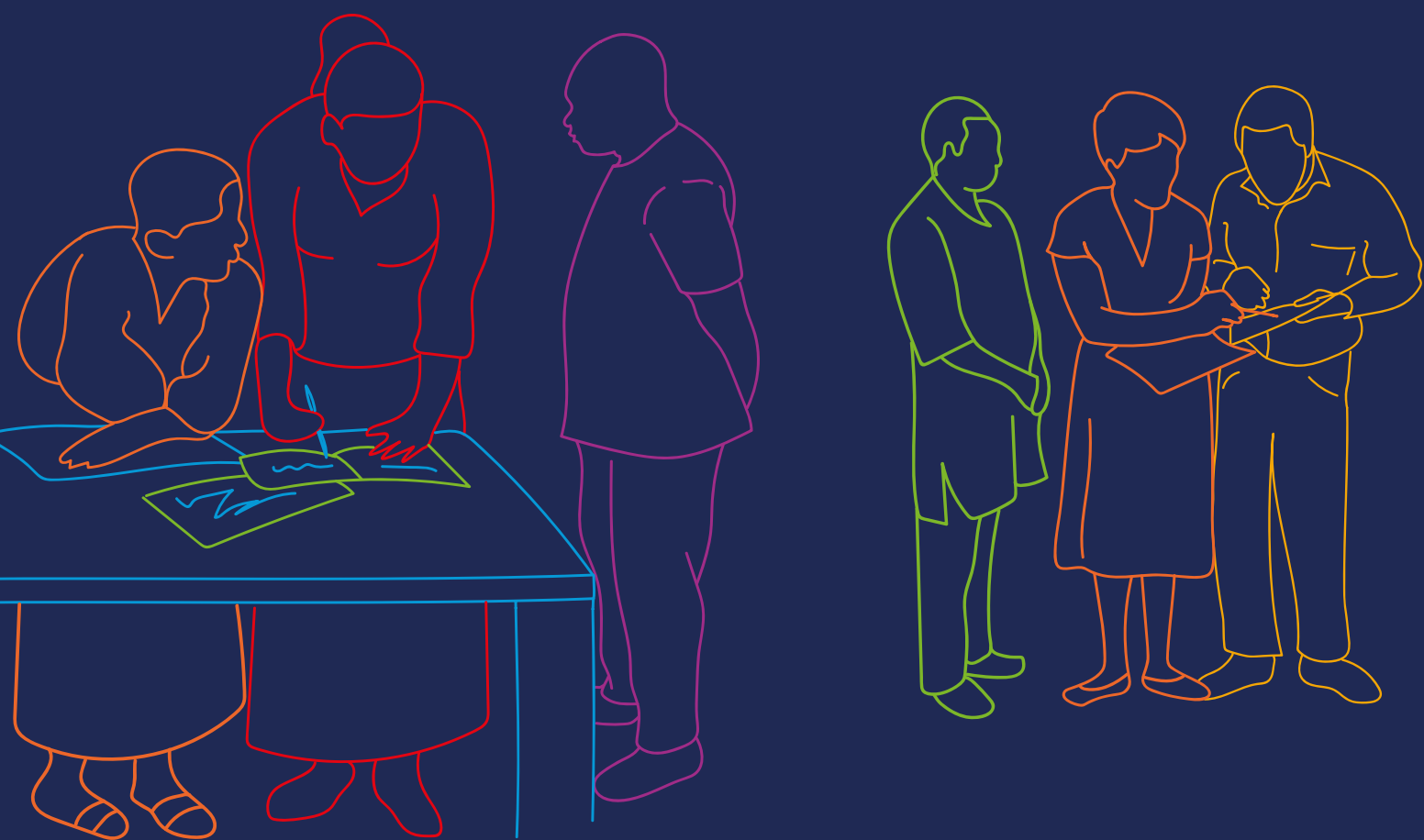# WHO competency framework, risk communication and community engagement

For stronger and more inclusive health emergency programmes

World Health Organization

WHO competency framework, risk communication and community engagement

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WHO competency framework, risk communication and community engagement: for stronger and more inclusive health emergency programmes

Contents

Preface

In the evolving landscape of global public health, the importance of effective risk communication and community engagement (RCCE) has become increasingly recognized. Communities are critical partners who must be positioned at the centre of emergency preparedness, readiness and response functions. RCCE is both a technical discipline and a culturally attuned pillar of activity which is essential for achieving Community Protection. In an emergency context RCCE has a special role in ensuring communities are engaged and empowered. Recent public health emergencies have again proven the importance of evidence-based RCCE in aligning health emergency programmes with community needs, capacities and expectations for more inclusive, equitable and effective action.

The RCCE competency framework outlines and defines essential behaviours and activities necessary for inclusive, effective and efficient RCCE. These have been identified through a rigorous process, including evidence review, expert consultation, and practical insights gathered from real-world experiences. They represent a synergy of theory and practice, designed to equip public health professionals with the competencies they need to navigate the complexities of communicating about risk and engaging with communities safely and effectively, using data-driven social-behavioural approaches.

This framework emerges during a pivotal juncture, where our collective experiences with public health crises have emphasized the need for clear, credible communication and the active involvement of communities before, during and after health emergencies. It stands as a testament to our commitment to assimilating valuable lessons from these experiences and to fostering a proficient and capable RCCE workforce.

As you explore this competency framework, I encourage you to consider not only the technical dimensions of RCCE activities but also the profound responsibility inherent in these roles, as articulated through the behavioural competencies presented. Our words and actions wield the power to shape public perceptions, influence behaviours, and ultimately, affect the health outcomes of communities and save lives during emergencies. This responsibility necessitates expertise and knowledge, underscored by compassion and integrity.

On behalf of the Country Readiness Strengthening Department (CRS) and the Community Readiness and Resilience Unit, I extend my heartfelt appreciation to all who have contributed to the RCCE competency framework. Your expertise, dedication, and insights are invaluable in shaping a future where the strength of RCCE nurtures prepared and empowered communities, enabling them to navigate public health emergencies with fortitude, solidarity and resilience.

Dr Nedret Emiroglu
Director, Department of Country
Readiness Strengthening

Acknowledgments

Acronyms

CDC	United States of America Centers for Disease Control and Prevention
CSO	Civil-society organization
HEPR	Health emergency prevention, preparedness, response and resilience
IHR	International Health Regulations
IM	Infodemic management
IMS	Incident management system
JEE	Joint External Evaluation
MEL	Measurement, evaluation, and learning
NGO	Non-governmental organization
RCCE	Risk communication and community engagement
SPAR	States Parties Self-assessment annual reporting
SOP	Standard operating procedure
ToR	Terms of reference
WHO	World Health Organization

Glossary

Multiple conceptualisations and definitions exist for the terminology relating to competencies within a workforce. Effective application of a competency framework requires clarity and consistency of terms, definitions and concepts. This framework adopts the below explanations for the terms used in the document.

Attitude	A person's feelings, values and beliefs that influence behaviour and performance of tasks.
Behaviour*	Observable conduct towards other people or tasks, that expresses a competency. Behaviours are measurable in the performance of tasks.
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.
Behavioural science	The rigorous and systematic application of multidisciplinary scientific methods that deal with human action, its psychological, social and environmental drivers, determinants and influencing factors.
Community	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 health emergency response cycle *(1)*.
Community protection	Implementation and uptake of population and environmental interventions to protect health and well-being of people who are affected by emergency events in ways that are acceptable, meaningful and relevant to them and do not inadvertently do harm *(2)*.
Competence*	The state of proficiency of a person to perform required activities to a defined standard. This incorporates having the competencies to do this in a given context. It is multidimensional and changes with time, experience and setting.
Competency*	The abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable.
Competency-based curriculum*	A curriculum that emphasizes the complex outcomes of learning rather than what learners are expected to learn about in terms of subject content.
Competency framework	An organized and structured representation of a set of interrelated and purposeful competencies need for effective performance in a particular area of work.
Domain*	A broad, distinguishable area of content; domains, in aggregate, constitute a general descriptive framework.
Health emergency cycle	The phases of prevention, preparedness, readiness, response and recovery relating to health emergencies to reduce the impact of a crisis. Countries and communities may be engaged in different phases for multiple outbreaks and emergencies simultaneously.
Evidence	Evidence is the outcome of a systematic and structured process where data is collected, processed and analysed to answer a specific predefined question.

Evidence-informed decision making	A systematic and structured transparent approach to identify, appraise, and use evidence for decision-making processes, including for implementation. Decisions should be informed by the best available evidence from research, as well as other factors such as context, public opinion, equity, feasibility, affordability, sustainability, and acceptability to stakeholders *(3)*.
Infodemic	An infodemic is an overabundance of information, accurate or not, in the digital and physical space, accompanying an acute health event such as an outbreak or epidemic *(4)*.
Knowledge*	The informational base of competencies and activities: The recall of specifics and universals, the recall of methods and processes, and/or the recall of a pattern, structure, or setting.
Outbreak	Occurrence of cases of a disease above 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.
(Individual work) performance*	What an organization hires one to do and do well. Performance is a function of competence, motivation and opportunity to participate or contribute. Competence reflects what a person **can** do, performance is what a person **does** do.
(Practice) activity*	A core function of practice comprising a group of related tasks. Practice activities are time limited, trainable and, through the performance of tasks, measurable.
Proficiency*	A person's level of performance (for example, novice or expert).
Readiness	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.
Resilience	The ability of a system, community or society exposed to hazards to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management *(1)*.
Response	The phase of a health emergency or outbreak activated once a 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 face health threats. Its purpose is to provide people with accurate and timely information and to support them to making informed decisions to mitigate the effects of a threat *(1)*.
Skill*	A specific cognitive or motor ability that is typically developed through training and practice and is not context specific.
Stakeholders	A stakeholder is an individual or group with an interest or concern in a particular project, organization, or decision, potentially affected by or influencing its outcomes.
Supervision*	The provision of guidance and support in learning and working effectively by observing and directing the execution of tasks or activities and making certain that everything is done correctly and safely, from a position of being in charge.
Task*	Observable unit of work within a practice activity that draws on knowledge, skills and attitudes Tasks are time limited, trainable and measurable.

Key definitions are referenced. Those marked with * are consistent in Mills et al., 2020 and WHO, 2022 *(6,7)*.

Executive Summary

The RCCE competency framework is a resource that details the essential behaviours and activities necessary for effective communication and engagement with communities before, during and after public health emergencies. They are essential for creating inclusive, fair and cohesive health emergency programmes that build trust and protect the most vulnerable. RCCE enables and empowers individuals and communities to assess risk, and to take informed decisions that protect their health during emergencies. Further, through participatory and inclusive practice that draws on community assets and social connections, RCCE builds on and strengthens community resilience. Behavioural competencies, which are vital for RCCE practitioners' professional performance, can be observed in how individuals interact with others and how they carry out specific tasks. Together, the behaviours and activities are instrumental in building resilient, trusted relationships with communities and fostering collaboration with teams throughout the health emergency management cycle.

