WHO-EM/IHR/015/E

Regional guiding framework for risk communication and community engagement for the COVID-19 response in the Eastern Mediterranean Region/Middle East and North Africa

December 2020

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PREFACE

One year into the COVID-19 pandemic, our Region is reflecting on the many challenges that have been endured and the daunting effort still required of us individually and collectively. A key lesson is that it is absolutely critical to engage communities and ensure that they trust public health advice.

Risk communication and community engagement (RCCE) efforts recognize that communities can be active agents of change. With the right support, they are well placed to assess risk and identify locally appropriate and sustainable solutions. While "informing" or "consulting" communities has long been a routine part of health programmes, RCCE entails genuine engagement with communities and building local capacity and ownership for the long term.

This Regional RCCE Guiding Framework is a product of collaboration by the Regional RCCE Interagency Working Group, co-chaired by the World Health Organization, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC). The framework emphasises the need to localize our efforts, to move beyond the idea of a single national response and towards *coordinating multiple simultaneous responses* that reflect deeper understanding of the needs of different parts of each community, in collaboration with communities themselves.

Throughout the pandemic, a diverse range of knowledge, skills and other resources has been mobilized within communities, the private sector, different levels of government, and among international and local cooperating partners. Our role in supporting critical connections between communities and public health structures and demanding more sustainable and institutionalized approaches is more important than ever as we strive to capitalize on the hard-won gains already made. We encourage country teams to use this Regional RCCE Guiding Framework to go beyond traditional approaches and join hands with communities as co-designers of a COVID-19-safe future.

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PURPOSE OF THE FRAMEWORK

This document outlines a framework to guide risk communication and community engagement (RCCE) outlines RCCE components of coronavirus disease (COVID-19) prevention, preparedness and response for countries in the WHO Eastern Mediterranean Region[1] and UNICEF's Middle East and North Africa region[2]. It is intended for use by national authorities and partners to strengthen the RCCE component of the national COVID-19 response. As such, the framework accepts that the challenges posed by COVID-19 will not be brought under control by short term remedies alone, but rather that longer term measures are needed to bolster intersectoral synergies that will help communities navigate not only COVID-19, but a range of secondary health impacts and indirect socio-political and economic impacts as well – towards living with a "new normal". The document does not provide step-by-step guidance on how to develop and implement RCCE plans for COVID-19; this can be found in the COVID-19 RCCE action plan guidance on COVID-19 preparedness and response *(1)*. Nor is it a "how-to" guide for RCCE. Rather, it is intended to complement other resources already in circulation that provide more detailed information on RCCE, including case studies and other resources *(2,3)*. To this end, extensive referencing appears throughout this document, with hyperlinks wherever possible for convenience. Developed by the Regional RCCE Interagency Working Group, this guiding framework reflects current knowledge of the COVID-19 outbreak and previous experience in the response to other respiratory pathogens and public health threats of international concern *(4,5)*. It is also informed by evidence collected from the Joint External Evaluation (JEE) of the International Health Regulations (2005) (IHR) in the WHO Eastern Mediterranean Region between 2016 and 2019 *(6)*, as well as COVID-19-specific institutional assessments conducted by the UNICEF Middle East and North Africa Regional Office and the WHO Regional Office for the Eastern Mediterranean between March and May 2020 in a cross-section of countries (Annex 1).

The framework supports a multisectoral approach that can address the widespread and enduring primary impacts of the COVID-19 pandemic as well as the secondary socio-political and economic impact experienced by every country in the Region. In so doing, a range of mandates, policies and partner capacities will need to be harnessed, guided by the human rights-based and evidence-based approaches embraced by various relevant international conventions and treaties including the UN Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of Persons with Disabilities (CRPD), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their families (MWC), The Global Compact for Safe, Orderly and Regular Migration (GCM), and International Covenant on Economic, Social and Cultural Rights (ICESCR). All of these instruments highlight the importance of information-sharing, awareness-raising, communication and participation for men, women, families, communities, service providers, migrants, refugees, internally displaced persons (IDPs) and vulnerable groups, among others, to mitigate their risks and vulnerabilities and build self-efficacy and resilience across a range of development and humanitarian contexts.

[1] For countries in the WHO Eastern Mediterranean Region see: Countries in the WHO Eastern Mediterranean Region. Cairo: WHO Eastern Mediterranean Region; 2020 (https://www.who.int/about/regions/emro/en/, accessed 6 September 2020).

2 For countries in the UNICEF Middle East and North Africa region see: Countries in the UNICEF Middle East and North Africa Region. Amman: UNICEF Middle East and North Africa Region; 2020 (https://www.unicef.org/mena/where-we-work, accessed 6 September 2020).

> *"…Strengthen community engagement, empower individuals, and build trust by addressing mis/disinformation and providing clear guidance, rationales, and resources for public health and social measures to be accepted and implemented…"*
>
> IHR Emergency Committee, 1 August 2020

WHY IS RCCE IMPORTANT?

On 30 January 2020, the WHO Director-General determined that the outbreak of coronavirus disease (COVID-19) constituted a Public Health Emergency of International Concern and confirmed its continuation on 30 April 2020 *(7)*. Countries of the Eastern Mediterranean Region/Middle East and North Africa region are at different stages of the transmission of the virus *(8)*. Countries have implemented several policies and public health measures, including promoting a range of hand and respiratory hygiene measures, decontamination practices and other mitigation measures, such as social distancing and restricting movement, to reduce human-to-human transmission (see Annex 2). As the pandemic persists over time, pressure is increasing to relax these measures to varying degrees, despite ongoing transmission of the infection. As part of a coordinated response, RCCE can directly assist in helping countries to continue to drive down COVID-19 cases, while simultaneously learning to live with COVID-19 in the longer term.

