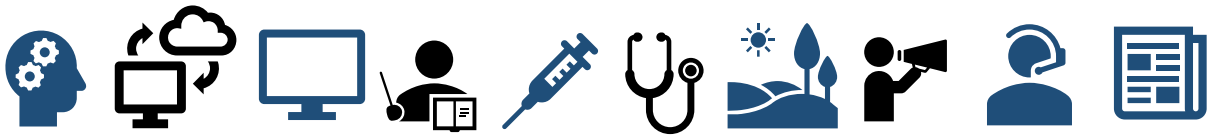
INTERNATIONAL MEDICAL CORPS

COVID19 Risk Communication & Community Engagement: Process and Tools

February, 2021



GLOBAL NUTRITION CLUSTER
Technical Alliance

Acknowledgement

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About the Global Nutrition Cluster Technical Alliance

The Global Nutrition Cluster (GNC) Technical Alliance (previously GTAM) is a common global mechanism endorsed by over 40 Global Nutrition Clusters. GNC partners provide systematic, predictable, timely and coordinated nutrition technical assistance in order to meet the nutrition rights and needs of people affected by and at risk of emergencies. It is led by the United Nations Children's Fund (UNICEF) with World Vision International (WVI) as co-lead. The Alliance Technical Support Team (TST), formerly known as Technical Rapid Response Team (Tech RRT), is led by International Medical Corps and funded by USAID/BHA, SIDA, Irish Aid, UNICEF and Save the Children. More information about the Alliance can be found here: ta.nutritioncluster.net.

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COVID19 Risk Communication and Community Engagement: Process and Tools

Adapted for International Medical Corps from the WHO RCCE Action Plan Guidance

Introduction

International Medical Corps (IMC) has collaborated closely with the World Health Organisation (WHO), the Centre for Disease Control (CDC) and other coordinating bodies to support global CoVID-19 response efforts and maintain ongoing programming in all its sectors (health, nutrition, MHPSS, WASH, Child Protection, GBV and FSL) through business continuity plans. IMC has issued critical disease-control guidance and information to the 7,000 staff in 30 countries where we operate. Risk communication and community engagement (RCCE) has formed a substantial component of the approach. IMC is leveraging community health workers / volunteers in more than 18 countries to disseminate COVID-19 information, promote healthy behaviours, and support community-based surveillance.

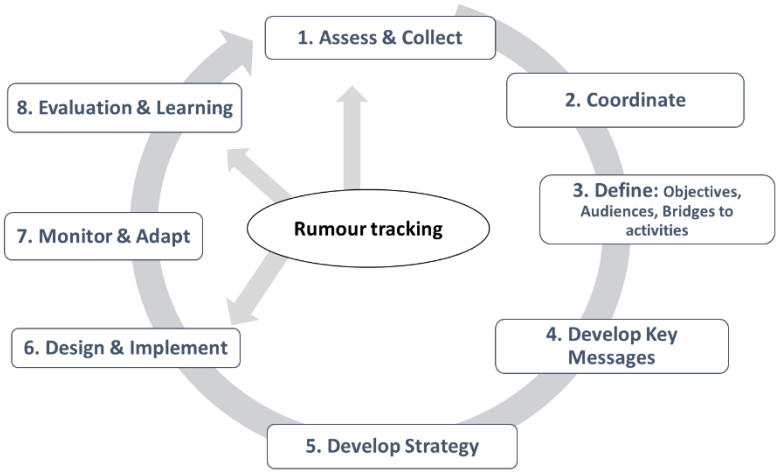
This document is intended to guide IMC staff in-country who are either supervising or themselves acting as frontline workers in communities affected by COVID-19 in developing context specific RCCE action plans. It builds on the WHO RCCE guidance[i] to also integrate social and behavior change (SBC) aspects to ensure maximum impact. The guidance is also based on an initial needs assessment conducted with IMC staff at the country, region and global levels so as to tailor it to the requirements for COVID-19. However, the process is easily adaptable and relevant for other issues that require RCCE.

Underlying principles:

Key principles that need to be kept in mind while developing and implementing the RCCE action plan are 1) People from the communities that we are working with must be active participants in every part of the process and not just passive recipients of messages or information. 2) Coordination with other stakeholders in the area, including government, humanitarian actors and community-based organizations is critical to ensure that we all leverage on each other's efforts and avoid duplication.