The purpose of this framework is to establish and promote a common understanding of these behavioural competencies and how they should be applied for high-performing and community-centred health emergency programmes. It is intended to support the development of standardized training programmes, professional development and talent acquisition and to enhance the capabilities of public health professionals involved in RCCE. Its goal is to inform the establishment of a skilled, well-trained RCCE workforce that consistently understands and executes the necessary behaviours and activities required to conduct RCCE activities with competence and professionalism.

The framework is organized into five behavioural competency domains and three technical areas of practice activities. This structure is in alignment with World Health Organization (WHO) guidance and standard operating procedures for developing competency frameworks *(7-9)*. The activities are categorized based on two systems that countries use to evaluate and report RCCE progress: the States Parties Self-assessment annual reporting tool (SPAR) and the Joint External Evaluation (JEE) which combine risk communication and community engagement as an integrated capacity *(10,11)*. These tools are used to measure compliance to the International Health Regulations, 2005, and as such are familiar to governments and health emergency response teams.

BEHAVIOURAL COMPETENCIES

Domain 1
Community-centred approaches

Domain 2
Leadership and decision-making

Domain 3
Communication

Domain 4
Collaboration

Domain 5
Evidence-informed practice

PRACTICE ACTIVITIES

Technical area 1
RCCE system for emergencies

Technical area 2
Risk communication

Technical area 3
Community engagement

These competencies, tasks and activities represent the latest understanding of how RCCE, as a technical discipline, works to inform and empower communities in crisis. They emerged from a rigorous review of existing frameworks and evidence as well as the experience of leading RCCE practitioners.

The framework provides a comprehensive and cohesive set of competencies and activities that can and should be adapted to develop skills among RCCE practitioners working across the health emergency management cycle. It provides a blueprint for effective cross-functional teams. It can be used by and is applicable for RCCE focal points working for a broad range of agencies and partners including, from governments, United Nations (UN) agencies, international and local nongovernmental organizations (NGOs), civil society, health emergency response teams and capacity-building experts.
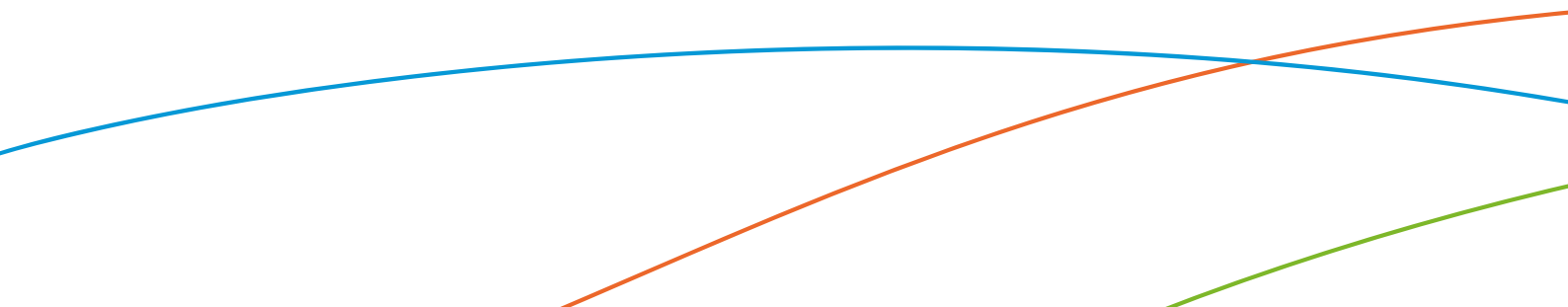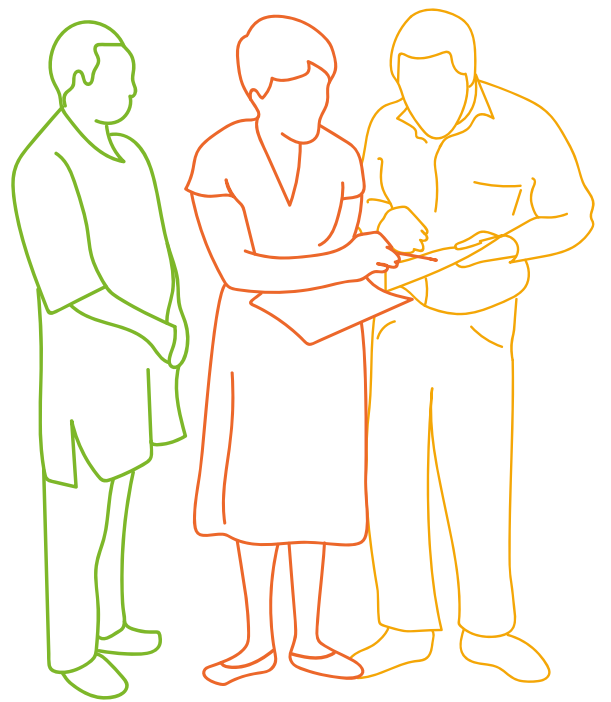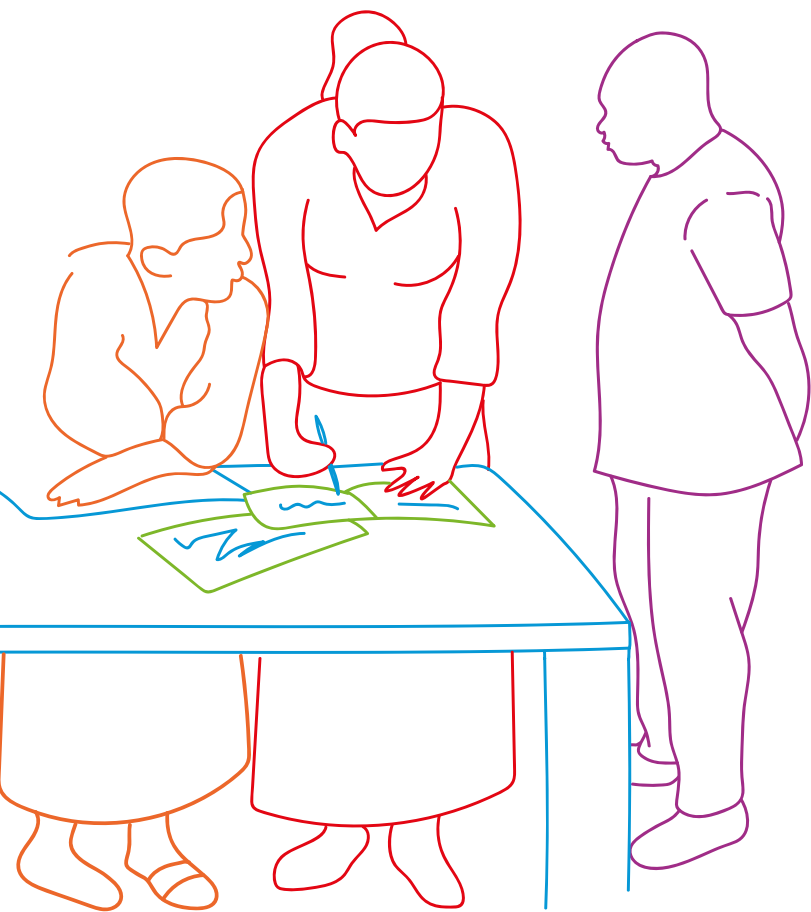
1. Introduction

1.1 RCCE as a technical area of work

Risk communication and community engagement (RCCE) is a critical public health intervention and technical discipline that should be applied across all phases of the health emergency management cycle. Effective RCCE teams collaborate and align with other technical units to increase trust through strategic communication, co-develop solutions with communities and maintain RCCE capacity at emergency levels, even in the absence of an emergency *(12)*. RCCE actions should be consistently informed by evidence that draws on social and behavioural science to bring communities to the forefront of action. Informed, engaged and empowered communities can help to detect new diseases and organize more rapid and cohesive responses to disease outbreaks or crises, saving lives and minimizing the broader social and economic impact *(2)*.

RCCE involves two closely linked concepts that are increasingly seen as a combined technical area. Risk communication is a fundamental capacity that all countries must develop as signatories to the International Health Regulations (IHR), 2005 *(13)*. However, updated IHR reporting mechanisms (the SPAR tool and the JEE) and IHR benchmarks present risk communication with community engagement as a set of combined and linked capacities *(1,10,11)*.

It is important to understand the distinctions of the two concepts:

Risk communication is a multi-level and multi-faceted process; it aims to help stakeholders define risks, identify hazards, assess vulnerabilities, and promote community resilience *(14)*. It involves the real-time exchange of information, advice and opinions between experts or officials and individuals facing health threats. It enables people to make informed decisions to mitigate the effects of a threat and take protective and preventive measures *(1)*.

Community engagement develops relationships and structures for stakeholders to work together to promote well-being, achieve positive health outcomes and empower communities to lead, plan and implement initiatives as equal partners. It co-develops solutions and adapts and localizes health emergency programmes by working collaboratively with groups of people affiliated by geographic proximity, identity, ways of communication, shared interest, similar situations, or health conditions *(1)*.

Taken together as RCCE they have proven themselves essential for more inclusive, equitable and effective health emergency programmes that save lives and protect livelihoods. As such, they are now routinely included and joined in key global and regional frameworks. The framework for Health Emergency Preparedness, Response and Resilience (HEPR), built from over 300 recommendations from lessons learned during the COVID-19 pandemic, positions RCCE as a core technical approach for protecting the health and well-being of those directly affected by health emergencies *(2)*. Community protection is achieved through population and environmental interventions that are specifically targeted to the health emergency. These interventions reduce the risk and scale of infectious disease transmission by reducing exposure to the pathogen or making exposure safer. Implementing these interventions can create social and economic disruption and, if not done in a way that is sensitive to existing inequities and context, they can inadvertently do harm. RCCE can enable strategies for implementing interventions in ways that are acceptable, meaningful and relevant to those affected by accounting for these wider contextual dimensions. Further, HEPR has strong alignment with regional strategies for health emergency preparedness readiness and response while The Pandemic Influenza Preparedness Framework further highlights the need to continue investing in RCCE for strengthened community protection *(2,15)*.

1.2 Purpose of the RCCE competency framework

The purpose of this framework is to describe the competencies needed by the RCCE workforce to perform their work effectively and confidently, delivering outcomes that protect the health and well-being of those affected by health emergencies and strengthen resilience.

Recent public health emergencies, including the COVID-19 pandemic, have offered crucial lessons about integrating RCCE into strategy and planning initiatives to better align emergency programmes with the needs and expectations of communities. To respond to these lessons, a structured approach to promote consistency in RCCE practice is needed. This framework is therefore positioned as a foundational component of a comprehensive RCCE curriculum being developed by WHO. The framework is designed to act as a reference tool; it is not intended as a regulatory tool.

Key areas where this framework can be applied.

- **Workforce development:** as a standardised reference for developing competencies of a team.

