risk of mpox understand the various modes of transmission, protective behaviours and care-seeking behaviours. Settings or communities who have not previously experienced mpox outbreaks may have higher levels of uncertainty.

During mpox outbreaks, there may be uncertainty about the route of transmission, risky behaviours, which communities are at risk and access to vaccines, testing and care. Approaches for managing and addressing uncertainty should be included in RCCE strategies and plans to maintain trust throughout the outbreak. Key steps for managing uncertainty include:

- assessing the situation to understand what is known and unknown;
- identifying key uncertainties that may affect community understanding and response;
- being transparent and honest;
- setting realistic expectations;
- providing timely updates when new evidence emerges;
- explaining what is being done to find out more;
- acknowledging that what is known may change;
- listening and responding to community concerns; and
- being prepared to adapt (26).

Annex 2 contains a template early announcement for an mpox outbreak that can be adapted to support early, transparent communication and to tackle early uncertainties.

Understanding, preventing and addressing stigma and discrimination

Stigma and discrimination connected to any disease, including mpox, are never acceptable. They can have a serious impact on health outcomes and undermine the outbreak response by making people reluctant to come forward or seek care. This increases the risk of transmission — both within the most affected communities and beyond.

Mpox outbreaks have provoked stigma and discriminatory behaviours and language against people from affected countries, and against affected population groups. A scoping review of socio-behavioural research on mpox during the ongoing global outbreak confirmed the presence of stigma and discrimination against mpox patients, which is influenced by homophobia, and is expressed through the media and social media through the display of language that refer to mpox as “a gay disease”. It confirmed the need for more knowledge and awareness against health care workers, the general public, and university students, particularly those studying health and medicine.

Data from research on the experiences of people with mpox in Europe and the Americas *(16)* identified feelings of guilt or shame because of having mpox or its association with transmission via sexual contact and only shared their diagnosis with a limited number of people, especially if lesions or scars were not

noticeable. Instances of discrimination in health care and workplace settings were reported *(16)*.

RCCE plans and activities during mpox outbreaks must aim to raise awareness among the general population to prevent and address stigma and discrimination in the workplace for people absent because of mpox or returning to the workplace after isolation. They should also be designed to educate the health workforce to prevent and address stigma and discrimination in all healthcare settings for anyone who may have mpox.

The impact of stigma and discrimination on the mpox outbreak must be mitigated through active strategies to prevent people being unable or unwilling to access health services and support and to create an enabling environment where people feel able to report their symptoms.

WHO has developed risk communication and community engagement public health advice on understanding, preventing and addressing stigma and discrimination related to mpox. Refer to this guidance *(27)* for more information on the impact of stigma and discrimination during mpox outbreaks, approaches for understanding, preventing and addressing stigma and discrimination, considerations for different actors and guidance on non-stigmatising terminology.

Communicating with empathy

Empathy should be at the centre of all RCCE activities for mpox outbreak readiness and response. This is essential for establishing and maintaining trust with affected communities, addressing the emotional needs of those affected, encouraging collaboration and adherence to protective and care-seeking behaviours, reducing stigma and fear, supporting psychological well-being, enhancing two-way communication and promoting adherence to guidance and recommendations *(28-30)*.

When engaging with affected communities, it is important to recognize that mpox can lead to significant emotional distress among those affected because of its physical symptoms, the disruption of daily activities as a consequence of isolation, sometimes including loss of income or employment, and stigma and discrimination that can intersect with homophobia, biphobia, transphobia and HIV-related stigma *(16)*.