RCCE process:

Country/program teams are currently at different stages of providing support to ongoing government efforts to prevent the spread CoVID-19. While it is highly desirable to follow all steps from 1 to 8 as shown in the figure and mentioned below, it is probably more practical to expect that teams are able to identify which steps are already covered and the most relevant step to start from to use the corresponding tool/s based on the status of CoVID-19 related work in the country to strengthen ongoing efforts. The key recommended steps adapted from the WHO guidance are:



1. Assess and collect: While this is a recommended first step, ***it is not a one-time activity***. Especially during a pandemic where the situation is dynamic and we are constantly learning new things even on the technical aspects, it is extremely important to keep listening to what the people in communities are talking or hearing about the disease so as to be able to act on time to address any concerns, misinformation or rumors. We need to understand how perceptions of COVID-19 are evolving, the practices around COVID19 prevention, and factors influencing behaviors, to identify trusted influencers and active community network/groups, and how people's daily life is affected during COVID19 crisis (e.g. access and utilization of health services, GBV, transportation, their feelings about the pandemic – fear, anxiety, stress) , and finally, to identify preferred communication channel and possible media for remote engagement. This will also help in regular identification of barriers to behavior change that need to be addressed and enablers that can support our efforts. The following three sub-steps are therefore recommended:
   a. The team identifies what information is already available from recent surveys/rapid assessment and what other information needs to be collected, using the tool provided at ***Annexure I***[ii]
   b. Based on the information required, adapt the tool at ***Annexure II*** to conduct a rapid assessment. The tool can be adapted for focus group discussions (FGDs) as well as in-depth interviews (IDIs) and conducted as face-to-face or remote activities (e.g. phone interviews). However, questions asked during these interviews should be specific for the people being interviewed. For example, a District Health Officer or Health Facility Manager should have different questions than a community member as their perspectives and input are different. The number of FGDs/IDIs would depend on a range of factors, however, in general, it is important to have at least two FGDs from each area that is socio-culturally distinct and IDIs with at least two each from the key influencer groups such as community leaders, service providers and religious leaders.
   c. To ensure that we are continuously listening to the communities, identify a mechanism for regular dialogue with the community and recording of information from the field as well as the frequency in which the information will be collated. A sample tool to collect the information, which can be adapted to each program context is at ***Annexure III*** and a tool to collate and keep track of the rumors (Rumor tracking tool) is at ***Annexure IV***[iii]. This ongoing conversation can also provide an additional entry point to collect feedback/complaints and increase accountability.

2. Coordinate: Most, if not all country teams are part of an existing coordination mechanism to engage with stakeholders on different aspects of addressing CoVID-19, including on RCCE at all levels of the response: local, regional and national. The stakeholders include health authorities, ministries and agencies of other government sectors, international organisations (WHO, UNICEF, IFRC, MSF, etc.) NGOs, academia, and cover a number of sectors (Health, Nutrition, Protection/GBV, MHPSS, WASH). To ensure synergy in the RCCE plans with all stakeholders, leverage on the work being done already and avoid duplication, it is recommended to identify key stakeholders to be part of the process of RCCE strategy development, right at the beginning. Develop and maintain an up-to-date contact list of all partners and their focal points. Maintain contact with relevant focal points on a regular basis and take into consideration any studies being done by others in the area. Ideally, the focal points should be engaged in the process from steps 3 to 7. However, in case it is not feasible to do so, the draft strategy, once developed, can be shared with the focal points for their inputs (e.g. contribution to mapping of available services/initiatives and criteria to access support).

3. Define: Findings from the information collected form the basis for defining and prioritizing objectives, framing key messages and identifying the bridges to activities or what we need to aim to achieve from different sets of activities.
   a. **Objectives:** To integrate SBC in the entire process, it will be essential to include objectives that specify the behaviors that need to change, rather than restricting risk communication to information dissemination. The objectives also need to be prioritized based on the findings. For example, if the findings show that of the key COVID prevention behaviors, there is lack of conviction that wearing masks in public places is necessary or if there is a stigma against people wearing masks, it will be critical to address this behavior as a priority since it has direct implications for CoVID prevention. Similarly, if there is a stigma against going to health centers for fear of contracting CoVID-19, that will impact the health seeking behavior and should hence be included as a priority objective. Sample objectives that can be developed/adapted are included at ***Annexure V.***
   b. **Priority audiences and preferred channels:** To ensure that our communication is effective, it needs to be tailored to specific audience segments. The messaging and selection of channels and activities can then be based on the preferences, barriers and enablers for these audience segments. Because we are looking at a public health matter, the objective is to reach everyone. Consider developing specific communication actions for audiences with special needs. See ***Annexure VI*** for guidance on the different groups to be considered and prioritized for CoVID-19 prevention behaviors, and selection of preferred channels for communication for each audience group based on findings from step 1. The channels need to be considered credible, they must be easy to access for the identified audience groups, affordable within project resources and provide scope for interaction.
   c. **Bridges to activities:** Barriers and enablers identified in the first step, will help determine the bridges to activities. Defining the bridges to activities also helps in developing more focused messages and specific activities that will help address the barriers identified. The SBC framework with an example filled in for reference, is included at ***Annexure VII***[iv].