The effectiveness of the response relies on public trust and compliance with advice on specific hygiene practices and broader public health measures – both of which are important functions of RCCE *(2)*. Community engagement is defined as a process of developing relationships that enable people of a community and organizations to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes *(9)*. Risk communication is defined as a multi-level *(10)* and multi-faceted process which aims to help stakeholders define risks, identify hazards, assess vulnerabilities and promote community resilience *(11)*. Together, community engagement and risk communication are important strategies in themselves for listening to the affected populations, taking into consideration the social, religious, cultural, political and economic context in which events occur, and ultimately building trust, which is essential to the effectiveness of the entire pandemic response *(12,13)*.

One of the key lessons of major public health events of the twenty-first century – including outbreaks of the severe acute respiratory syndrome coronavirus (SARS-CoV), the Middle East respiratory syndrome coronavirus (MERS-CoV), influenza A(H1N1) and Ebola virus disease – is that RCCE is integral to the success of the response *(2,12)*. Accordingly, the IHR (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19) endorses RCCE as a core component of global and national response systems to address public health threats *(14)*. In the case of COVID-19, RCCE works in concert with the other elements of COVID-19 preparedness, prevention and response, including leadership and coordination, epidemiology, surveillance and contact tracing, rapid response systems, logistics and supply management, points of entry, referral facilities, case management and infection prevention and control measures.

RCCE utilizes a range of interdisciplinary strategies to influence behaviours that prevent the spread of COVID-19, build public trust and help communities cope with the impact of COVID-19, including:

- facilitating two-way communication to support accurate information and counter rumours and misinformation;
- applying social and behavioural science to reduce risk and increase specific hygiene practices such as covering coughs and sneezes, hand washing, physical spacing and social distancing, decontamination of surfaces, voluntary quarantine and isolation of persons with illness, and health-seeking behaviours sustained over time;
- strengthening community systems and local solutions that will help address COVID-19 and non-COVID-19 challenges in the long term; and
- liaising with communities, national authorities, the media and other partners to guide a cohesive response.

Strong community engagement is particularly important in developing the trust that is required for the success of the entire response *(15)*. To this end, coordination within RCCE activities and across the response is paramount, so that community expectations are met; for example, when communities are promised safe, timely and effective services, that is what they should receive.

> *"...we have to create a new partnership. A new deal between government services and community action. Communities [and] individuals have to be empowered, educated... They have to want to participate."*
>
> Dr Mike Ryan, Executive Director, WHO Health Emergencies Programme

OVERVIEW OF COVID-19 RCCE PREPAREDNESS AND RESPONSE SO FAR

Countries have been implementing a mix of containment and mitigation measures to prevent, detect and respond to COVID-19 transmission. While there were widespread social distancing restrictions in countries as part of the mitigation strategies initiated from March 2020, and public confidence in the authorities and acceptance of these measures was relatively high at the time (with some exceptions), these were mainly of a relatively short duration. Despite the risks, pressure increased over time to lift restrictions, including on mass gatherings, especially those of religious and cultural significance. By the end of April, some countries in the Region had started to cautiously relax social distancing measures using a stepwise approach. The majority of countries in the Region followed suit by early June, using a mix of approaches, such as the limited/phased re-opening of schools, marketplaces, trade and businesses, and relaxing limitations on gatherings, tourism, the hospitality sector and selected modes of public transportation. As a result, a surge of cases has been observed in countries amid the relaxation of social restrictions and is expected to worsen as relaxation of restrictions continues.

Even as COVID-19 vaccines become available, sustaining hygiene and mitigation measures will still be prudent. As eagerly as a new vaccine is awaited, concerns linger over ensuring universal access and that existing vaccine hesitancy, fears and public perceptions of risks will undermine deployment of the vaccine. Adjusting RCCE strategies will be critical to preparing the public for the roll out of vaccines, whilst simultaneously reinforcing preventive behaviours and supporting communities and systems to learn to "live with" COVID-19 in the medium to long term.

Between March and May 2020, the UNICEF Middle East and North Africa Regional Office and WHO Regional Office for the Eastern Mediterranean conducted rapid online assessments through their respective country offices to assess the state of preparedness of RCCE systems

and capacities. These data were complemented with information collected by JEE missions to countries in the Region and interactions with partner national societies and organizations. A summary of the key findings appears below, with more detail provided in Annex 1.

Key findings of the assessment of the early stage of the COVID-19 RCCE response

RCCE national plans

- Most countries have specific COVID-19 plans, but the plans are not, in general, linked to broader national plans related to COVID-19 or pre-existing emergency plans.
- There is a lack of resources to implement plans, linked to inconsistencies in capacity and implementation.

Internal and partner communication and coordination

- There is a lack of formal coordination and integration of RCCE within the broader COVID-19 response, including within the incident management system (IMS) and emergency operations centre (EOC) system.
- There is an absence of standard operating procedures for communication coordination and connection with EOC structures.
- Communication and coordination are made more difficult due to the fragmented governance systems in countries with ongoing emergencies.

Availability of data and use of evidence and feedback, particularly at local levels

- There is a lack of real time, disaggregated, behavioural data at the local level.
- There are delays in the collection, analysis and application of evidence for decision-making.

Outbreak communication and social media

- Most countries have repurposed existing media capacity for COVID-19 and regularly share updates.
- There is a lack of understanding of pandemics and their behavioural dimensions.
- There is a lack of social/media strategies in most countries.