Other tools and products for mpox outbreaks

Guidance	
Interim guidance for risk communication and community engagement (RCCE) for mpox outbreaks *(31)*	Outlines recommendations, considerations and methods to raise awareness, manage risk perception, maintain trust and proactively support people at risk to make informed decisions to protect themselves and others from mpox. Available in English.
Q&As, key messages and factsheets	
General mpox Q&A *(7)*	Answers to the most frequently asked questions from the general public on mpox. Available in Arabic, Chinese, English, French, Russian, Spanish.
Testing for mpox: individuals and communities *(32)*	Answers to the most frequently asked questions from individuals and communities on mpox testing. Available in Arabic, Chinese, English, French, Russian, Spanish.
Testing for mpox: health workers *(33)*	Answers to the most frequently asked questions from health workers on mpox testing. Available in Arabic, Chinese, English, French, Russian, Spanish.
Mpox factsheet *(6)*	Key information about mpox transmission, signs and symptoms, diagnosis, treatment and vaccination, self-care and prevention, outbreaks and WHO response. Available in Arabic, Chinese, English, French, Russian, Spanish.
Mpox. What we know. Infographic *(34)*	Infographic that outlines what we know about mpox, key messages, modes of transmission, diagnostics, vaccines and treatment. Available in English, French, Spanish.
Public health advice	
Public health advice for gay, bisexual and other men who have sex with men on the recent outbreak of mpox *(35)*	Focusses on key information for gay men, bisexual men and other men who have sex with men on mpox. It is intended for use by individuals, community leaders, influencers, health workers, partners and health authorities affected by or working on the mpox outbreak. It contains information to help people reduce their risk of mpox and to help slow the spread of the virus. Available in Arabic, Chinese, English, French, Russian, Spanish.
Public health advice for sex workers on mpox *(36)*	This document includes public health advice for sex workers of all genders on protecting themselves and others against mpox. It is intended for use by sex workers, sex worker-led organisations, community leaders, advocates, health service providers (especially those in sexual health service delivery) and organisations working to promote the health of sex workers.

Public health advice on mpox and sex-on-premise venues and events *(37)*	Advice on how to control the spread of mpox while enabling venues to stay open and events to continue to take place. It contains practical advice that should be adapted to local settings. Available in Arabic, Chinese, English, French, Russian, Spanish.
Risk communication and community engagement public health advice on understanding, preventing and addressing stigma and discrimination related to mpox *(27)*	WHO advice providing information on the potential impact of stigma, recommended language and actions to counter stigmatizing attitudes and discriminatory behaviours and policies related to the mpox outbreak. It is intended for use by Governments, UN agencies, civil society organizations, non-governmental organizations, health workers, community leaders and the media working on mpox. Available in Arabic, Chinese, English, French, Russian, Spanish.
Public health advice for gatherings during the current mpox outbreak *(38)*	Advice to host governments, public health authorities, national or international organizers, and professional staff involved in the planning and delivery of gatherings in the context of mpox outbreaks, including people organizing smaller gatherings or attending gatherings of any type and size.
Infographics and social media content	
Mpox: what you need to know *(39)*	Key messages on mpox for communities. Available in Arabic, Chinese, English, French, Russian, Spanish. Also available in editable format for other language translations and as social media tiles.
Recovering from mpox at home *(40)*	Key messages on recovering from mpox at home. Available in Arabic, Chinese, English, French, Russian, Spanish. Also available in editable format for other language translations and as social media tiles.
Getting tested for mpox: what you need to know *(41)*	Key messages on getting tested for mpox. Available in Arabic, Chinese, English, French, Russian, Spanish. Also available in editable format for other language translations.