- **Needs assessment:** to guide development of tools for self-assessments and/or observed assessments to identify individual or group competencies, capacities and areas in need of improvement.

- **Professional development:** to guide the creation of learning pathways and planning for achieving higher proficiency levels.

- **Recruitment:** as a reference source for more consistent terms of reference (ToR) and job descriptions.

- **Performance assessment:** as a reference source for developing indicators to assess performance.

- **Programme development:** as a foundation for learning and training programmes and curricula development.

1.3 Scope of the RCCE competency framework

The scope of this document reflects current accepted best practice in RCCE as a core component of strategic frameworks for managing health emergencies in community-centred ways. It encapsulates the most recent developments and understanding in RCCE and reflects the ongoing evolution in the global architecture and pillars for prevention, preparedness, readiness, response and recovery. It will be periodically reviewed and updated to integrate new knowledge and experiences. The application of the framework across technical pillars should contribute to overall resilience: enabling systems, communities or societies to resist, absorb, accommodate, adapt to, transform and efficiently recover from the effects of an emergency *(5)*.

The framework is intended to be adapted and applied by RCCE teams at regional and country levels and, where relevant, shared with other stakeholders. Its application may be enhanced by aligned guidance, training curricula and frameworks from related fields and technical areas, tailored to the team's size and scope. A list of selected resources which can inform these processes is provided in the Selected Further Reading section of this document. While the framework's primary focus is RCCE, its content and principles may also be adapted to support other aligned programmatic areas, such as Health Promotion, Accountability for Affected Populations, Social Behaviour Change and Community Engagement and Accountability.

There is considerable diversity in the range of roles and job profiles within RCCE teams and in different settings. This framework emphasizes the importance of identifying behaviours and tasks to be done, rather than defining competencies for specific job profiles *(7)*. However, the framework can serve as a foundation for the development of job profiles and in designing performance evaluations for specific roles.

Application of the framework will contribute to stronger more consistent RCCE planning, coordination, implementation and human resource management needed by teams working on RCCE at all levels throughout the health emergency management cycle. It will also encourage participation, which helps build the trust and social cohesion that are essential for successful RCCE practice. Structured to align with IHR benchmarks and reporting mechanisms *(1,10,11)*, the application of the framework will also support activities associated with IHR compliance and reporting.

1.4 Target audiences

The RCCE competency framework caters to a broad range of stakeholders. It is a tool which can be applied in different ways by each of the following groups:

- **RCCE teams** who undertake the design, implementation, and evaluation of strategies and plans that aim to provide tailored, equitable and effective RCCE;

- **academic institutions and capacity development experts** that offer training programmes related to public health, or RCCE;

- **emergency response teams** involved in response before, during and after health and complex emergencies;

- **policymakers and health administrators** making decisions in the health sectors at governmental and non-governmental levels;

- **civil society and community-based organizations (CSOs)** involved in local health and community initiatives;

- **health and development partners** working on public health issues and/or RCCE;

- **the public health workforce** involved in service provision and community outreach.

Section 4 of the framework provides more detail on the application of the framework by these groups.

1.5 Goal and objectives of the framework

The goal of this framework is to inform the establishment of a consistent, well-trained RCCE workforce with a common understanding of the behaviours and activities required to conduct RCCE activities for public health emergencies properly and professionally. To achieve this goal, the framework has the following objectives:

1. **Establish a universally recognized, accepted and consistent set of behavioural competencies and practice activities that will:**

   - enhance RCCE capabilities for more equitable and community-focused action;

   - strengthen coordination and collaboration among stakeholders;

   - position communities as active, equal partners in preparedness, readiness and response activities;

   - establish effective, inclusive and multi-directional communication mechanisms.

2. **Provide foundational resources to standardize RCCE practices by supporting the development of:**

   - educational curricula and learning initiatives;

   - evaluation tools for ongoing assessment and oversight of professional RCCE practices and outcomes;

   - staff recruitment processes tailored to local needs, ensuring the acquisition of suitable human resources for RCCE.

2. How was the framework developed?

2.1 Methods

The Risk Communication and Community Engagement team at WHO in Geneva developed this framework through an exploratory and consultative process. There were three main steps to link conceptual and theoretical insights with expert participation to establish the competencies detailed herein.

Step one – Foundational work

Desk review

– Existing competency frameworks, RCCE guidelines, job profiles and best practices to identify foundational elements were reviewed; training material was assessed to identify operational and capacity strengths and challenges faced by RCCE teams when preparing for and responding to emergencies.

Stakeholder engagement

– Expert RCCE practitioners and capacity development academics were engaged to take part in two rounds of interviews, discussions and consultations.

Step two – Formulation of competencies

– A needs analysis was done, with contributions from the stakeholder group to evaluate current gaps in RCCE capabilities, capacities, and practices at global, regional and country levels, and provide formative content for competencies.

– Personas were developed to represent individual role-specific tasks that could inform development of generic competencies.

– A set of draft competencies was developed and shared with the stakeholder group. Feedback was incorporated.

Step three – Alignment and structure

– The competencies formulated in step two were complemented by existing published relevant frameworks and resources *(7,11,16-23)*. Another round of feedback was undertaken.

– The competencies were refined by the WHO RCCE team who then structured it in alignment to the foundational model for competency frameworks commonly used and applied by WHO and the RCCE core capacities for preparedness in the JEE/SPAR tools *(7,10,11)*.

– The consolidated framework document was drafted in alignment with WHO SOPs and guidance. It was shared with the working group and agreement on the revised structure and content was reached through participation in a final review meeting.

BEHAVIOURAL COMPETENCIES
Domain 1 Community-centred approaches
Domain 2 Leadership and decision-making
Domain 3 Communication
Domain 4 Collaboration
Domain 5 Evidence-informed practice

PRACTICE ACTIVITIES
Technical area 1 RCCE system for emergencies
Technical area 2 Risk communication
Technical area 3 Community engagement

2.2 Foundational models

The core content of the framework is organized into five behavioural competency domains and three technical areas of practice activities:

The structure of separating behaviours and activities is in alignment with WHO guidance, and standard operating procedures for developing competency frameworks *(7-9)*. Together, they should guide users toward a common understanding of the essential competencies that underpin all RCCE practice and demonstrate how these competencies can be applied to foster more equitable and cohesive RCCE programmes. These resources emphasize the importance of an individual's behavioural competencies that enable them to perform activities and tasks. The inclusion of behaviours into this framework is important (see Section 3.1); they are often overlooked by learning and training programmes, yet they are essential elements of effective action between emergency response systems and communities. Frameworks that identify competencies in isolation can be abstract whereas those that focus exclusively on activities can overlook the necessary behaviours of the individual who performs those activities *(7)*.

The framework defines the technical areas of practice activity through which the behavioural competencies are applied by RCCE practitioners and other health emergency staff (see Section 3.3). They are categorized according the RCCE capacities set out in the IHR SPAR and JEE tools *(10,11)*. These tools informed the selection of practice activities and were also complemented other relevant competency frameworks and resources. Annex 1 provides supplementary detail on putting behavioural competencies into practice, drawing from the conceptual frameworks on which this document is based.

KEY CONCEPTS

Behaviour is defined as the observable conduct towards other people or tasks that express a competency. Behavioural competencies are, "the abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context" *(6)*. They are durable, trainable and, can be measured through the performance of tasks. Behaviours are person-centric. They represent ongoing habits that enable an individual to perform different roles and responsibilities.

Practice activities comprise the observable core functions of work, they are groups of tasks that may be undertaken by individuals or groups of individuals. They are time-limited and through the performance of tasks, measurable. Effective performance of activities is underpinned by multiple competencies, usually simultaneously *(7)*.

2.3 Structure of the framework

RCCE comprises public health interventions that should be applied across all phases of the health emergency management cycle; it is essential to coordinate the various activities that span the wide range of tasks and behaviours. The components of this framework are deliberately generic and designed to be localized and applied in all health emergency settings.

Ideally, the foundations of activities are initiated during prevention, preparedness and readiness phases, then maintained throughout response and recovery. The content of the framework was compiled by the WHO RCCE team, informed by the consultation process with the stakeholder group and existing RCCE literature. A summary of key tasks and when they take place across the health emergency management cycle is shown in Fig. 1.

Fig. 1 Key behaviours and tasks across the health emergency management cycle

BEHAVIOURAL COMPETENCIES				
Community-centred approaches	**Leadership**	**Communication**	**Collaboration**	**Evidence-informed practice**
Places communities at the centre of all RCCE practice and promotes community empowerment	Exhibits leadership, professional conduct, methodical decision-making, applies technical expertise, manages conflict	Listens actively and attentively and communicates purposefully and professionally	Cultivates teamwork and builds partnerships and collaborative engagement	Advocates for the principles of evidence-informed practice and assesses and uses relevant data and evidence

TASKS

PREVENTION	PREPAREDNESS	READINESS	RESPONSE	RECOVERY
• Map readiness and response actors	• Develop RCCE plans	• Update RCCE plans	• Maintain coordination mechanisms	• Conduct after-action reviews
• Map capacity	• Assess available evidence	• Collect and compile evidence	• Integrate RCCE activities into response pillars	• Adapt capacity building initiatives based upon lessons learned
• Identify vulnerable and/or under-represented groups	• Establish coordination mechanisms	• Prime coordination mechanisms and operational resource plan	• Create and implement evidence plan	• Revise RCCE plans
• Identify gaps in knowledge and systems	• Maintain partners and relationships	• Continue testing content	• Use evidence	• Reinforce partnerships and relationships
• Establish partnerships and relationships	• Pre-position plans	• Maintain partners and relationships	• Adapt content	• Plan longer term capacity building
• Develop, test and deliver content and messages	• Continue testing and delivering content and messages	• Initiate MEL processes	• Adapt and deliver RCCE activities	
	• Develop MEL processes	• Respond to capacity building needs	• Conduct inter-action reviews	
	• Assess and respond to capacity needs		• Implement MEL plan	
			• Continue to develop capacity	

2.4 RCCE principles and values

It is crucial that members of RCCE teams are aware of the guiding principles (illustrated in Fig. 2) of RCCE practice in public health emergencies *(24)*. The principles are relevant to all areas of RCCE action and should be supported by the values that underpin any individual's professional RCCE behaviour. Values are the basic and fundamental beliefs that guide or motivate attitudes or actions *(25)*. Those presented in Fig. 2 are the core values commonly documented in the RCCE literature and were identified in the process of developing the behavioural competencies for this framework.

Fig. 2 Principles and values for RCCE

| NATIONALLY LED | COMMUNITY CENTERED | PARTICIPATORY | NURTURES TRUST | OPEN AND TRANSPARENT |

PRINCIPLES OF RCCE

| INFORMED BY DATA | INTEGRATED | COORDINATED | INCLUSIVE | ACCOUNTABLE |

VALUES

Respectful, collaborative, ethical, impartial, tactful, equitable, empowering, honest, culturally sensitive.