Dynamic listening and rumour management

- There is only ad hoc rumour detection and management, within the context of an often overwhelming "infodemic".[1]
- There is good access to traditional and new media in most countries but weak health literacy.
- There is limited attention given to the language used or focused outreach to vulnerable groups.

Community engagement

- Good practices in social mobilization campaigns are being implemented in most countries, with wide use of influencers.
- There is high trust in face-to-face communication channels, but weak capacity for ongoing community engagement at the local level, compounded by COVID-19 restrictions on movement and contact.

LEARNING TO LIVE WITH COVID-19

From the assessments carried out by WHO and UNICEF, several strengths and areas for development in the response have emerged so far. Discussions among the Regional RCCE Interagency Working Group partners have led to the identification of key shifts that are required in the next stage of the pandemic, and which inform the framework.

Key shifts

As the pandemic continues over time, compliance with the required measures is difficult to maintain – in part because systems and communities have not yet made the shift from short-term measures to accepting that the threat of COVID-19 will be with us for the long term. The mounting indirect impact of public health measures is also an important factor in compliance, especially for those populations already under stress before COVID-19. In the early stages of the pandemic, the focus was on short term, urgent changes to behaviour at the individual, community and broader societal levels. However, even a best-case scenario suggests benefits to sustaining these changes, to some degree, in the long term. As vaccines become available, it is clear that the roll out will be phased, starting with health workers and others who are considered most vulnerable. RCCE will need to respond to the reality of vaccines not being universally available as well as the challenge of varying public acceptance. Without very high coverage, entire populations will not be comprehensively protected. Therefore, hygiene and other mitigation measures, even if uncomfortable initially, will need to be maintained as long-term social norms that yield net benefits.

While many of the immediate impacts of COVID-19 may feel negative, its long-term legacy need not be. An integrated RCCE approach that has a keen focus on building community resilience and stimulating community organization has a better change of addressing needs. Prevention measures for COVID-19 cannot be sustained without public commitment, but this

[1] An infodemic is "…an overabundance of information, both online and offline. It includes deliberate attempts to disseminate wrong information to undermine the public health response and advance alternative agendas of groups or individuals. Mis- and disinformation can be harmful to people's physical and mental health; increase stigmatization; threaten precious health gains; and lead to poor observance of public health measures, thus reducing their effectiveness and endangering countries' ability to stop the pandemic." *Managing the COVID-19 infodemic: Promoting healthy behaviours and mitigating the harm from misinformation and disinformation* [website]. Geneva: World Health Organization; 2020.

public commitment cannot be imposed. Rather, as communities are engaged more directly in decision-making and action, trust and respect will have an opportunity to grow, along with ownership and joint accountability. In concert with a range of sectors and complementary strategies and policies *(16)*, RCCE will be critical to the process of making the shift to a focus on reducing transmission, while living with COVID-19 in the long term, rather than to a world free of the threat of COVID-19.

Table 1 provides indications of the kinds of key shifts required in RCCE and across the broader response as part of adapting to living with COVID-19 in the long term, also known as "the new normal".

Table 1. Key shifts in the pandemic towards the new normal of living with COVID-19

Initial focus of the response (where we were)	**Living with COVID-19 (where we want to be in the long term)**
Short-term containment of COVID-19 and behaviour change	Long term, sustainable changes: • Address pandemic fatigue • Mitigate risks to facilitate "COVID-19 safe" education, work, markets and trade, worship and traditions • Adapt to COVID-19 safe social norms integrated into everyday life.
Individual	Collective community systems: • Focus on building trust through localized approaches to build collective resilience, ownership and hope – hearts and minds • Strengthen community mechanisms and joint accountability • Enhance feedback loops and intensify efforts to manage uncertainty and the infodemic • Direct resources closer to communities for community-led solutions.
Blanket approach	Multiple simultaneous local scenarios: • Coordinate localized responses to rapidly adapt to low and high threat levels in different locations and contexts • Embed RCCE across the response.
COVID-19 specific response	COVID-19 + non-COVID-19 considerations: • Increase access to behavioural data and data on socio-behavioural determinants disaggregated to local level • Consider implications of secondary impacts of COVID-19 that compel people to take greater risks • Increase access to data about secondary impacts on health, education, work and infrastructure • Consider the implications of existing emergencies and systems within the Region.
Centralized decisions and capacity	Diverse engagement methods and localized resources: • Innovate in physical and virtual engagement methods to accommodate risks and address stigma and the specific needs of vulnerable groups • Invest in long term community capacity and inclusive participatory governance.

THE GUIDING FRAMEWORK'S KEY OBJECTIVES AND OUTPUTS

Building trust and localizing the response is at the centre of the regional guiding framework for RCCE for the COVID-19 response, which is structured around four objectives:

1. Localize the response to facilitate community-led approaches and improvement of the quality and consistency of RCCE approaches
2. Strengthen evidence and innovation
3. Enhance local capacity
4. Improve coordination at all levels.

These four key objectives align with those of the revised COVID-19 Global Risk Communication and Community Engagement Strategy (October 2020), as indicated in the text below. While adaptation of the guiding framework will need to be done based on local context (see Annex 3), suggested outputs are outlined under each objective as a guide only (see Fig. 1).

An overview of recommended actions that represent the basis for regional level inter-agency collaboration and joint technical support are outlined in Annex 4. As Table 1 (above) outlines, the guiding framework recognizes the need to shift from the immediate actions of the first 6 months of the response, towards a longer term, localized and sustainable approach that takes into account the twin tracks of: (a) the primary impacts of COVID-19; and (b) a range of secondary and indirect impacts.