4. Develop key messages: An overall set of key messages and sub-messages can be first developed based on the barriers and enablers identified in step 1. The team developing messages must refer to any corresponding messages already in place by the Ministry of Health or WHO to ensure technical accuracy and alignment. However, it is extremely important to ensure that the messages are tailored to specific socio-cultural contexts. Contextualizing the messages would hence include more than just translation in local languages or use of visuals that appeal to people locally – it will need to include an understanding of how people perceive the messages that they are already receiving, what are the religious and social influences on the identified audiences. For example, if the community has strong religious sentiments and believes that they are safe from CoVID19 because they drink the holy water or pray regularly, messages that only convey the scientific rationale for CoVID19 prevention, will not be effective. The strategy will need to create a narrative that is coherent with the views and values of the believers. It is also recommended to include messages on normalizing some of the expected stress reactions that people may face, e.g. allowing for initial stress, anxiety, anger, shock and resistance to hearing about this. As it is usually required, all materials developed based on the key messages will need concurrence/approval by the MoH. A sample matrix that can be used to develop key messages based on findings from the field, is included at ***Annexure VIII***[v].

5. Develop RCCE Strategy: Use the tool at ***Annexure IX*** to bring together the different elements of the RCCE strategy that has been worked out in previous steps. It is recommended that the strategy development should be done in a workshop involving representations from all key stakeholders identified in step 2. Of the stakeholders, representation from the communities we work in (community leaders or other influential) will be the most critical. The workshop can be conducted over a day, where-in inputs will be sought on objectives, priority audiences, messages and activities developed in the previous steps. The workshop would also include discussions to identify areas for collaboration among partners. Components of the RCCE strategy will include the following:
   a. **Context:** Give a brief description of the socio-cultural context, the status of CoVID-19 in the area/region/country and the studies referred to or carried out in the area. Here we will also mention what we have found from the formative research – what proportion of people in the community are aware about the signs and symptoms as well as prevention measures, what are the perceptions of people on critical gender dimensions as well as mental health aspects, what are some of the common myths, misconceptions and rumors in the area. Include any nutrition related aspects also, including misconceptions/beliefs surrounding food handling, what to or not to eat, infant and child feeding etc.
   b. **Objectives:** State the RCCE objectives identified in step 2.
   c. **Audience:** List the audiences identified in step 2, divided into primary audience groups (those who are the focus for adopting the desired behavior) and secondary audience groups (those who influence the behaviors being promoted). Add further description of the audience groups – demographic, socio-cultural and lifestyle details that are likely to impact CoVID-19 prevention behaviors.
   d. **Action plan:** An expanded version of the behavior change framework that includes key messages, activities/channels/tactics, responsibilities and timeline can be found at *Annexure IX.*
   e. **Monitoring activities and tracking rumors:** Identify how will each activity be monitored and evaluated and by whom. Include a mechanism to collect feedback from the field on a regular basis to track rumors (using tool at ***Annexure IV)***, develop a rumor tracking log (sample at ***Annexure V)*** and use the information to tweak/redesign the messaging as required.

6. Design and implement: A first step after the RCCE strategy is finalized, would be to work out details of each activity planned and begin designing the communication materials required. Aspects to be considered while detailing each activity are:
   a. **Making sure the activity includes two-way communication**. Where mass media channels are being used, extensions of the activity at the community level can be planned. So, if it is a radio talk show, CHWs can inform the community in advance and encourage them to phone in to ask questions; listener groups can be created where people gather together to listen to the program and have a brief discussion after the program etc. If there are mass sms being sent out, ensure there is a contact number or hotline included in the message for two-way communication, etc.
   b. **Linking activities for maximum impact**: Every activity can be linked to at least one other activity to increase effectiveness. Examples mentioned above are also ways to link the mass media with community level activities. Another example would be – using radio to ask specific questions about what people are hearing and believing about the CoVID-19 pandemic (as done by Africa Voice Foundation in their program *Imaqal*); collating the responses with information around

questions being asked on a hotline and developing messages to address the concerns, questions or misconceptions through both radio and at the community level through CHWs.