Source: Adapted from Collective Service (2019) COVID-19 global risk communication and community engagement strategy – interim guidance *(24)*.

3. The RCCE competency framework

3.1 Behavioural competencies

The competencies detailed in this section represent the behaviours that RCCE practitioners are expected to exhibit in their professional roles. The behaviours are interconnected, and they often occur together within a single task and across multiple tasks associated with the role and responsibilities of RCCE practitioners. While attitudes, beliefs and motivations are intrinsic to these observable behaviours, they are not explicitly described here *(7)*. The behaviours described should be universal to good RCCE practice and are important to drive organizational success and foster an environment where RCCE practice can thrive.

BEHAVIOURAL DOMAIN 1. COMMUNITY-CENTRED APPROACHES

These behaviours are central to delivering RCCE initiatives that incorporate community perspectives and solutions. They emphasize community-centric and whole-of-society approaches for managing public health emergencies. Empowering communities to have increased control over their lives is a critical factor in building community resilience and in the success of health emergency response. Meaningful participation and sustained engagement of all communities and individuals are fundamental to community resilience and emergency programming as there is an established relationship built on trust, ownership over interventions and accountability between stakeholders *(24)*.

Competency 1. Places communities at the centre of all RCCE practice

1.1. Integrates the principles and values of RCCE into engagement with communities.

1.2. Adopts an approach to RCCE practice that is non-discriminatory, non-judgemental and non-stigmatizing.

1.3. Tailors RCCE activities, tools, products and programmes to reflect the local context, giving priority to the protection of vulnerable groups and harmonizing with local structures.

1.4. Displays sensitivity to distinctive local circumstances, including diversity, vulnerabilities, norms and customs, focusing efforts on the specific needs of affected populations.

Competency 2. Promotes community empowerment

2.1. Demonstrates respect for the autonomy, perspectives, preferences, priorities and rights of communities, acknowledging that affected populations are knowledgeable and legitimate partners in preparedness, readiness and response efforts.

2.2. Engages and collaborates with communities and their representatives, ensuring timely and effective two-way information sharing, learning and consensus building.

2.3. Enhances the capacities and capabilities of affected populations, equipping them with the understanding they need to participate in driving change, making decisions and co-creating solutions that are acceptable and workable for them.

2.4. Represents community interests, and advocates for their needs, facilitating mechanisms that allow communities to keep duty-bearers accountable for their promises and actions.

BEHAVIOURAL DOMAIN 2. LEADERSHIP AND DECISION-MAKING

RCCE teams must be capable of operating in uncertain and rapidly evolving situations whilst upholding the highest professional standards and ensuring the welfare of their colleagues. All actions taken by an RCCE practitioner in the course of their work require judicious management and decision-making which has consequences for others with whom they work, or the communities they serve. The complexity of the decisions to be made, the implications of those decisions, and the level of judgement differ based upon one's role and responsibility. However, to implement RCCE, all team members require competencies in leadership and to making effective and timely decisions in a variety of circumstances.

Competency 3. Exhibits leadership

3.1. Articulates a clear vision and adjusts priorities to respond to evolving situations and demands.

3.2. Delegates authority judiciously, optimizes roles and responsibilities to maximize team strengths and operational efficiency within collaborative frameworks.

3.3. Fosters an environment that empowers and motivates, aligned with RCCE principles and values.

3.4. Sets a strong personal example, maintaining composure under pressure and applying emotional intelligence to address differences of opinion and manage stressful situations.

Competency 4. Applies a methodical approach to decision-making

4.1. Demonstrates critical thinking to reach decisions that are judicious, evidence-based and actionable, using a strategic and analytical mindset.

4.2. Makes decisions that reflect the complexity and urgency of a situation.

4.3. Assesses the potential outcomes and implications of decisions made.

Competency 5. Demonstrates professional conduct

5.1. Takes ownership of and responsibility for consistently delivering work of the highest standards of professional excellence, recognizing situational constraints, risks and benefits.

5.2. Maintains self-awareness by acknowledging personal beliefs, biases, emotional responses, assumptions and values.

5.3. Organizes RCCE activities effectively to ensure that intended outcomes are achieved, and legal and ethical principles are maintained.

5.4. Acts accountably and ensures adherence to organizational standards for human resources, financial and administrative management.

Competency 6. Constructively manages tensions and conflicts

6.1. Proactively recognizes and addresses areas of potential tension or conflict.

6.2. Values different perspectives in the pursuit of compromise, consensus or resolution, within the team and in RCCE practice.

6.3. Actively intervenes to prevent and mitigate instances of abuse, harassment or other forms of disruptive behaviour within the team and in RCCE practice.

Competency 7. Applies technical expertise

7.1. Exhibits role-appropriate understanding of core technical areas: public health, community protection, health emergency frameworks (e.g. HEPR, IHR, incident management system (IMS)), and interrelationships between policymakers, global agencies and other stakeholders.

7.2. Considers potential risks and unintended consequences of RCCE activities and identifies how to mitigate those risks.

7.3. Champions the role of RCCE across the health emergency management cycle and upholds humanitarian principles with conviction.

7.4. Applies specialized technical expertise commensurate with level of responsibility.

7.5. Pursues ongoing professional development to enhance theoretical knowledge and practical skills.

BEHAVIOURAL DOMAIN 3. COMMUNICATION

Communication is important in all professional work, and for RCCE practitioners it is fundamental in how they effectively guide, inform, support, mobilize and collaborate with communities, emergency response actors, the media and other stakeholders. Communication is an interactive process that requires mindful expression of one's own verbal and non-verbal communication. This competency underscores the foundational principles that shape communication behaviours. For specific practice activities and tasks relating to communication, refer to section 3.3 of this framework.

Competency 8. Listens actively and attentively

8.1. Demonstrates empathetic and active listening and provides thoughtful responses.

8.2. Supports others to ask questions and openly express ideas and opinions and share experiences.

8.3. Responds sensitively and non-judgementally to what others express.

Competency 9. Communicates purposefully and professionally

9.1. Adheres to principles of communication by providing information that is relevant, timely, accurate, clear, coherent, concise and logical.

9.2. Strives for multi-directional engagement with communities using the best approaches to reach different groups and transparently explaining their identity and actions.

9.3. Communicates using accessible language and terminology, explaining complex content with understandable terms, adapting style for different types of output and audiences and acknowledging the influence of language and culture on communication.

9.4. Uses a variety of communication tools and techniques, including verbal, non-verbal, visual, written and digital approaches.

9.5. Places an emphasis on being first, fast and accurate with information sharing and engagement.
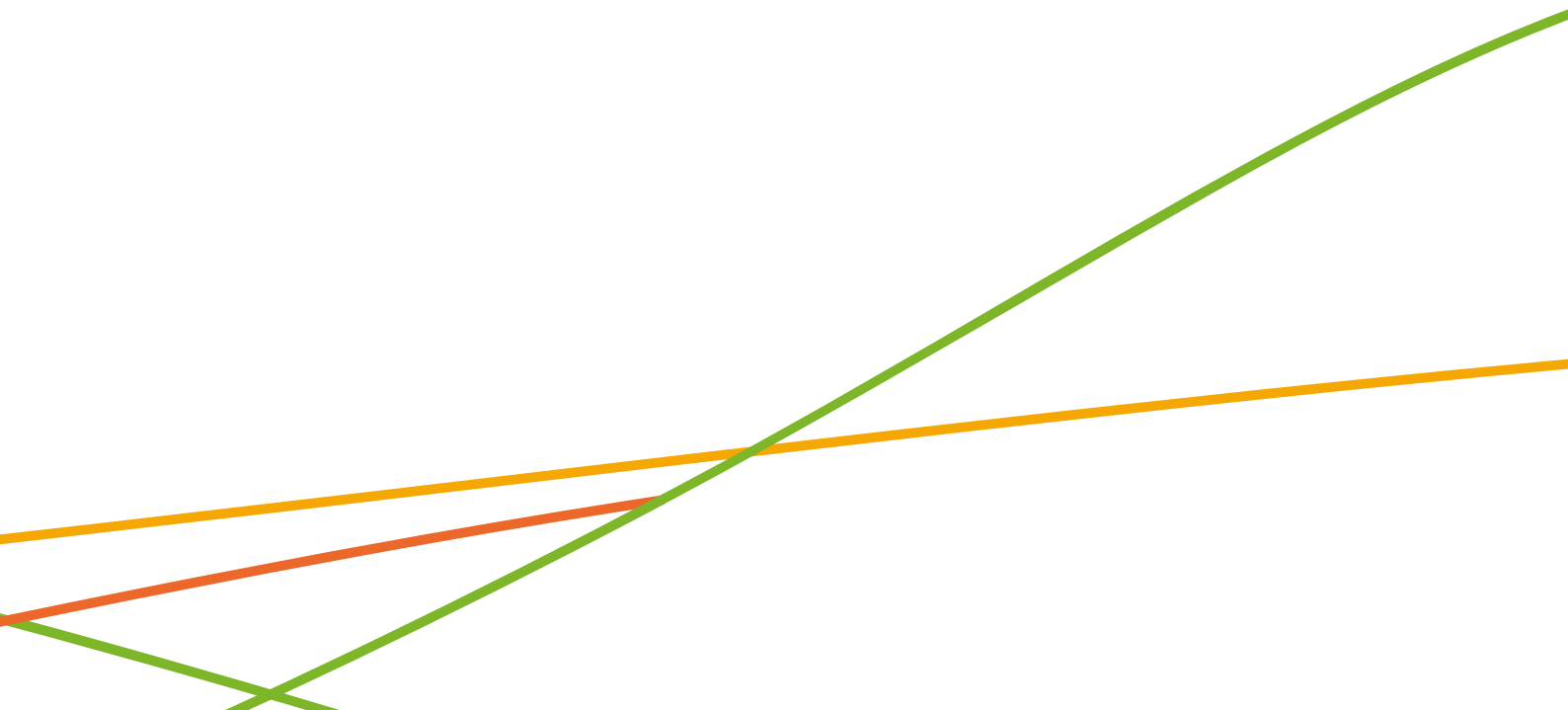
BEHAVIOURAL DOMAIN 4. COLLABORATION

Collaborating with teams, affected populations and the broadest array of stakeholders is critical before, during and after a public health emergency. It is essential for whole-of-society approaches that engage and empower local communities and stakeholders. Strong coordination and collaboration is essential for emergency management to ensure that resources and partners are working effectively together *(26)*.

Competency 10. Cultivates teamwork

10.1. Upholds high professional standards in all interactions, both within the team and with external partners.

10.2. Delivers constructive, sensitive and timely feedback, support and advice, nurturing an atmosphere conducive to transparency and psychological safety.

10.3. Builds and maintains relationships in the team, engaging and collaborating through consensus and problem solving despite cultural, geographical, organizational and sectoral differences.

10.4. Employs different approaches to facilitation and collaboration techniques to understand and document concerns, perspectives and suggestions.