Under the auspices of the Regional RCCE Interagency Working Group, the four key objectives and the corresponding outputs of the guiding framework were distilled from a multifaceted process that included the following key steps:

- an expert consultation in December 2019;
- a literature review *(17)*;
- direct consultation and assessments of the early stage of the COVID-19 RCCE response undertaken by UNICEF and WHO through their country offices; and
- consulting other regional and global strategies and policies, especially those of IFRC, UNICEF and WHO.

Supported by the Regional RCCE Interagency Working Group, the intent is that countries will adapt the guiding framework for use at national and subnational levels to foster timely, coordinated and effective RCCE, strengthened and sustained during the post-peak COVID-19 period, in subsequent waves and over the long term.

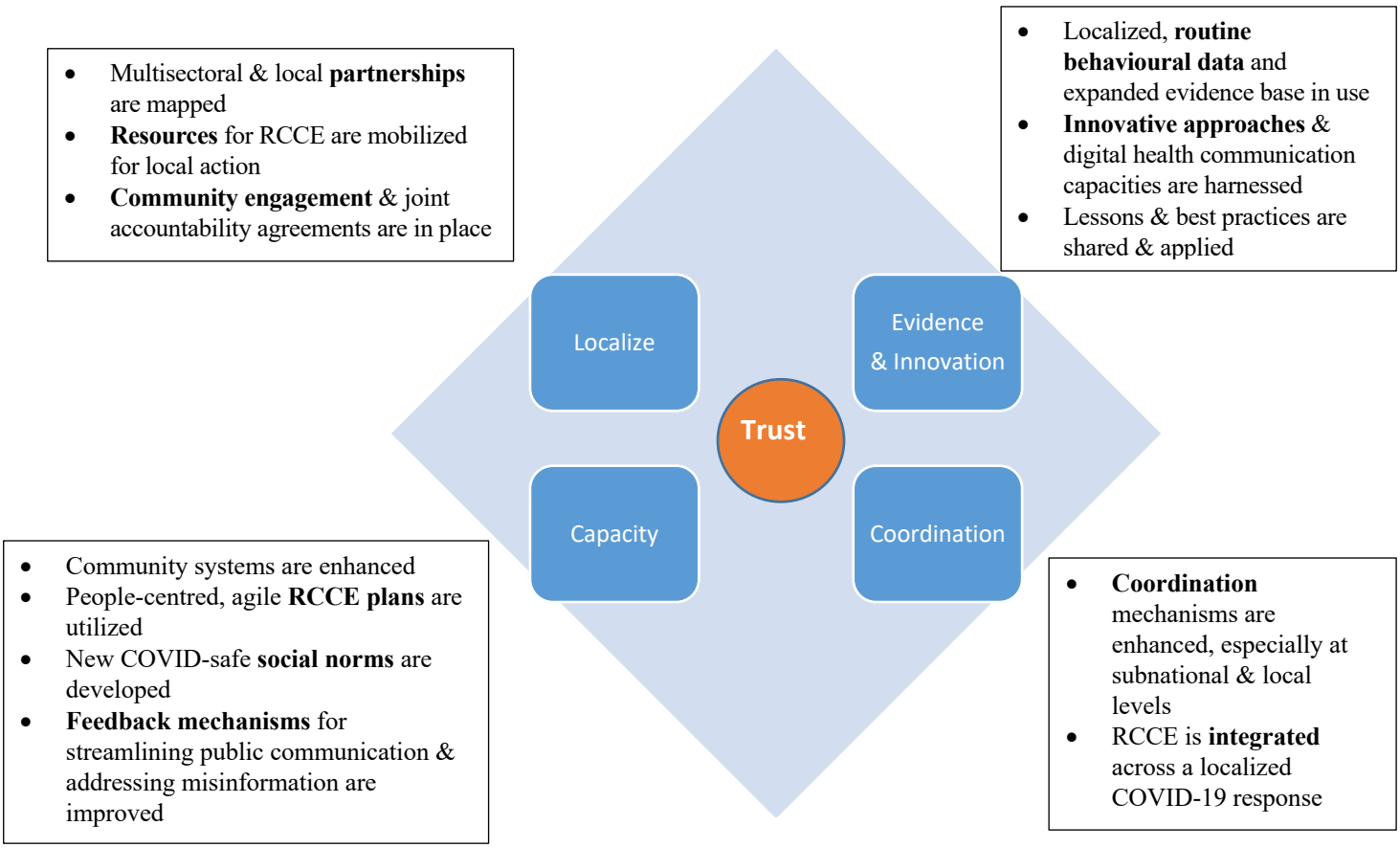

Fig 1. The key objectives and outputs of the Regional Guiding Framework for RCCE for the COVID-19 response in the Eastern Mediterranean Region/Middle East and North Africa

Regional objective 1. Localize the response to facilitate community-led responses and improvement of the quality and consistency of RCCE approaches

Linked to: Global objective 1. Facilitate community led responses through the improvement of the quality and consistency of RCCE approaches

Output 1. Multisectoral and local partnerships are mapped

Localizing the response relies on mapping and collaborating with all relevant sectors, agencies and institutions to yield long-term benefits. As a cross-cutting area, RCCE sits at the intersection of prevention, preparedness, response and recovery, with the potential to create useful synergies. At this stage in the pandemic, this guiding framework calls for innovative partnerships and integrated efforts that reach local communities, such as with national societies, women's groups, youth groups, Red Cross and Red Crescent societies, and those representing vulnerable groups. Diversity fosters creativity and local level engagement helps to strengthen trust, respect and ownership of the response within communities. It is important not to lose sight of the fact that many people involved in the response are respected members of wider communities that we seek to influence – for example, women from diverse communities are involved in the health response and other social support and care systems *(18)*. Where community mechanisms are nurtured and sustained as a "public good", and supported by larger systems, government and other networks, they can be utilized to deliver a range of benefits

over time. While the initial response phase emphasized the role of health systems, a wider multisectoral partner network will be needed in the longer term to address the secondary impacts of the pandemic, including the continuity of services not previously addressed, such as services for mental health and violence, and maternal and child health, as well as broader economic support to address food insecurity and other pressures.