c. **Ensuring effectiveness of communication materials**: A key point to remember is that information or knowledge alone does not change behaviors. To be effective catalysts for behavior change, communication materials need to address the local barriers or build on the enablers. Gender considerations are also non-negotiable and communication should not reinforce harmful stereotypes nor stigma. The checklists at ***Annexure X***[vi] can be used to ensure that the materials are designed to be effective and include gender considerations.

d. **Coordination – internal and external**: All team members involved in implementation of the strategy need to be brought on the same page, especially the field level staff. A separate training on rumor tracking and asking appropriate questions to be able to listen to rumors, would be essential for the field staff. It is also recommended that the trainings planned should include a component on normal stress reactions so that they can assess the communities' stress reactions and work with that when they are messaging etc. In addition, external coordination with partners must also continue on a periodic basis.

7. Monitor, track changes and adapt: Develop tracking tools to monitor each activity in the RCCE action plan. The tool needs to track whether the activity was done on time, quality of implementation, challenges if any and immediate response to the activity. Regular analysis (at least monthly) of the monitoring will help identify any red flags that need to be addressed around miscommunication, stigma or rumors that can influence behaviors.

8. Evaluation and learning: Develop an evaluation and learning plan as part of the RCCE strategy (step 5). Establish a baseline (for example, note the level of awareness, knowledge of a community and link to current practices at the time before the RCCE plan is implemented). Measure the impact of the RCCE strategy by analyzing changes in the baseline during and after RCCE strategy activities are implemented. Document every step of the strategy development process and implementation to capture the successes but also to learn from what did not work.

Finally, it is essential to remember that the situation, especially during a pandemic, is constantly changing. It is hence very important to treat the RCCE strategy as a living document that will need continuous updating and modifications based on the changing realities on ground. A periodic review of the strategic elements, ideally at least once a quarter, should be carried out to ensure its relevance.

Annexure I - Formative research: Summarizing the information and knowledge gaps

This tool should ideally be used after a desk review of all data/information available on a topic.

Key decisions	What do we currently know? (Available data)	What do we need to know? (Information gap)
What is the problem or challenge?		
Who do we need to reach?		
What behaviors do we need to promote to address the problem/challenge?		
What are they currently doing? (with reference to the behaviors being promoted, how is the community perceiving the communications)		
What barriers do they face to perform the proposed behaviors? (including feelings of stress/fear/anxiety that may impact behavior and wellbeing)		
How does gender impact the proposed behaviors?		
What benefits and motivations do they have (or need) to adopt the proposed behaviors? (from their perspective)		
What are the social norms that act as a barrier for the proposed behavior?		
What are the social norms that can be enablers for the behavior?		
Which channels/media are the most trustworthy and popular among the people we are trying to reach?		
What are other partners in the area doing to promote the behaviors? How do we coordinate with the partners?		

Filled in Sample: This is an example that is not based on any real context, just as a sample for the information to be filled in. The column on 'what we currently know', should come from a desk review of existing studies or experience of the field staff in the absence of any recent study.

Key decisions	**What do we currently know? (Available data)**	**What do we need to know? (Information gap)**
What is the problem or challenge?	Increasing cases of COVID-19 in the country	Status of COVID-19 in our project area (may already know this)
Who do we need to reach?	Key influencers in the community who can set the trends	Who are these influencers in the community and how does one reach them
What behaviors do we need to promote to address the problem/challenge?	Keeping a safe distance from people in public places Wearing a mask appropriately in public places	What are the bridges to these behaviors – what makes it difficult or easy to keep distance and wear a mask
What are they currently doing? (with reference to the behaviors being promoted, how is the community perceiving the communications)	People in the community are not adhering to physical distancing and wearing masks	What prevents them from adopting these behaviors in spite of knowing the benefits. What motivates those who are following the practices – how do they overcome the barriers?
What barriers do they face to perform the proposed behaviors? **(including feelings of stress/fear/anxiety that may impact behavior and wellbeing)**	Lack of space in markets for physical distancing Feel they cannot afford masks and not convinced about the need to wear it They fear that if they wear masks, people will think they are infected	What can be done to ensure physical distancing in public places? What safe and affordable or free options are available for masks? What is a credible way to convince people about the need? What are the people feeling about the pandemic – what are the stresses/fears/anxiety if any?