Competency 11. Builds partnerships and collaborative engagement

11.1. Guides partners and teams to align with and actively contribute to the vision, purpose and strategic objectives of RCCE.

11.2. Cultivates positive and forward-thinking relationships and partnerships (including with affected populations and the media), characterized by mutual trust and strategic value.

11.3. Collaborates with diverse community representatives and stakeholders to ensure inclusive representation in RCCE activities and to pursue common objectives.

11.4. Seeks to engage partners with different capacities and backgrounds, inspiring and mobilizing collective action and joint problem resolution.

BEHAVIOURAL DOMAIN 5: EVIDENCE-INFORMED PRACTICE

Making sure that RCCE practice is based on evidence ensures that technical work and solutions are grounded on a solid and rigorous and foundation. RCCE teams play a critical role in transforming evidence into messages, materials and interventions that influence behaviours and can save lives. A structured and accessible approach to using evidence fosters trust, inclusion and shared ownership of strategies and actions. Generating, analysing and using diverse sources of scientific data and research is fundamental to effective emergency management. Using evidence from social and behavioural sciences is crucial, as well as data from biomedical and other public health technical areas. It should promote inclusive public health emergency management, meaningful engagement and community-centred practice.

Competency 12. Advocates the principles of evidence-informed practice

12.1. Articulates the importance of RCCE practice being rooted in scientific approach and rigour and informed by evidence.

12.2. Promotes use of evidence to inform RCCE and wider response activity.

12.3. Collaborates with networks of experts, scientists and academics to facilitate evidence generation, interpretation and use.

12.4. Ensures external researchers adhere to appropriate ethical standards in their work.

Competency 13. Assesses and uses relevant evidence

13.1. Participates in seeking evidence from social and behavioural sciences to inform RCCE activity.

13.2. Uses a structured and replicable approach to gather evidence to deliver key RCCE tasks.

13.3. Uses evidence for specific purposes and can describe that purpose.

13.4. Critically evaluates the limitations, quality, relevance and application of evidence.

13.5. Communicates structured, comprehensible and accurate evidence and analytics with appropriate audiences to update and enhance RCCE practice.

3.2 Applying behavioural competencies to practice activities

The behaviours described in the previous section should be demonstrated in the activities and tasks of RCCE practitioners described in the following section. An individual's behavioural competencies enable them to perform their tasks.

The practice activities are organized into three technical areas (shown in Fig.3, see next page). These areas align with the current country reporting mechanisms (SPAR and the JEE) used to assess capacities for RCCE preparedness under the IHR *(1,10,11)*.

Each practice activity describes a core technical function of RCCE, collectively forming a comprehensive set of activities for RCCE practice across the health emergency management cycle. It is important to acknowledge the dual nature of RCCE practice – one aspect involves engagement with affected populations, while the other entails collaboration with technical response teams. Activities therefore must ensure alignment between technical aspects and community needs.

The individual practice activities encompass groups of related tasks that may be undertaken by individuals or groups. A single occupational group or role is not expected to have responsibilities across all practice activities. Roles and responsibilities and the number of RCCE team members vary significantly across countries and teams. Therefore, this framework does not assign tasks to specific roles but serves as an organising framework to describe the range of RCCE activities and tasks. The scope of an RCCE team to undertake the activities and tasks will depend on the size of the team.

The specific scope and level of ambition of the activities undertaken are intended to be adapted, refined, based on local circumstances and contexts and priorities. Teams are expected to select and allocate tasks to members in a way that suits their organizational structures. In combination, the behavioural competencies and tasks can be used to identify capacity gaps, determine the capacity development needs of teams, support professional development and continuous improvement and inform recruitment processes.

The tasks in one area will often be closely connected to tasks in others. Throughout the framework key linkages between tasks have been added in brackets (e.g. refer to activity 2) to help identify how they relate to and complement each other.

Fig. 3 Structure of practice activities

PRACTICE ACTIVITIES

TECHNICAL AREA 1: RCCE SYSTEM	TECHNICAL AREA 2: RISK COMMUNICATION	TECHNICAL AREA 3: COMMUNITY ENGAGEMENT
Strategic planning and coordination	Risk communication operations	Community engagement operations
Evidence to inform action and planning	Media engagement	
Resource managment	Infodemic managment	
Capacity development		
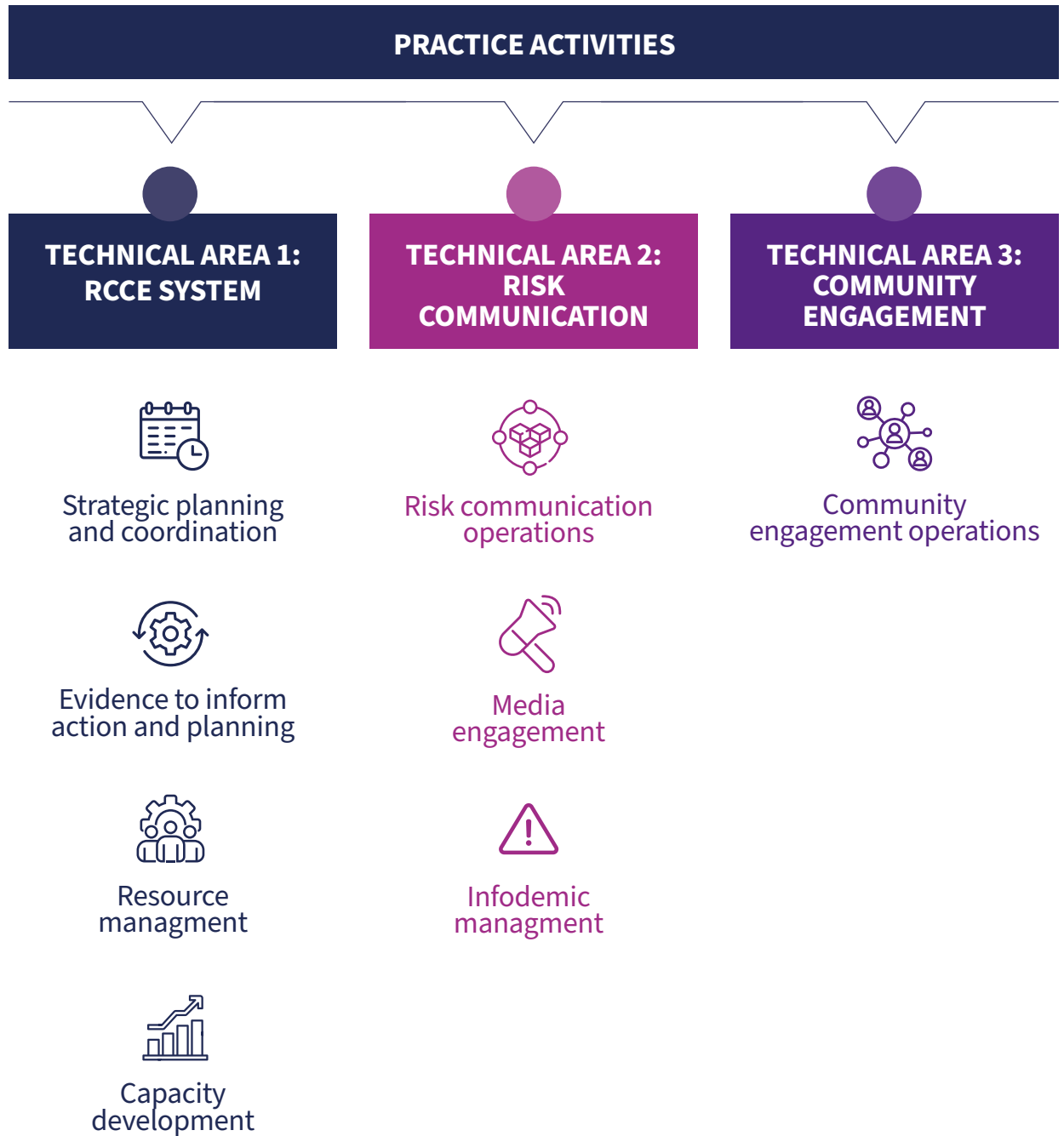
3.3 Practice activities

Technical Area 1. RCCE system for emergencies

This technical area focuses on establishing and maintaining the systems and structures required to coordinate, plan, deliver and evaluate RCCE. It therefore informs and supports **all** the activities and tasks in the other two technical areas. Ideally the activities should be initiated during preparedness or readiness phases so they can be applied for response.

Strategic planning and coordination		
Practice activity	**Tasks**	
1. Plan for prevention and preparedness phases	1.1.	Develop annual and multihazard plans based on anticipated risks, e.g. seasonal events, outbreaks and mass gatherings.
	1.2.	Identify and map parties involved in readiness and response (refer to activity 5). This should:
		• answer the 4Ws: who does what, where and when;
		• dentify community members who can work as focal points.
	1.3.	Establish and implement processes to identify under-represented disadvantaged, vulnerable and marginalized groups (refer to activity 5).
	1.4.	Map the RCCE capacity needs of partners and stakeholders.
	1.5.	Create a repository of tools and templates for future rapid development of new RCCE products.
	1.6.	Pre-position existing RCCE strategies and/or plans to implement prevention and preparedness interventions.
2. Establish and maintain RCCE coordination and (multisectoral) partnerships	2.1	Collaborate with ministries (including across government, as appropriate and relevant) to establish and align coordination platform with national structures; detail the structures, functions, aims and objectives of the platform (refer to activities 13 and 20). This includes:
		• developing or reviewing SOPs and ToRs for RCCE coordination;
		• developing a protocol for community mobilization;
		• integrating RCCE functions into national preparedness and response structures and plans and the incident management system.
	2.2	Identify and engage operational stakeholders, including technical teams (e.g. health promotion, epidemiology, surveillance, infection prevention and control etc.), pillar focal points, coordination bodies and other operational agencies to ensure:
		• their integration into decision-making processes (including assessments, planning and monitoring) related to RCCE to prevent duplication;
		• sharing of communications and evidence.
	2.3	Determine the frequency of meetings and modes of communications with stakeholders to ensure effective coordination.
	2.4	Collaborate with national leadership and technical teams to contribute to RCCE policy documents and position papers.

SOP: standard operating procedure; ToR: terms of reference.