Output 2. Resources for RCCE are mobilized for local action

Directing resources closer to communities will be a key indicator of the shift from national to local level responses. Raising awareness of the value of RCCE and what can be achieved will be critical to mobilizing and directing resources to the local level where they can be most effective – for example, for addressing the specific needs of vulnerable groups such as IDPs, migrants, refugees, disadvantaged groups and older people.

The Regional Interagency RCCE Working Group partners are a key asset for conducting joint advocacy to mobilize sufficient financial resources to establish the foundations for RCCE at country level and for harmonizing, and in some cases re-directing, support for long term country-level benefits, particularly where systems and capacities are weakest.

Output 3. Community engagement and joint accountability mechanisms are in place

With localized coordination and partnerships comes the opportunity for joint accountability between communities and other partners. The process of jointly agreeing on the terms of community engagement strategies brings greater transparency and fosters the ownership and trust needed to sustain the activities in the long term *(19)*.

The Regional RCCE Interagency Working Group is central to genuine partnerships, collaboration and coordination at the country level across the Region. The Working Group supports the effective functioning of national and local level mechanisms and encourages participation in national-level COVID-19 RCCE coordination mechanisms, and other joint efforts and common approaches.

Regional objective 2. Strengthen evidence and innovation

Linked to: Global objective 2. Generate, analyse and use evidence about the community's context, capacities, perceptions, and behaviours

Output 1. Localized, routine behavioural data and expanded evidence base in use

Information about both the host (the community) and the agent (the virus/COVID-19) are required to respond effectively. While epidemiological data has been critical, much greater use of behavioural data – community perceptions, knowledge, motivations, attitudes and behaviours – is required to bring COVID-19 under control in the next phase, as communities adjust to the long term "new normal". Mapping community needs, rapid access to disaggregated information and routine feedback, are essential for effective decision-making and to keep pace with the changing nature of risk perception, as well as the pandemic itself. Innovative approaches that can facilitate the flow of information among partners and

communities, and accelerate the planning and implementation of RCCE activities, including for vulnerable populations, will be important for scaling up proven and promising initiatives.

Output 2. Innovative approaches and digital health communication capacities are harnessed

A range of new digital technologies are being applied to COVID-19 and other health challenges as a part of RCCE interventions. However, rapid access to specific technical capacity to support dissemination, tracking and monitoring of messaging and engagement through these channels needs to be stepped up, for low technology settings in particular. The framework recognizes digitalization as a priority and urges investment/resource allocation to enhance this area.

Output 3. Lessons and best practices are shared and applied

Given the relative dearth of evidence in the area of RCCE in public health, there is a significant need to gather, curate and share evidence and lessons learned across the Region to accelerate the uptake of best practices. As such, operational research and documentation of regional experiences in applying the guiding framework will contribute significantly to the field of RCCE.

The Regional Interagency RCCE Working Group plays a key clearinghouse role by gathering and recommending use of evidence and innovation, research, best practice experiences and lessons learned. A regional knowledge repository is intended to support the sharing of key materials, guidance documents, tools and templates. Regional partners are promoting a common monitoring framework to track the progress of RCCE across the Region and provide technical support to countries to strengthen performance. Recommended actions intended for adaptation by countries are outlined in Annex 4.

Regional objective 3. Enhance local capacity

Linked to: Global objective 3. Reinforce local capacity and local solutions to control the pandemic and mitigate its impacts

Output 1. Community systems are enhanced

Despite the challenges of the necessary COVID-19-related restrictions – and also because of them – there is a need to improve community engagement on the ground for sustaining behaviours and for formalizing community systems for the longer term. Linking community mechanisms and organizations to formal infrastructure (such as ministries and local government), establishing certification systems and training by peers and technical experts, and supporting communities of practice and other ways of sharing experiences, are all important ways to strengthen the capacity of the wide range of community organizations and influencers to identify sustainable solutions at the local level.

Output 2. People-centred, agile RCCE plans are utilized

While most countries have national RCCE plans in place, the guiding framework calls for localized RCCE plans that bridge traditional structures with people-centred, community engagement for the long term. While existing capacity is often significant, innovative ways of providing additional capacity-development will be needed to create shared understanding, manage expectations and support communities to assess their own needs and contribute to local

level plans, including reaching the most vulnerable and marginalized communities, such as migrants, refugees, older people, people with disabilities and others. Furthermore, much of the Region is already dealing with pre-existing emergencies, conflicts and natural disasters, and the risk perceptions held by communities often differ to those of the authorities. Effective RCCE can help bridge gaps by determining what people know, how they feel and what they do in response to disease outbreaks, and by adapting the response accordingly.