How does gender impact the proposed behaviors?	Not known	Does gender impact the proposed behaviors?
What benefits and motivations do they have (or need) to adopt the proposed behaviors? (from their perspective)	Not known	Identify benefits and motivations
What are the social norms that act as a barrier for the proposed behavior?	Greeting people warmly with a physical embrace Buying fresh vegetables everyday (hence getting exposed to crowded places everyday)	What other social norms act as a barrier?
What are the social norms that can be enablers for the behavior?	Caring for the health of older people is given due importance in respectable families	Are there other norms that can be enablers?
Which channels/media are the most trustworthy and popular among the people we are trying to reach?	Radio, whatsapp, mobile loudspeakers, local newspapers, CHWs/Hygiene Promoters, Health Service Providers	No further information required
What are other partners in the area doing to promote the behaviors? How do we coordinate with the partners?	Have a strong radio program that they are using as a platform for collecting information on rumors (should include all known efforts by partners)	How do we complement the efforts and use the information gathered by them?

Annexure II - Rapid Qualitative Assessment FGD Guide for Community Perspectives on COVID-19

Names of the facilitators: _____

General introduction:

Hello everyone, my name is_____ and this is my colleague_____. As you know, we work for _____ and today, we want to discuss what people in your community are saying about the coronavirus disease. We will not collect your name, and all information we write down will be anonymous. We want to use this information to plan a response to the new coronavirus and make sure people receive useful information that answers their concerns and fears. At the end of the discussion, we will try to answer your own questions about the disease. Since this is a new disease, we might not have all answers, but we will try our best and get back to you with accurate answers in case we don't know. Our discussion will last around 60 minutes.

Before we start, we need your permission

Consent:

1) Do you agree to us taking notes, and using the information we gather (that will be anonymous)?

☐ YES (all agree) ☐ NO (if NO, thank those individuals for their time and allow them to leave)

2) Do you agree to us taking and using your photos for example in reports or on the website?

☐ YES ☐ NO (If NO, do not take photos of the person/s at any time)

Location (District/block/village): ……

Number of participants: Women …… Men …….

Community Leaders (if any)

Description of participants (e.g. mothers of children <2 years or Fathers or caregivers etc.)

……

1. What have you heard about the coronavirus disease? (Facilitator to list all points mentioned by the participants, in relevant rows in the table below, probe for what else have they heard. If specific aspects mentioned below do not come up in the response, these should be probed. Make a note if there are people in the group who have not heard about it or have heard very little)

How do people get infected/how does it spread?	
What are the signs and symptoms?	

What happens when a person is infected (how dangerous is it?)	
How can people protect themselves from being infected?	
What should someone do if they suspect that they may have got infected?	
Any other information that they may have heard	

2. You have shared information that you have heard about coronavirus. Which information do you believe in completely and which do you have some doubts about? Why do you have the doubts?

……
……
……
……

3. Where have you got this information from? (Tick all sources that are mentioned and specify if any other mentioned) For each source/media, fill the following columns:

Source	**Access** (Is it easy for them to get information from this source or is it difficult?)	**Credibility** (Do they think this source gives correct information or do they doubt the information from this source?)
Mass Media ☐ Radio ☐ TV ☐ Newspaper/magazine **Social media platforms** ☐ WhatsApp ☐ Facebook ☐ Instagram ☐ Other **Outdoor media** ☐ Billboards ☐ Posters ☐ Mobile miking (announcements made by a mike on a moving vehicle, e.g. Sound truck)		

☐ Use of Megaphone (used by volunteers or people dedicated to public announcement) **Individuals** ☐ Health unit/Health care worker ☐ Family members		
☐ Friends ☐ Community health workers ☐ NGOs and other charities ☐ Community leaders ☐ Religious leaders ☐ Phone sms/voice message ☐ Any person from the community Other, specify……		

4. Are there any doubts or fears or questions about the disease that are still unanswered? If yes, what are they? (probe specifically for fears)

……
……
……

5. How would you treat a person in your neighborhood who gets infected with the virus?

……
……

6. How would you treat a person in your neighborhood who has recovered from coronavirus?

……
……

7. Is there any other information that you would like to share with us?

……
……

8. Do you have any questions for us? (Make a note of all questions asked. Respond in detail only if you are sure of the response and it is from a credible source/as per the government guidelines. Otherwise, please say that you will check and get back to them with the response – and do so at the earliest)

Annexure III - RUMOUR TRACKING FORM

This form is taken from the Internews Rumour Tracking Methodology, which does not use questionnaires but unstructured and informal conversations open questions such as asking what challenges community members are facing, what information they need, what they have heard but not seen, or information they have heard that they weren't sure of etc.