3. Develop and implement RCCE plans through the coordination platform	3.1	Review existing evidence from other pillars and technical areas e.g. national risk assessments, readiness assessments, priority public health threats, epidemiological data (refer to activity 5).
	3.2	Use as systematic and structured approach to integrate key issues from existing evidence and from RCCE evidence (detailed in activity 5).
	3.3	Design a flexible national RCCE plan to influence behaviours that is based on evidence and aligned with national priorities and stages of the emergency cycle. This includes: • setting out strategic outcomes and objectives to guide the direction and focus of the plan; • identifying and agreeing upon key activities, interventions and processes with relevant technical teams and deadlines to support the plan; • localizing the plan to sub-national levels as appropriate.
	3.4	Establish processes to implement each activity through the national plan.
	3.5	Implement RCCE interventions set out in the plan, through the coordination platform (refer to activities 14, 18 and 21).
4. Measure, evaluate and learn	4.1	Develop MEL plan focused on outcomes, using guidance and tools* to define measurement, determine performance indicators related to RCCE interventions (including measuring changes in the community), systems and plans.
	4.2	Implement the MEL plan: Apply indicators to test and measure progress and effectiveness of plans and interventions; conduct inter-action and after-action reviews.
	4.3	Assess whether plan and/or intervention was feasible and acceptable, was delivered as intended, and whether it had an effect on the target behaviour.
	4.4	Use MEL findings to regularly update and modify RCCE plans and operations.
	4.5	Share MEL data and findings through coordination platform and with communities.
	4.6	Promote the inclusion of RCCE indicators and minimum standards in national response plans.

MEL: Measure, evaluate and learn.
*Refer to Selected Further Reading section for suggested guidance on indictors.

Evidence to inform planning and action

Note: The approach and tasks required for evidence production will vary based on the setting, level of resources, type of emergency and degree of urgency. During the initial stages of emergencies, evidence production often occurs concurrently with response activities.

Practice activity	Tasks
5. Produce evidence to inform planning	5.1 Compile existing evidence to inform RCCE planning (refer to activity 3). Consider: • context / situational analysis to identify political, economic, social, technological, environmental, legal aspects affecting preparedness and response initiatives; • community mapping of platforms at national and sub-national levels; • needs analysis for effective engagement with CSOs, NGOs and community stakeholders; • vulnerability mapping to identify institutional barriers for disadvantaged and marginalized groups; • communication and media mapping to determine the communication approach and style as well as strategy. This includes identifying credible media sources, communication channels and influencers for different audiences; and, understanding how different social groups engage with the different channels such as access, usage, accessibility and preferences; • mapping of key RCCE stakeholders, including those in the media and working on information management. 5.2 Identify if there are recent data and evidence available (e.g. from partner agencies) to inform the RCCE plan. 5.3 Where gaps exist, use a systematic and structured approach to prioritise and produce the types of evidence listed in task 5.1 and following the approach described in activity 6.
6. Produce evidence to inform action	The following tasks are adapted according to the response challenge that is being faced. 6.1 Review existing evidence to deepen understanding of the issue and identify the need for new evidence. 6.2 Identify who will use the new evidence and how. Define their need and involve them early. 6.3 Decide the purpose of using new evidence i.e. to understand the problem (e.g. define in terms of behavioural/social/cultural aspects, drivers, barriers); to develop solution; or, to assess usefulness of an intervention. 6.4 Create brief ToR to guide the process, e.g. why the evidence is needed, the question, how to answer the question (the method), who will do the work and what resources are needed (refer to task 7.3 and 7.4 on how to develop and maintain processes). 6.5 Commission and/or conduct data collection and analysis. Consider, collaborating with experts and community representatives to assess the evidence: quality, relevance, robustness, trustworthiness and context sensitivity of the evidence to inform MEL processes (refer to activity 4). 6.6 Communicate findings (refer to task 2.2 and activity 20) to interpret and co-develop recommendations with responsibilities and timelines assigned. Include all relevant stakeholders and community representatives identified and through the coordination platform. 6.7 Integrate recommendations into design of RCCE interventions and actions (refer to activities 14 and 21).

7. Develop and maintain processes to support robust evidence production	7.1	Set up a data management system that addresses security, sharing, ownership, sensitivity, storage access, and plans for the preservation or destruction of data.
	7.2	Ensure clear ToR are developed for external consultants / researchers who are engaged in data collection, including on how they share evidence with other stakeholders and the processes for data collection, analysis, interpretation and use. Consider assisting in developing and contextualizing tools.
	7.3	Check methods are appropriate to answer the research question and can lead to concrete, actionable recommendations:
		• Consider collecting social and behavioural data using mixed methods adapted to emergencies, e.g. apid anthropological studies / behavioural assessments, community/social listening data, community feedback, community dialogue and other qualitative and participatory approaches.
	7.4	Check data are collected on key social and behavioural variables of relevance to RCCE a nd fill the evidence gaps, e.g. communities' risk perceptions, confidence, suggestions, expectations, trust, attitudes, communication needs, motivation and capability to respond to risk.

Resource management

Practice activity	Tasks	
8. Manage operational resources	8.1	Create an operational resource plan to support the coordination platform, e.g. staffing, operational expenses, capacity-building, data collection and monitoring.
	8.2	Work jointly with other teams, departments and agencies to mobilise resources, including budgeting and joint planning with pillars of the response, e.g. Incident Management System structure.
	8.3	Allocate financial, material and human resources as per agreements.
	8.4	Measure and evaluate use of financial, material and human resources to ensure efficiency and effectiveness.
9. Manage human resources	9.1	Define clear organizational structures with delineated roles, responsibilities, delegation of authority, and reporting systems.
	9.2	Collaborate with key agencies and ministries to establish and agree upon necessary roles and responsibilities for RCCE, ensure efficient collaboration and prevent duplication of roles.
	9.3	Where needed recruit, train and support staff to ensure they have the relevant skills, experience and capabilities for RCCE.
	9.4	Reach consensus on whether there is a need for surge deployments, including inter-agency RCCE roles.

Capacity development

Note: The approach and tasks required for evidence production will vary based on the setting, level of resources, type of emergency and degree of urgency. During the initial stages of emergencies, evidence production often occurs concurrently with response activities.

Practice activity	Tasks
10. Design capacity development and learning experiences	10.1 Formulate or update a learning strategy, e.g. for technical teams, media and community networks/representatives.
	10.2 Identify learning needs through assessments covering each relevant practice activity.
	10.3 Collaborate with subject matter experts and stakeholders to establish learning objectives and outcomes that align with RCCE goals and the needs and objectives of learners.
	10.4 Connect training initiatives to operational practice to demonstrate enhancements in capacity and function.
	10.5 Create or select RCCE learning materials that align with RCCE goals.
	10.6 Design and integrate simulation exercises that mimic real-world scenarios and allow learners to apply knowledge and skills in a controlled environment.
11. Deliver capacity development and learning experiences	11.1 Deliver role/learner appropriate capacity development initiatives.
	11.2 Implement simulation exercises to evaluate learners' performance in real-world settings
	11.3 Create opportunities for learners to connect with mentors and peers to build a supportive learning community.
	11.4 Ensure that learning materials and resources are current, relevant and accessible to learners.
12. Assess learning	12.1 Collect feedback effectiveness and efficiency of learning experiences and strategies.
	12.2 Assess the impact and evaluate the effectiveness of learning experiences.
	12.3 Evaluate learners' knowledge and skills to ensure learning objectives are met.
	12.4 Adapt capacity development initiatives based upon measurable indicators of success.
	12.5 Review and revise learning outcomes to reflect changes in learner needs or programmatic requirements.

Technical Area 2. Risk communication

Risk communication operations	
Practice activity	**Tasks**
13. Plan content	13.1 Examine the content from national RCCE plan to identify objectives for risk communication content (refer to activity 3).
	13.2 Determine priority risk communication needs and priorities of affected populations by: • segmenting priority audiences and developing risk communication objectives based on data and informed by response strategy; • identifying themes and opportunities to align with evolving communication objectives.
	13.3 Participate in the Joint Information Centre or equivalent structure to coordinate and align communications outputs between agencies (refer to activity 2).
	13.4 Maintain ongoing communication with relevant technical teams to ensure alignment and responsiveness (refer to activity 2).
14. Develop, test and deliver content	14.1 Develop specific risk communication outputs and interactions based on the evidence on priority audiences, information needs, and communication channels.
	14.2 For each communication output / interaction, define communication objectives and outcome (e.g. single overarching communication outcome), target audiences and timing. • Use technical health information, infodemic data and social-behavioural evidence relating to the target population and context.
	14.3 Develop overarching and supporting messages to convey health risks and drive change in behaviour; test messages as part of routine activities.
	14.4 Create compelling narratives and content based on messages to effectively communicate health risks, incorporating relatable stories that resonate with community values. • Strike a balance between factual information and emotionally resonant content, complemented by visual elements.
	14.5 Tailor and adapt narratives and messages to resonate with specific audiences and cultural sensitivities, using culturally relevant examples and language. Ensure that content: • aligns with RCCE goals, objectives and evidence to encourage behaviour change; • empowers audiences, encourages audience participation and directs people to sources of additional or updated information and communicates uncertainty where applicable; • maintains timeliness, consistency, clarity, conciseness, audience relevance informed by the latest available data; • navigates sensitive topics with ethical consideration and cultural awareness.
	14.6 Deliver communication interventions through diverse media platforms and approaches to reach diverse audiences, e.g. call-ins for radio and TV, drama and comedy programming, discussion and magazine programmes, speeches, community meetings, animations and posts for digital platforms, videos, posters, etc.
	14.7. Continually update based upon new insights, data and evaluation.

15. Content evaluation	15.1 Monitor content effectiveness according to the MEL plan (refer to activity 4).
	15.2 Regularly assess the impact of content on audience comprehension and behaviour to test the effectiveness and suitability of each risk communication output.
	15.3 Collect feedback to refine content and approaches.

Media engagement	
Practice activity	**Tasks**
16. Build relationship with / capacity of media organisations	16.1 Refer to communication and media mapping (activity 5).
	16.2 Foster relationships with media representatives, networks, digital influencers and content creators, including organizations training and coordinating with media in emergencies.
	16.3 Develop an RCCE media and communication engagement plan with clearly defined objectives, timelines and tailored strategies for print, broadcast, and online media and key influential platforms. It should identify which organizations and individuals will be involved in providing communication activities, including infodemic management.
	16.4 Regularly communicate with the media, while building their capacity to report accurate information. Including:
	• developing clear, concise, and informative press releases at regular intervals that align with RCCE objectives and emergency response updates;
	• creating opportunities for the media to ask questions and get answers to build their understanding of health issues and response;
	• collaborating in the development of media communication materials and talking points, one-to-one briefings and interviews;
	• producing content for the media containing essential information such as situation overview, actions taken, and calls to action;
	• supporting management and hosting of press conferences and high-level interviews;
	• providing risk communication support and training to spokespersons and media representatives (refer to practice activity 11);
	• providing access to behaviour change expertise to support the development of communications formats for traditional media and digital platforms to support engagement as well as risk communication.
	16.5 Contribute to the MEL plan to assess the effectiveness of the media engagement and communication engagement plan. Include reviewing media content as well as understanding audience engagement and impact.
	16.6 Monitor and measure the reach and impact of media engagements.
	16.7 Adapt the approach to media engagement based on feedback, the MEL plan and evolving circumstances.