In addition to addressing specific COVID-19 concerns, a longer-term approach needs to address both the primary and secondary impacts of the pandemic, including wider community concerns that extend beyond physical and mental health, and new ways of operating in education, work, worship and other social spheres need to be considered. Community engagement, through its participatory approaches, can help to create more relevant and practical plans that clearly define principles, priorities, roles, responsibilities, capacity and reporting modalities to ensure a systematic approach to COVID-19 and non-COVID-19 concerns. In addition, community level and localized structures are likely to be more agile and responsive to changes in the COVID-19 pandemic.

Output 3. New COVID-19 safe social norms are developed

Social norms are very strong drivers of behaviour and the primary and secondary impacts of COVID-19 have already challenged many social norms previously taken for granted – from limitations to the basic structures of society, such as education, work and trade, to gatherings and religious rituals, such as weddings and worship, and informal social norms, such as handshakes and greetings. As the threat of COVID-19 continues, communities and society at large will need to develop new "COVID-safe" social norms to meet the long-term challenge of minimizing transmission while living with the threat of COVID-19. Engaging with communities and strengthening their capacity will be essential to that process so that the new norms feel like their own, rather than imposed from outside.

Output 4. Feedback mechanisms for streamlining public communication and addressing misinformation are improved

Risk communication relies on transparent, reliable and strategic communication and exchange of timely information between the authorities, leading stakeholders and, especially, the public. Examples of key behavioural measures and supportive messaging for different stages of the COVID-19 response appear in Annex 2. Social media, digital technologies and other innovations have become critical components in the development of a two-way, formalized system for dynamic listening. Whether online or offline, rumour and misinformation management helps authorities to avoid the consequences of an "infodemic" *(20)*. This also means communicating early, regularly and transparently, to influence individuals, families and their communities, collectively. Existing public health communication networks and new media need to be strengthened to localize the focus through an array of reliable and innovative channels to foster trust, as well as to cater for special needs (such as addressing different linguistic, geographical and cultural factors).

The Regional RCCE Interagency Working Group can play a key role in providing access to technical support facilities for countries. Common guidance, tools and templates for public/outbreak communication messaging, materials development and training will serve community engagement efforts and capacity development across the Region.

Regional objective 4. Improve coordination at all levels

Linked to: Global objective 4. Strengthen coordination at global, region and sub/national levels, to increase quality, harmonization, optimization and integration of RCCE across the different technical areas

Output 1. Coordination mechanisms are enhanced, especially at subnational and local levels

As the pandemic evolves and the response encompasses a wider range of primary and secondary impacts, coordination becomes both more challenging and more critical. Effective coordination within RCCE systems, across sectors and across all levels of the broader national COVID-19 response will be essential. While the formal mechanisms are well established at the national level through incident management systems and emergency operation centres, additional measures are often needed at the local level. These include community representation and reliable internal communication systems, along with well-defined standard operating procedures that engage communities and are relevant at the local level. Decades of research show that diversity is linked to better organizational governance, social responsibility, lower physical and mental health risks, and healthier economies bolstered by higher labour force participation *(18)*.

Output 2. RCCE is integrated across a localized COVID-19 response

Unified advocacy by all partners is critical for embedding RCCE within the overall response architecture, with adequate resourcing and capacity to respond to local needs. Although countries are increasingly embracing the importance of RCCE, there is still a significant gap in RCCE representation and influence in formal structures and in implementation capacity. RCCE needs to feature across the suite of guidance *(21,22,23)*, including that for the incident management systems established to respond to emergencies and the emergency operation centres, for information-sharing, risk assessment and coordination of response operations. In countries where cluster coordination mechanisms exist, RCCE needs to be part of this structure in order to create synergies across different components of the response and respond to local needs.

THE CONTEXT FOR IMPLEMENTATION

The nature of the response in the Region is particularly challenging because of the differential impact of the primary (COVID-19-specific) and secondary (non-COVID-19) consequences of the pandemic on individuals and groups within communities. Understanding the working context will guide adaptation of the framework to support strong results at national and subnational levels.

WHO Eastern Mediterranean Region/Middle East and North Africa overview and situation analysis

As of 1 August 2020, WHO had confirmed more than 1.5 million cases of COVID-19 in the 22 countries of the WHO Eastern Mediterranean Region and more than 40 000 deaths. This represents approximately 400 000 more cases, and almost 20 000 more deaths, for the Region in the month since 1 July 2020. The risk of rapid transmission is high in the Region, especially in countries that are already experiencing complex emergencies and conflict, such as Iraq, Libya,

Palestine, Syrian Aran Republic and Yemen, and in countries where refugees and IDPs are living in congested camp-like settings with inadequate sanitation, compounded by fragile health systems, overwhelmed response capacities and a suboptimal level of public health preparedness.

The WHO Eastern Mediterranean Region is home to more than 660 million people *(24)* living in 22 countries and is marked by significant disparities that are likely to be amplified by COVID-19. In addition, health system capacities within these countries vary widely. Emergencies are a defining feature of the Region and, directly or indirectly, affect two thirds of the countries. These vary from country to country and include natural disasters, human-made emergencies, disease outbreaks, environmental emergencies and population displacement. Some countries in the Region have been dealing with protracted emergencies for many years *(25)*. As resources have been focused on addressing the threat of COVID-19, the cost of secondary health impacts and exacerbation of pre-existing non-COVID-19 concerns has become clearer, particularly for the poor and other vulnerable groups. For example, we know from the West Africa Ebola virus disease outbreak, and recent research, that there is a high potential cost for interruption of schooling *(26,27)*. In particular, it is harder for girls to find their way back into learning for many reasons; girls are more likely to experience gender-based violence, child marriage and teenage pregnancy. In effect, missing an education has a high cost in missed participation throughout life *(28)*.