Other reference tools	
WHO mpox emergency page *(8)*	This web page provides updates on WHO's response to outbreaks of mpox and links to key resources. Available in Arabic, Chinese, English, French, Russian, Spanish.
Mpox strategic preparedness, readiness and response plan *(42)*	Outlines a framework of priorities for aligning collective efforts towards the goal of stopping mpox outbreak.
Mpox strategic preparedness, readiness, and response: Operational planning guidelines *(43)*	Practical guidelines outlining the public health measures needed to prepare for and respond to mpox outbreaks.
Surveillance, case investigation and contact tracing for mpox: interim guidance *(44)*	Interim recommendations for surveillance, case investigation and contact tracing for mpox in the context of the current global multi-country outbreak.
Vaccines and immunization for mpox: Interim guidance *(45)*	The Strategic Advisory Group of Experts (SAGE) on Immunization Working Group on smallpox and mpox vaccines advises WHO on the use of mpox vaccines for prevention of mpox and for post-exposure prophylaxis. This guidance has been developed on the basis of the advice issued by SAGE.
Standing recommendations for mpox issued by the Director-General of the World Health Organization (WHO) in accordance with the International Health Regulations (2005) (IHR) *(5)*	The standing recommendations which are in effect for all States Parties from 21 August 2023 until 20 August 2024.
Responding to the global mpox outbreak: ethics issues and considerations: a policy brief *(46)*	Guidance on ethics issues that have emerged in the context of the global mpox outbreak and its response, primarily: (i) stigma and discrimination, (ii) equitable access to interventions and (iii) action in the face of uncertainty.
Clinical management and infection prevention and control for mpox: Interim rapid response guidance *(47)*	Guidance for clinicians, health facility managers, health workers and infection prevention and control practitioners including but not limited to those working in primary care clinics, sexual health clinics, emergency departments, infectious diseases clinics, genitourinary clinics, dermatology clinics, maternity services, paediatrics, obstetrics and gynaecology and acute care facilities that provide care for patients with suspected or confirmed mpox.

Case studies

Rallying to defeat mpox in Nigeria

In 2022, Nigeria experienced a significant rise in mpox cases compared to the year before. Health authorities ramped up control measures in response to the surge, including community sensitization, which is essential to ensure early detection and notification of the disease. WHO provided information, education and communication materials to sensitize health workers and communities on preventive and protective measures to curb monkeypox. Read the full story here *(48)*.

Peru responds to mpox by engaging affected communities

Before the first case of mpox was detected in Peru in June 2022, health authorities had already begun to implement a response plan prepared with technical support from the Pan American Health Organization (PAHO). The plan included collaborating with the community to communicate the risks of mpox and provide prevention tips to help people make informed decisions about their health. Health authorities made the most of existing contacts and networks, involving health services and community representatives focused on HIV prevention and response, to engage networks of men who have sex with men. Read the full story here *(49)*.

Six months of working with communities against mpox in Europe

Men who have sex with men, recognising their knowledge and engagement as essential in the drive to control and eliminate mpox. RCCE was instrumental to every area of the response, from providing access to testing, to engaging people in contact tracing, to informing those who may be at higher risk about treatments and how to prevent spreading the disease to others.

The summer season of festivals and events offered both the possibility of increased mpox transmission. It was also a powerful opportunity to bring information to those whose behaviours may make them more likely get monkeypox. Read the full story here (50).

Mpox training resources

7

Training	Overview
OpenWHO 9-minute video course on mpox and the 2022-2023 global outbreak *(51)*	This course is designed to complement the OpenWHO introductory training on mpox and the extended training on prevention and management of mpox. It can be viewed before or after the first two courses prepared prior to the global outbreak.
OpenWHO Mpox introductory training *(52)*	**Mpox: Introductory course for African outbreak contexts** This course provides a general introduction to mpox and is intended for health personnel responsible for prevention and control of mpox.
OpenWHO Mpox epidemiology, preparedness and response in-depth training *(53)*	**Mpox: Epidemiology, preparedness and response for African outbreak contexts*** This course offers public health officers and health workers in-depth information to understand the epidemiology, modes of transmission, clinical presentation, diagnostics, and treatment of mpox, as well as the strategies needed for effective prevention and outbreak investigation and response.*
SocialNet: Empowering communities before, during and after an infectious disease outbreak *(54)*	This comprehensive online training includes modules on community engagement, data collection and analysis, considerations for interventions, risk communication and interpersonal skills. This course aims to equip all frontline responders with the knowledge they need to better contain disease outbreaks and manage health emergencies.

* The content and scope of these courses on mpox have been tailored for outbreaks in African countries where the disease is endemic. The course material was last updated in 2021 and may not reflect most recent WHO guidance issued for the multi-country outbreak in 2022.