Ideally this form is set up and used via mobile data collection with Kobo toolbox/ODK. Use dropdown menus for location, age range, gender, protection, answered directly and referred sections and a tick box for consent.

Rumour Tracking Form		
Community correspondent/liaison officer name:		
Date:	Location:	
Asked for consent?	Gender:	Age range:
Community data (feedback, rumours, questions etc…) as verbatim as possible:		
Is this a protection-related complaint? yes / no / unsure		
Did you give an answer directly: yes / no		
Did you refer the person to another organisation (if yes, write which one):		

Annexure IV - MASTER FEEDBACK/RUMOUR TRACKING TABLE

for managers or identified feedback focal points

This is only part of the table for ease of reference but a formal excel template including all columns can be found at: https://internews.org/rumour-database

Date received	Name of staff or volunteer who received complaint/feedback	Location	Individual or group?	Sex	Age	If group: number of people in group; age range; gender	Community data (rumours, concerns, questions, etc.)

EXAMPLE RUMOR LOG

NB: This tool was adapted from the CDAC Network's *Rumor has it: A practice guide to working with rumours*[vii], 2017

Date	Location	Rumor	Channel	Risk rating	Verification status	Engagement activities	Monitoring outcome
When was the rumor heard?	*Where was it heard?*	*Details of the rumor*	*How was the rumor heard? How is it being spread?*	*Low Medium High*	*True Untrue*	*Details of who, what, when, where and how you engage the community*	*Has the rumor stopped?*
15/1/14	XYZ province, Vietnam	Outbreak of Covid-19 among school children, prompting parents to keep their children at home and out of school	Reports from school officials	Medium	Untrue – there was an outbreak of seasonal flu in one school, verified by medical professionals and responders	Held online and in person forums with school administrators, teachers and parents to address concerns and to build confidence; worked with MOH to build a hotline to address parent's questions; aired broadcasts with parents of children with seasonal flu to refute rumor; addressed rumor on the MOH "reality check" website; distributed messages to mobilizers, to address rumor if it is repeated.	Ministry of Education reported an increase in school attendance as of 15/1/30

Annexure V - Defining and prioritizing your RCCE objectives

Identify objectives that best define what is required to be achieved within your specific context. This will be based on findings from step 1 regarding the status of behaviors related to CoVID-19 prevention. For long term interventions, the objectives can be broad, such as increase in the proportion of people adopting CoVID-19 prevention measures. However, it is useful to develop short term specific objectives, which in turn help in making the RCCE strategy and activities more focused. Some examples of objectives that can be reviewed and adapted to different contexts are given below. The important part is to ensure that the objective is related to a behavior and not 'awareness generation' or 'increase in knowledge' as that will only be a first step towards behavior change. Further, as many studies have already shown, knowledge about CoVID-19 prevention behaviors is quite widespread owing to the initial information dissemination efforts, however, it is changing behaviors that is still a challenge that needs to be addressed.

Broad Objective:

- To increase the proportion of people in ……(project area) adhering to COVID-19 prevention measures by …….. (year)

Specific Objectives:

- To increase % of people adhering to physical distancing norms and wearing masks in public places for COVID-19 prevention in …….. (project area) by…….. (year)
- To increase proportion of young people adhering to wearing masks in public places (*if the data shows that most young people are not adhering to this behavior*)
- To increase the proportion of women and men living with older people or those with vulnerabilities adhering to prevention measures (define this) in …….. (project area)
- To increase proportion of vulnerable population (define this based on the project area) adhering to prevention measures (describe specific behaviors in the footnote)
- To increase proportion of health staff adhering to CoVID-19 prevention protocols in health centres *(if findings indicate this is not being done)*
- To increase % of mothers with children < 6 months old, exclusively breastfeeding with adequate precautions for prevention of CoVID-19
- To increase % of pregnant women accessing ANC services at health facilities while adhering to COVID-19 prevention measures
- To reduce stigma against Health Care Workers (HCWs) (reduce % of people who believe that HSPs spread COVID-19 and hence should be avoided)

Prioritize your objectives based on the situation on ground, the resources available to you and the time by when you aim to achieve the objectives (project time period in case this is a specific project). As far as possible, it will be productive to identify objectives that are aligned to other project initiatives that you are implementing in the area. Review objectives regularly, asking if the communication products and activities you are developing are serving these most important priorities. If they are not, consider expending more energy on high priority objectives or changing your objectives (if circumstances have changed). A phased-in approach to your plan should also be considered.