The Region is also characterized by a significant cohort of young people, high unemployment rates, and persistent poverty and gender inequality. Some of the basic infrastructure required to address COVID-19 is not consistently available, such as clean water, and climate change vulnerabilities are increasingly evident.

An additional 1.2 million under-five deaths could occur in just 6 months due to reductions in routine health service coverage levels and an increase in child wasting. While the available evidence indicates the direct impact of COVID-19 on child and adolescent mortality to be very limited, the indirect effects on child survival may be substantial and widespread. The indirect impact on children, as well as other populations, mainly stems from strained health systems. Diversion of resources towards COVID-19 can mean disruption to other non-COVID-19 services and preventive interventions, such as vaccination *(25)*.

The impact of COVID-19 on economies is likely to be significant. For example, in the Arab States 1.7 million jobs are expected to be lost in 2020, including 700 000 jobs for women, who make up almost 62% of those working in the informal sector *(29)*. Moreover, the ongoing economic and food security impact of COVID-19 is substantial and appears likely to worsen over time. Forecasts and predicted potential scenarios warn that economic hardships brought about by the COVID-19 pandemic could deepen aid-dependency in countries. In countries experiencing conflict, millions already live with limited access to health care, food, shelter, clean water and electricity, as well as with volatile prices and eroded infrastructure. It is likely that new short- and longer-term health and protection needs will emerge, and that otherwise relatively resilient communities will need assistance. Food insecurity is increasing in severity, with the rural and urban poor considered the most at risk, followed by displaced people, migrants and informal workers.

RCCE can mobilize cultural and social characteristics that tend to be under-represented in traditional systems. For example, the role of women in the response has been underplayed so far, despite abundant research that shows that gender balance in leadership often results in stronger governance and more socially responsible practices, including less harm to the environment and

community. Women and men tend to exhibit different ways of working and different leadership styles, with women favouring values that are more inclined to social welfare and collective well-being. Studies show that women tend to be more collaborative and consultative, and more democratic and participatory in decision- making, as demonstrated by several female leaders during the COVID-19 pandemic *(18)*. Such qualities will be extremely valuable.

Collectivism (rather than individualism) and commitment to family and community are strong values across the Region, which are reinforced by religious commitment *(17)*. These values can be harnessed to address fatalistic and negative mindsets exacerbated by the ongoing disruption of daily routines, especially by the strict "lockdown" measures. Working collectively to maximize physical and emotional resources can help to reassure and stabilize communities, otherwise overwhelmed by uncertainty about COVID-19 itself and how long people (and systems) will need to cope with these disruptions. Greater mobilization of the resourcefulness of communities can mean that other resources can be used to target heightened vulnerability to additional risks, such as mental health, gender-based violence and substance abuse, and fear and stigma directed towards migrants and refugees, health workers and others.

RCCE can be effective on both the community (demand) side and the health care system (supply) side. For communities, RCCE can help to respond to rumours and promote the importance of care-seeking in general as well as for specific protective measures against COVID-19. On the health system side, RCCE can provide useful feedback to improve services and direct the community to well-prepared services. As the pandemic endures and matures, the response will also need to change. The initial need to establish awareness and behaviours, has given way to the need to sustain behaviours, and ultimately to learn to live with COVID-19 in the longer term. As such, RCCE efforts need to go well beyond simple messaging, to include broader social mobilization and community systems, as well as creating linkages across the response.

MONITORING AND EVALUATION

In adapting the guiding framework into a plan of action, governments and partners will need to work together to monitor and evaluate implementation, and apply the lessons learned to improve impact and outcome level results. The Regional RCCE Interagency Working Group can provide technical support to countries and provide valuable insights based on the analysis of trends across the Region.

An outline of the type of key performance indicators that will be relevant to national level monitoring and evaluation – and ultimately strengthening performance – is provided in Annex 5 that includes indicators that are relevant at programme level and those for higher-level monitoring, such as the recommended global core indicators, which are indicated by an asterisk (*).

More detailed information related to the monitoring and evaluation of RCCE is available from the Save the Children's Ready: Global Readiness for Major Disease Outbreak Response initiative.

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ANNEX 1. ASSESSMENTS OF THE EARLY STAGE OF THE COVID-19 RCCE RESPONSE

This section provides more detail on the rapid online assessments mentioned in this document, conducted by UNICEF's Middle East and North Africa Regional Office and the WHO Regional Office for the Eastern Mediterranean between March and May 2020 through their respective country offices to assess the state of preparedness of RCCE systems and capacities. The UNICEF assessment was conducted in 16 country/areas offices, with a response rate of 100%. The WHO survey was administered to identify strengths and gaps in responding to COVID-19 in 22 countries of the WHO Eastern Mediterranean Region, with a response rate of 60%. While the two assessments are not directly comparable because of different country coverage areas and the slightly differing scope of the questions asked, they nevertheless provide very similar findings that reinforce the points outlined below. The data has been complemented with information collected from the joint external evaluation (JEE) missions conducted in 18 (80%) countries of the Region and in interactions with national organizations. A summary of these results is described below.

- **Risk communication and community engagement national plans.** The majority of countries have RCCE-specific plans for COVID-19 that have been completed or are underway, although these are mainly based on those informal structures or ad hoc systems that are in place for communicating risks with vulnerable populations in public health emergencies and that have been applied to COVID-19. There is a lack of RCCE structures with dedicated units and staff in countries. Only a minority of countries have national all-hazard and multisectoral plans for RCCE in public health emergencies that are formally endorsed. Across the Region, there is a lack of clarity regarding the roles and responsibilities of different units, such as health promotion, health education and community-based initiatives. RCCE, in many countries, is considered and used as a reactive – rather than proactive – intervention, and only during emergencies.