Media engagement*	
17. Plan infodemic management	17.1 Establish a platform for dynamic multisource listening and/or social media tools to support event and community-based surveillance, rumours and inform broader risk communication activities.
	17.2 Establish taxonomies for priority national hazards to support in rapid responses during emergencies.
	17.3 Develop a plan to integrate infodemic management as part of a national RCCE plan (refer to activity 3). Taking into account:
	• information: Amplifying factual information, filling information voids, debunking false information, information tracking;
	• providing infodemic resources for public health communicators;
	• providing resources and standards for media organizations, key digital influencers, journalists, and fact checkers, managing scientific literature, resources for infodemic researchers and managers, social media regulation, policy and legislation (refer to activity 16);
	• enhancing digital, media and health information literacy.
	17.4 Share SOPs for infodemic management with relevant technical pillars (through the coordination platform, activity 2) for consideration in risk assessments as well as informing ongoing operational responses.

* More detailed competencies and activities for those whose work focuses on infodemic management are set out in the WHO Infodemic Management competency framework (20).

Technical Area 3. Community engagement

Building relationships with communities is a priority during preparedness and readiness phases; tasks during these phases should seamlessly transition and be maintained in response phase activities.

Strategic planning and coordination	
Practice activity	**Tasks**
20. Build relationships with communities	20.1 Examine content from national RCCE plan and evidence (activity 6) to identify community engagement objectives. E.g. consider participation of all relevant population groups and networks in processes, such as goal setting, readiness and response activities and identifying community focal points for information dissemination.
	20.2 Determine priority community engagement activities to align with goals and mechanisms for participation, based on evidence: • community mapping and identified trusted community structures, particularly among vulnerable groups (refer to task 1.3 and activity 5); • conducting participatory assessments with communities to identify needs, capacities, resources, support structures, communication channels, practices and behaviours, and stakeholders, and sharing the results.
	20.3 Mobilize existing assets and community-based health initiatives, such as community-based surveillance and detection; reporting; community-led responses, leveraging local capacities and resources.
	20.4 Undertake localised preparedness and response planning with communities: • identify community risks, priorities, needs, resources and solutions, and ensure that they are integrated into plans and proposed interventions; • consider everyday threats, e.g. food security, availability of safe shelter, access to transport, which may impact wellbeing.
	20.5 Establish ongoing and proactive outreach through multiple channels (e.g. hotlines, complaint systems, community listening, feedback mechanisms) and clear lines of two-way communication for routine feedback on community concerns and issues of interest. Emphasis should be placed on: • vulnerable and under-represented groups in distinct, targeted feedback mechanisms; • seeking formal approval and acceptance from local leadership and community representatives.

21. Maintain engagement with communities	21.1	Maintain mechanisms that support collective and participatory approaches to enable effective communication and feedback mechanisms with communities, address feedback and lead to corrective action. Establish or maintain a community listening system to: - document and track communities' concerns and perspectives, both offline and online, including about response interventions and their social/ economic impacts; - validate community listening and social listening data; - communicate actions resulting from community feedback.
	21.2	Develop action plans with communities to prioritize activities, ensuring inclusive approval from an inclusive range of leaders.
	21.3	Design locally relevant engagement activities, using participatory techniques e.g. co-designing with community representatives, human-centred design. This includes: - emphasising response to priorities and needs identified by marginalized and disadvantaged community members; - co-developing solutions to social or economic impacts arising from response interventions; - adapting community engagement tools/activities to local languages and contexts; - mapping details of planned community engagement events.
	21.4	Use multimodal channels to engage with communities, including two-way communication at community and household levels, mass media, digital platforms and social media.
	21.5	Collaborate with communities to analyse evidence needs and co-develop recommendations to inform further action.
	21.6	Provide briefings and supervision to community outreach groups.
	21.7	Conduct training and regular refresher sessions for community outreach groups.
	21.8	Design and deliver capacity development activities that enhance locally relevant skills and tools, including: - building the capacity of affected populations to collect their own data, design methodologies and identify data gaps and requirements; - supporting community capacity and resources to make decisions and take action.
22. Monitor community engagement	22.1	Establish monitoring mechanisms to systematically incorporate community feedback.
	22.2	Monitor community feedback mechanisms and share findings back to communities.
	22.3	Adapt interventions based on monitoring results and feedback.

4. Application and future adaptation of the RCCE competency framework

The RCCE competency framework is designed with adaptability in mind and should be contextualized to meet the specific needs and arrangements where it is being applied. It provides a comprehensive universal structure of the range of behavioural domains and technical areas which are essential for the effective implementation of RCCE activities to prepare and respond to public health emergencies. Recognizing the diverse capabilities across different settings, countries will need to select and prioritise those competencies that are most essential and relevant to their specific contexts.

How the framework is put into practice will vary based upon who is using it and what they aim to achieve with it. The framework does not propose a single method for its use. This section provides several suggestions on how the framework may be used or applied by different users and audiences.

The framework serves as a reference tool and can be used to:

- identify and address capacity gaps, determine capacity development needs and monitor their evolution over time; support professional development; and, in inform recruitment of RCCE workforce (see 4.1).

- guide the development of training programmes and learning resources (see 4.2).

- provide a consistent and standardized understanding of the technical area of RCCE for other stakeholders (see 4.3 and 4.4).

The framework is supplemental and not intended to supersede existing or established RCCE operational guidelines.

4.1 RCCE teams at regional, national or organizational levels

Leaders of RCCE teams are encouraged to tailor the framework as a standardised reference for their teams to plan the development of a comprehensive set of competencies which are suitable for their specific operational environment. While it will not always be feasible to for a team to perform all the activities described, the framework should serve as a foundational element for setting goals and augmenting team capabilities, alongside guiding overall team

objectives and workplans. The goals and objectives will be influenced by the size of the team, the availability of resources and local priorities. WHO has planned the development of additional resources to support these processes, these will be integrated into the forthcoming RCCE curriculum.

Capacity needs assessments

The framework is intended to serve as a reference tool for designing or refining needs assessments to identify capacity or capability gaps in individual team members or across broader RCCE teams. The results of needs assessments can be used to develop performance indicators that align with the key learning needs and expected competencies of teams and/or individuals. In contexts where the results of needs assessments identify a shortfall in team capacity, the results can be used to seek additional support through enhanced training, funding or staff augmentation.

Performance evaluation and continuous professional development

At an individual level, the framework can be used to guide the setting of performance objectives and indicators. For this purpose, it is important to acknowledge that behaviours are observable, making the behavioural competencies of this document suitable for developing behavioural indicators relevant for any role. Successful task performance demonstrates the application of behavioural competencies in practice (additional information is shown in Annex 1). Mastery of behaviours, measured against indicators, demonstrates competency in performing roles effectively *(27)*. Assessment tools for gauging competence must include clear criteria to decisively determine whether an individual has achieved the required level of performance to be considered competent *(28)*.

Having identified needs and /or evaluated performance, RCCE staff and leadership can collaborate to outline learning pathways and plans for achieving higher proficiency levels. The framework serves as a flexible tool rather than a directive. Team leaders are expected to choose and assign tasks to members in a way that align with their organizational structures and operational dynamics. The WHO Enhanced Global Competency Model and the Global Competency and Outcomes Framework for Universal Health Coverage

suggest approaches to assigning behavioural indicators to particular job grades *(7,21)*.

Recruitment

The competencies and activities described in the framework serve as a foundation for delineating job roles and developing consistent job descriptions and ToRs that correspond with the behaviours and tasks in the framework. While varied job titles may encompass identical tasks or identical job titles, the framework's flexibility allows for the correlation of specific behaviours may entail different responsibilities based on context. This flexibility allows for the correlation of specific behaviours and competencies to job-specific tasks in a given context or operational environment.

4.2 Learning experience designers

Using the framework to inform development of RCCE learning programmes.

The framework is to provide a foundational component of the comprehensive RCCE curriculum in development by WHO. When applied, the framework can inform the content of learning and training programmes developed by WHO headquarters and regional and country offices. It is also structured to support and enhance content developed in collaboration with, or commissioned by, academic partners and implementing partners.

The practice activities of the framework delineate the essential functions that RCCE teams should be proficient in, which forms an organizing framework for learning programmes and experiences. These competencies are contextualized through practice activities, rendering the framework a practical tool for curriculum development. Learning and training initiatives can be designed on the basis of what the learner will do in practice (practice activities encompassing the performance of tasks) and the standards to which these are performed (competencies demonstrated through behaviours *(7)*.

This framework is an initial component of a comprehensive, competency-based RCCE curriculum under development by the RCCE-IM team at WHO headquarters. Competency-based education is a framework for designing and implementing

education that focuses on the desired performance characteristics *(28)*. Although competence has always been the implicit goal of more traditional educational frameworks, competency-based education makes this explicit by establishing observable and measurable performance metrics that learners must demonstrate to be considered proficient in a particular area of study or occupation.

Main characteristics of a competency-based curriculum:

- Learner-centred approach: Focuses on outcomes important for learners' success and allows for personalized learning paths.

- Clear competencies: Involves well-defined objectives that describe the expected abilities of learners upon completion of the programme.

- Mastery learning: Ensures learners achieve a level of mastery in each competency before progressing to more complex skills.

- Flexible pacing: Allows learners to progress through the curriculum at their own pace, providing more time where needed to achieve mastery.

- Assessment alignment: Uses assessments that are directly aligned with competencies, ensuring that evaluation methods are authentic and directly related to the required skills and knowledge.

- Evidence-based: Requires learners to provide evidence of their competency, often through practical demonstrations, projects, or portfolios.

- Continuous improvement: Encourages learners to continuously develop their competencies beyond the minimum standards for proficiency *(28)*.

Applying the framework to evaluating learning pathways

After the development of learning programmes and training materials, the framework is instrumental in their evaluation. There are many tools which can be used for this purpose, depending on the exact needs and desired outcomes. One widely recognized and applied framework for evaluating the effectiveness

of training programmes is the Kirkpatrick Model of Learning Evaluation *(29)*. It comprises four levels: Reaction, Learning, Behaviour and Results. A sample of how this model can be applied to is set out in Annex 2.

4.3 Health and development partners working in health emergencies

RCCE practice involves engagement with CSOs active in local health and community initiatives and the public health workforce directly involved in service provision and community outreach. The framework provides these groups with a common lexicon and outlines a uniform approach to RCCE competencies and practices. This standardized approach is intended to empower partners to understand the effective management of health emergencies and the intersection of RCCE and how they can contribute to expected RCCE action through their roles and activities. The framework also delineates the competencies needed to communicate risks effectively and co-create solutions with the communities they serve.

4.4 Health policymakers and officials

Health policy makers and officials at all levels can use the information set out in this framework to deepen their understanding of the role of communities as active, equal partners in public health emergency preparedness and response activities. The framework also serves as a tool to advocate for national RCCE capacity building, to guide policies that facilitate adherence to IHR; and to ensure integration within emergency management structures to increase coordination and collaboration.