Annexure VI - Defining and prioritizing your RCCE audiences and other stakeholders

Who are your audiences, partners and other stakeholders?

Consider the categories of people who must be engaged in order to achieve outbreak control.

- Which are the groups most at risk?
- Who are the influencers, gatekeepers, decision makers and practitioners in the different communities that must be engaged to mobilize interventions?
- What other government sectors need to coordinate engagement and communication activities with your health authorities?
- Who are the local partners who will need to respond to requests for support?
- Are there some groups more difficult to reach or with less access to information (e.g. minorities who does not speak the main language, people with disabilities, etc) that require a specific communication action?

Under each category, identify specific groups, government units, types of individuals in your country who you will need to engage to achieve your objectives.

Add categories for key audiences, partners, and stakeholders who are important to your country that may not be included in the list below.

- All people at-risk of acquiring COVID-19, for example: elderly, people with underlying health conditions, health care workers, travellers, etc.
- Stakeholders and partners:
    - Key policy-makers (who provide funding or create legislation related to public health)
    - Other relevant government sectors (such as education and transportation)
    - NGO partners (who may have strong relationships with at-risk groups)
    - Community leaders and organizations
    - Religious leaders
    - International organizations
- Health-care providers (e.g. physicians' organizations, hospitals, community health centers)

What channels or engagement strategies can you use to share important information and guidance?

Identify channels and platforms that audiences use to seek health information and partners who regularly communicate with these groups. Refer to your studies/analysis in step 1 of this process.

For example:

Some channels that might reach broad national audiences: mass media, radio listeners club, daily emissions addressing different topics with open mic for public calls, social media platforms such as Twitter and Facebook.

Policy-makers and influencers might be reached through weekly engagement meetings with religious,

administrative, youth, and women's groups.

Individual communities might be reached through theatre performances engagement meetings with

women groups, edutainment, H2H activities, youth groups, training of peer educators, etc.

Ensure your organization has relationships and agreements with relevant partners and access to identified and trusted media channels including:

- Broadcast media: (television and radio)
- Trusted organizations' websites
- Social media (Facebook, Twitter, etc.)
- Text messages for mobile phones
- Hand-outs and brochures in community and health centers
- Town forums
- Community health boards
- Billboards

Plan to tailor key information and guidance to stakeholders and disseminate it through their preferred channels and trusted partners.

Annexure VII - Sample Behavior Change Framework

Behaviour	Priority group	Barriers and enablers from formative research	Other research findings	Bridges to activities	Activities
Adoption of CoVID-19 prevention measures by young people, especially wearing of masks in public places	Young people in the age group of 19 to 35 years	Young people feel they will not be infected with COVID-19, only old people and those with health conditions get infected so they don't adhere to wearing masks in public places	Knowledge levels of prevention behaviors is high but practice of the behaviors is low	Increase the perception that anyone, including young people could get infected with COVID-19	Testimonials from young people who have got infected. Through radio, phone messages, social media
Adequate physical distancing, wearing masks and washing hands regularly with soap for at least 20 seconds	Women and men who are in the vulnerable category for CoVID-19 (people with co-morbidities, older people)	A common perception in the community is - I have not heard of anyone known to me getting infected with COVID-19 so I don't need to take any precautions	Regular social gatherings in the community as part of cultural practices – fear of offending people in the community if they do not participate in the gatherings	Increase the perception that COVID-19 is a real threat even though numbers may be low in our area	Stories of neighboring areas where COVID-19 cases are on the rise (while lauding the efforts made in our area). Radio, social media, Local Leaders, group sensitization
Adoption of COVID-19 prevention measures	All women and men in reproductive age (15-49 yrs)	A common perception is that this is a disease that foreigners get, our people are immune to it	The people also believe that if they don't have symptoms, they are fine	Increase knowledge that asymptomatic cases of COVID-19 exist, who can spread the virus without even knowing	Messages from Doctors providing information on asymptomatic cases, testimonials from asymptomatic patients using radio talk shows

Annexure VIII - Message Development

Identify barriers and benefits of the desired behaviour

BENEFITS	**Audience 1**	**Audience 2**	**Audience 3**
Current situation:			
According to your target audience, what are the actual, perceived, or valued benefits of the behaviour?			
What encourages or supports the adoption or maintenance of the behaviour?			
• What **biological or physical** aspects?			
• What **psychological** aspects? (e.g. knowledge, attitude, awareness, skills, motivation and emotions)			
• What **social** aspects?			
• What **environmental or societal** aspects?			
Future situation:			
What additional incentives or rewards might assist the adoption or maintenance of the behaviour?			
BARRIERS			
Current situation:			
• What limits or restricts the behaviour?			
• What **biological or physical** aspects?			
• What **psychological** aspects?			
• What **social** aspects?			
• What **environmental or societal** aspects?			