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Annexes

Annex 1: Guidance for RCCE practitioners on the prevention and response to sexual exploitation, abuse and harassment

This guidance is a rapid reference point for RCCE practitioners working before and during health emergencies. For more in-depth resources, please refer to the WHO PRSEAH webpage. Please work closely with the country focal point for PRSEAH for context-specific guidance.

- Refresh your knowledge and understanding of PRSEAH prior to your engagement with communities.
- Engage with communities based on need and without any discrimination based on gender, sexual orientation, nationality, ethnicity, religion, age, or political affiliations.
- Ensure clear communication with community members on the reporting mechanisms at their disposal. Make it clear that reporting will not prevent them from receiving the support they are entitled to and that victims/survivors of sexual misconduct have a right to services regardless of their willingness to cooperate with an investigation.
- Be aware that victims and survivors of SEAH are afraid and often ashamed of reporting and may be at risk of further harm or stigmatization. Therefore, whenever possible make sure RCCE work includes the identification of trusted community networks, organizations or leaders, especially women's networks that can provide safety and support to those at risk or those who have already experienced SEAH.
- In your RCCE work gather intelligence on trusted channels of communication, the languages and literacy levels and preferences of those most at risk and integrate such intelligence in designing awareness campaigns and other PRSEAH actions.
- Your actions as an RCCE practitioner must be guided by the principles of do no harm, confidentiality, transparency, accountability and duty to report, prevention, non-discrimination and equality. Treat the populations you serve with respect and protect them from sexual exploitation, abuse and harassment by development and aid workers both during and outside working hours.
- Responders cannot demand or accept any sexual favours from community members or as a condition for employment, or in exchange for assistance due to communities. If you are working for or on behalf of WHO, comply with WHO's policy on preventing and addressing sexual misconduct at all times.

Country focal points for PRSEAH will, in many cases, also have information about local contexts including dedicated hotline numbers for reporting sexual misconduct established by the United Nations Country Team.

Annex 2: Draft outbreak announcement

Outbreak announcements are released to inform the public of a public health concern or threat. They aim to engage, reassure and provide early guidance to health care workers, and the public, particularly to the most affected communities. It is important to communicate early, transparently and with empathy in the event of a possible or confirmed mpox outbreak to maintain public trust, acknowledge unknowns and communicate with empathy.

This is a template that will need to be adapted to your local context:

On ***[date]***, a ***[country]*** resident tested positive for mpox after developing ***[describe symptoms: e.g. a rash, fever, muscle aches, etc.] [number of days]*** prior. Contract tracing has been undertaken to identify any contacts who may have been exposed.

The risk of onward transmission related to this case is currently ***[low as the case was immediately isolated and contact tracing undertaken/high because we have not been able to trace all the individual's contacts]***. ***[Provide context re: what you know about the source of the infection – consider importance of avoiding stigmatizing language]***.

[Country-specific response – describe what you are doing]

Example: We have initiated public health investigations to better understand the situation. We are also implementing control measures, such as case finding and contact tracing, as well as providing supportive care for patients.

[Country-specific response – define where the public can find information]

Example: Over the coming days and weeks and as we find out more, we will regularly share information regarding risks associated with mpox and if you are an at-risk group, advice on how to avoid infection and protect your health. Please check ***[a variety of places where members of your community access news and health information, e.g. the health authority website, social media accounts, national public service broadcaster, etc]***. Members of the public can also call ***[specific health service number if one exists]*** if they have any questions regarding the disease.

Country-specific response adapted to local context about mpox currently being seen in men who have sex with men (if this is what is driving transmission in the area), and how to minimize stigma towards this group]

Example: Mpox cases are currently occurring mainly but not exclusively among communities of men who have sex with men. The disease, however, can affect anyone who comes in close contact with someone who is showing the symptoms of mpox, regardless of their sexual orientation. Stigma and discrimination because of a disease is never acceptable.

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