4.5 Future adaptations and next steps for the competency framework

This framework will be periodically reviewed and updated to reflect advancements in RCCE research and instructional design best practices. Adaptations will be made based upon the following:

- revisions to IHR benchmarks and reporting tools;

- feedback on the framework's implementation process, ensuring its continuous refinement;

- emerging trends, technologies, and methodologies in RCCE, integrating them into the competency framework as required;

- research and studies on the effectiveness of RCCE practices, using findings to enhance the framework further;

- learner success tracking: monitoring and evaluating the impact of the framework on learner outcomes to inform necessary curriculum adjustments.

The creation of the RCCE Curriculum is based upon the competencies described in this framework. To enhance the practical application of the framework, a suite of tools and learning experiences – including RCCE-specific needs assessments, performance evaluations and structured training packages – are currently in development. These resources are set to be progressively released and to supplement and update existing materials accessible through WHO's digital platforms, such as OpenWHO and the Health Security Learning Platform (HSLP) and the HIVE community platform.

Current WHO learning offerings include scenario and simulation-based trainings, topical and disease-specific modules, preparatory courses for field deployment, and micro-learning sessions. To maintain consistency with this new framework, necessary existing materials will undergo revision. This initiative aims to ensure that learning outcomes are aligned with the competencies described, enabling learners to apply knowledge effectively in real-world settings and to engage in continuous professional development that is responsive to the evolving landscape of global health security.

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6. Selected further reading

This section provides a selection of reference resources to support the development of plans, tools and assessments for RCCE teams in their contextualization and application of the framework. Resources already provided as references within this document are not repeated here.

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Annexes

Annex 1. Foundational models

Additional information about behaviours and practice activities

There is considerable variation in the definitions of terminology used in competency frameworks in the health sector. Figure A1. provides a visual depiction of the key terms and how they relate to each other.

Two key resources provided the foundational framework which describe in informed the structure and approach to developing of the behaviours which are person centric and through which competencies are expressed (1,2). The models present these in conjunction with a core RCCE practice activities and tasks which are ascribed to specific occupational roles (illustrated in Fig. A.2) (1,2).

A given situation might require the integration of multiple competencies, and every competency has the potential to underpin the performance of any practice activities within an individual's role and responsibility. They are embodied by an individual, are non-technical and cross-cutting: they translate across multiple roles, activities and tasks. Competencies can be expressed through numerous behaviours, they are the observable (explicit) components of competencies and encompass (implicit) knowledge, skills and attitudes. The existence of knowledge, skills and attitudes can be inferred from the presence or absence of the associated behaviours demonstrated through the performance of tasks (2,3). The foundational model for this framework presents the characteristics of the key terms adopted as follows (2).

Fig A1. Distinguishing attributes from competencies and activities.
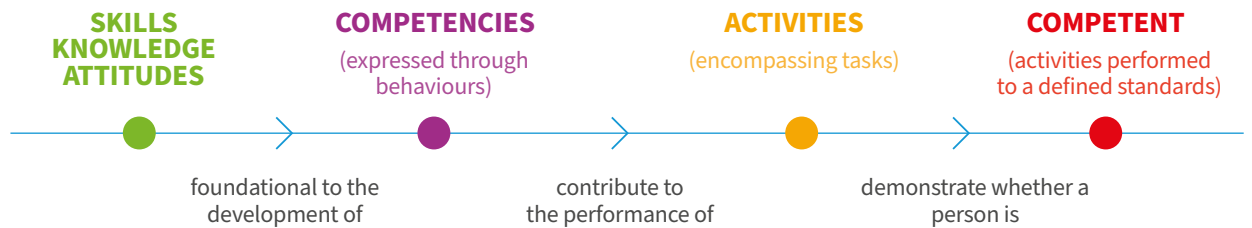
Source: Mills et al. 2020 (1)

Fig. A2. Differentiating between competency (as person-centric) and activity (as role centric).
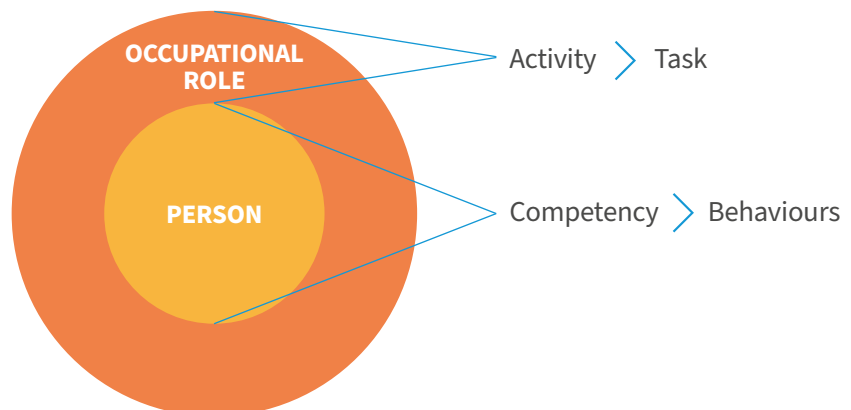
Source: Mills et al. 2020 (1)

Competency

Definition	The ability of a person to integrate knowledge, skills, and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable
Characteristics	• Continuous, ongoing abilities • May develop or erode with time • Enables performance of multiple practice activities • A person can possess a competency • A competency is demonstrated in the context of performance • Requires the integration of knowledge, skills and attitudes • The behaviour demonstrating the competency defines the standard for performance • A competency is multifaceted (demonstrated through multiple behaviours) • Behaviours are the measurable expression of a competency

Practice activity

Definition	A core function of health practice comprising a group of related tasks. Practice activities are time limited, trainable and, through the performance of tasks, measurable. Individuals may be certified to perform practice activities
Characteristics	• Describes the common goal of a group of tasks • Time-limited, discrete actions, observable from start to finish • Requires the application of knowledge, skills and attitudes • A person can perform a practice activity or task, but they cannot possess it • The unit of assessment, certification or regulation

Task

Definition	An observable unit of work within a practice activity that draws on knowledge, skills and attitudes. Tasks are time limited, trainable and measurable
Characteristics	• Time-limited, discrete actions, observable from start to finish • Requires the application of knowledge, skills and attitudes • A person can perform a practice activity or task, but they cannot possess it • The unit of assessment, certification or regulation • A smaller, measurable unit within a practice activity • Does not achieve a goal in itself; is abstract unless considered in the context of the wider practice activity • Performance is measurable on a dichotomous scale (yes or no)

References to Annex 1

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Annex 2. Applying the framework to learning pathways

The Kirkpatrick Model of Learning Evaluation is a widely recognized and applied framework for evaluating the effectiveness of training programmes *(1)*. It comprises four levels: Reaction, Learning, Behaviour and Results:

How the Kirkpatrick Model is used in training and learning experience evaluation:

Level 1: Reaction

At this initial level, the focus is on the participants' immediate response to the training or learning experience. Evaluation methods include surveys or feedback forms filled out by the participants post-training. Questions may cover the training's relevance, engagement level, and the participants' perceived value. This level aims to gauge the overall satisfaction and emotional response of the participants towards the training or learning experience.

Level 2: Learning

The second level assesses what knowledge, skills, attitudes, confidence, and commitment participants have gained from the training. This is typically measured through pre- and post-training assessments, tests, or interviews to quantify the learning outcomes. The goal here is to determine the extent of learning that has occurred as a direct result of the training.

Level 3: Behaviour

This level evaluates the extent to which participants apply what they've learned during training in their everyday work life. Behaviour change is assessed through observations, interviews, or by reviewing performance metrics post-training.

Level 4: Results

The final level measures the impact of the training on organizational goals and outcomes. This could include improvements in metrics associated with each domain or practice activity. Level 4 aims to link the training directly to tangible results and the overall success of initiatives and activities.

In each domain, the Kirkpatrick Model helps to structure the evaluation of training programmes, ensuring that they effectively contribute to the enhancement of RCCE in global health emergency preparedness and response.

To illustrate the application of the Kirkpatrick Model to the behavioural competencies of the RCCE competency framework, examples for each behavioural domain are set out below. This approach can be further elaborated for each domain.

Domain 1: Community-centred approaches

Level 1: Reaction

Participants complete a survey after a workshop which covers community-centred approaches during a health emergency. They rate the session's relevance to their work and express their satisfaction with the interactive components that allowed them to practice community dialogue.

Level 2: Learning

Pre- and post-workshop assessments measure participants' understanding of community engagement/empowerment principles and their ability to identify key community stakeholders in emergency scenarios.

Level 3: Behaviour

Several months post-training, participants are observed facilitating community meetings to discuss emergency response plans, demonstrating their ability to place communities at the centre of RCCE practice.

Level 4: Results

The long-term impact is evaluated by measuring increased community participation in health emergency plans and the establishment of community-led initiatives as a result of the training.

Domain 2: Leadership and decision-making

Level 1: Reaction

Leaders provide feedback on a training event or module which covers leadership and decision-making, for example highlighting the practical exercises in methodical and action oriented decision-making.

Level 2: Learning

Assessments gauge the leaders' ability to apply a methodical approach to decision-making and manage tensions and conflicts constructively.

Level 3: Behaviour

Post-training, these leaders are monitored to see if they exhibit improved leadership and professional conduct during emergencies and/or emergency simulations.

Level 4: Results

The effectiveness of the training is measured by the agency's or ministry's improved response times and decision-making quality during actual health emergencies.

Domain 3: Communication

Level 1: Reaction

After a communication skills training, participants rate the training for its focus on, for example, active listening and purposeful, timely communication.

Level 2: Learning

Participants' skills in active listening and professional communication are evaluated through role-playing exercises and feedback from workshop or training facilitators.

Level 3: Behaviour

In their roles, participants are observed to ensure they are employing the communication techniques learned, such as during press briefings or community outreach.

Level 4: Results

The success of the training is linked to demonstrated public understanding of health communications.

Domain 4: Collaboration

Level 1: Reaction

Feedback from a collaborative skills workshop indicates the level satisfaction in the group activities, for example, those that simulated cross-sectoral partnership building.

Level 2: Learning

The acquisition of collaborative skills is measured through tests that require participants to design a collaborative RCCE plan for emergency response.

Level 3: Behaviour

Participants' ability to cultivate teamwork and build partnerships is assessed in their subsequent collaborative projects with other agencies and community groups.

Level 4: Results

The training's impact is evaluated by the number and quality of new partnerships and the effectiveness of joint emergency response efforts.

Domain 5: Evidence-informed practice

Level 1: Reaction

Reactions to a seminar on evidence-informed practice are collected and evaluated on, for example, collaborating with behavioural science experts.

Level 2: Learning

Participants' ability to assess integrate relevant data is measured through exercises where they must identify how evidence can be used to develop RCCE objectives.

Level 3: Behaviour

The application of evidence-informed practice is observed in participants' work, such as how they incorporate data into emergency response strategies.

Level 4: Results

The ultimate success of the training or learning experience is linked to more data-driven decision-making in the agency's or ministry's emergency preparedness and response activities.

References to Annex 2

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