Based on the information collated in the table above, develop the key messages specific to each audience, in the matrix below. Every message must either address a barrier, convey a benefit that is

considered important/attractive to the intended audience or do both. The following are some tips to keep in mind while developing the messages:

- Grab the audience's attention with something or some aspect that is appealing
- Appeal to the rational and irrational (i.e. the head AND the heart)
- Keep it simple
- Tell them what you understand will be acceptable in the cultural context
- Make sure the audiences trust you; use people/testimonials/influencers and channels they trust
- Ensure consistency at all time
- Have a call to action

(to add an example for CoVID-19 here)

Objectives	**Audiences**	**Key Messages**

Please note: It is critical to ensure that the messages are technically aligned with those of the Ministry of Health and WHO. Materials developed based on the key messages, should ideally be approved by the MoH/RCCE Working Group depending on what is mandated in the country.

Annexure IX - RCCE Action Plan

Objectives	Priority group (Audiences)	Key Messages	Bridges to activities	Activities	Timeline	Monitoring	Responsibilities

Annexure X - CHECKLIST FOR CREATIVES AND MATERIALS

Component	Questions	Yes	No
Accurate	Have experts reviewed the message content to ensure it is scientifically accurate?		
Consistent	• Do all messages in all materials and activities reinforce each other and follow the creative strategy?		
	• Do visual campaign elements/different materials have the same or similar graphic identity (Print materials use the same or compatible colors, types of illustrations/photographs, and typefaces. All materials include the program's logo or theme/tag line, if applicable)?		
Clear	• Are the messages simple and appropriate for audience?		
	• On print materials are there prominent visual aids such as photographs or typography that positions message well and reinforce messages to help the audience understand and remember them?		
Relevant	• Do the messages state benefits of the recommended behaviour that the audience will value? For example, emotional benefit (e.g. your baby will be healthier). Does this match formative research insights and suggested positioning?		
	• Is the presentation style of messages appropriate to the audience's preferences (based on formative research findings)? For example, rational versus emotional approach, serious versus light tone.		
	• Do the messages keep in mind regional differences, ranging from the language and dress of people portrayed in materials to the health care delivery mechanisms?		
	• Do the messages and materials address key barriers identified from the formative research?		
	• Do the messages suit the readiness of the audience to make a change?		
Credible	• Is the selected messenger/channel a credible source of information for the audience?		
	• If celebrity spokespeople are the messengers, have they been carefully selected? (Ideally, they should be directly associated with the message and practising the desired nutrition behaviour.)		
Appealing	• Does the creative treatment in materials stand out and draw the audience's attention?		
	• Is the tag line appealing from the audience's perspective and easy to remember?		
Call to action	• Do the messages clearly state the action that audiences should take?		
Gender sensitive and inclusive	• Messages do not reinforce inequitable gender roles or stereotypes.		
	• Message does not create stigma against a group of people. (e.g. people of a specific nationality/ethnic group, or profile – drivers, health workers etc.)		
	• Messages and materials include positive role models that will appeal to both men and women.		
	• Messages, materials, and channels/activities are appropriate for the needs and circumstances of both women and men. In particular, they consider differences in workload, access to information and services, and mobility.		

References

[i] https://www.who.int/publications/i/item/risk-communication-and-community-engagement-(rcce)-action-plan-guidance

[ii] Adapted from https://nutritionintl.org/wp-content/uploads/2019/02/BCI_Tool-kit_Digital_NI_2019.pdf

[iii] Source: https://internews.org/sites/default/files/2019-07/Rumor_Tracking_Mods_3_How-to-Guide.pdf

[iv] https://yourwaytobehaviourchange.org/a-step-by-step-process/

[v] Adapted from https://nutritionintl.org/wp-content/uploads/2019/02/BCI_Tool-kit_Digital_NI_2019.pdf

[vi] Adapted from https://nutritionintl.org/wp-content/uploads/2019/02/BCI_Tool-kit_Digital_NI_2019.pdf

[vii] http://www.cdacnetwork.org/tools-and-resources/i/20170613105104-5v7pb