- **Internal and partner communication and coordination.** There is a general lack of formal and continuing multisectoral RCCE and coordination mechanisms. In some countries, establishing multi-stakeholder communication coordination platforms and rolling out campaigns through decentralized structures has taken place as part of several priority health and development programmes. For COVID-19 preparedness and response, most countries in the Region have established RCCE coordination mechanisms led by government with co-leadership support from UNICEF and WHO. However, integration of RCCE within the incident management and emergency operations systems is less systematic in the absence of standard operating procedures for communication coordination and connection with the emergency operation centre structure. Furthermore, fragmented governance systems in countries experiencing conflict have led to difficulties or disruption in communication coordination.

- **Use of evidence and feedback.** Overall, there are few examples of comprehensive analyses related to national/local landscapes, audience formation, risk perception and feedback for COVID-19. While most countries use some form of evidence, there is a wide variation and inconsistency in the type and source of evidence used, commissioned or leveraged. In general, understanding the risk perception, knowledge, attitude and behaviour of target audiences in

(close to) real time has not been included in RCCE planning. Challenges have been noted, including: epidemiological data is not always available or relevant to local communities e.g. disaggregated by sex, age, vocation or disability; research, monitoring and evaluation-related capacities in countries are varied and sometimes weak; and social distancing and lockdowns in most countries have involved limited data collection. Feedback systems in the form of hotlines and social media listening are present in most countries, but there is variation in the types of mechanism and how they are being used.

- **Outbreak communication and social media.** Many countries have media/public relations departments that include planning and managing media relations for COVID-19 in their activities. Information, education and communication materials have been developed and adapted for vulnerable groups and relevant information has been widely disseminated, including through partners. The majority of countries have a process in place for the timely sharing of regular updates. Access to multilingual communication products in migrant- and refugee-hosting countries needs to be increased. Key media outlets in some countries have been identified and engaged, but in the absence of a digital/social media strategy for public health emergencies in most countries, activities have mostly been on an ad hoc basis.

- **Dynamic listening and rumour management.** Managing overwhelming levels of information (also known as an "infodemic") has been a critical challenge for most countries. An underlying lack of public trust in governments before and during emergencies can lead to misinformation and rumours. While most countries have some form of online and/or offline media monitoring, such as reactive or ad hoc feedback systems from hotline mechanisms, these efforts tend not to be formalized or systematic. Although capacity for the use of traditional and social media is strong in almost all countries, health literacy is weak and men tend to have greater access and influence than women. There is a critical need to enhance engagement with social media within public communications strategies for listening, information-sharing and addressing rumours.

- **Community engagement.** Good practices and successful implementation of community engagement and social mobilization campaigns are evident in almost all countries. These have been intensified during the COVID-19 pandemic, with a majority of countries initiating rapid on-the-ground social mobilization and capacity-building of key influencers and opinion leaders for outreach at the community and household level. The engagement of other sectors and nongovernmental organizations has also been accelerated in the response to COVID-19. There exist trained community health workers, volunteers and mobile health staff, including local responders such as Red Cross/Red Crescent societies (who have played an auxiliary role in support of governments in the response in some countries). However, much of the on-the-ground community engagement has now been either put on hold due to restrictions on movement or has been re-directed towards online engagement. The feasibility of mid-media and on-the-ground/face-to-face methods will need to be continually assessed, particularly where there is high trust in face-to-face channels and interpersonal means of communication. This is especially relevant for vulnerable populations living in camps and settlements or populations on the move. Mobilization efforts will need to be continued to promote the maintenance of behaviours, especially compliance with hygiene and social distancing measures, during the peak, post-peak and second wave stages of the pandemic.

ANNEX 2. KEY BEHAVIOURAL MEASURES AND SUPPORTIVE MESSAGING DURING COVID-19 PREVENTION, PREPAREDNESS, RESPONSE AND RECOVERY

The table below summarizes the key behavioural measures to address COVID-19, along with supportive measures addressing mental health and secondary social and economic impacts, that can be targeted through RCCE.

	Behavioural measures for COVID-19	Supportive measures
Prevention	• Hand hygiene through correct and frequent handwashing • Respiratory hygiene through covering of sneezes and coughs, use of masks and personal protective equipment (PPE) • Decontamination of surfaces through household and primary service facility-level infection prevention and control (IPC) measures • Physical spacing: at least 1 metre spacing between people • Avoiding mass gatherings and non-essential movements • Shielding at-risk and highly-vulnerable populations	• Psychosocial support to address anxiety, panic, fear, stigma, grief • Strengthen social solidarity and inclusion, including for specific communities • Other essential health and social services to minimize secondary impacts on households and communities over the long term
Preparedness	Prevention measures listed above plus: • Seeking medical assistance if at-risk or displaying symptoms	
Response	Prevention measures listed above plus: • Adherence to medication, nutrition, exercise and IPC during quarantine or isolation • Home-based care: medication, nutrition and exercise • Home-based and intensified IPC	
Recovery	Prevention measures listed above plus: • Continued adherence to these behaviours to generate social norms and habits that become part of daily life • Utilization of basic health and social services	

ANNEX 3. KEY STEPS IN THE CYCLE OF ADAPTING COUNTRY PROGRAMMES.

The figure below shows the key steps in the cycle of iteration involved in the adaptation of country programmes.

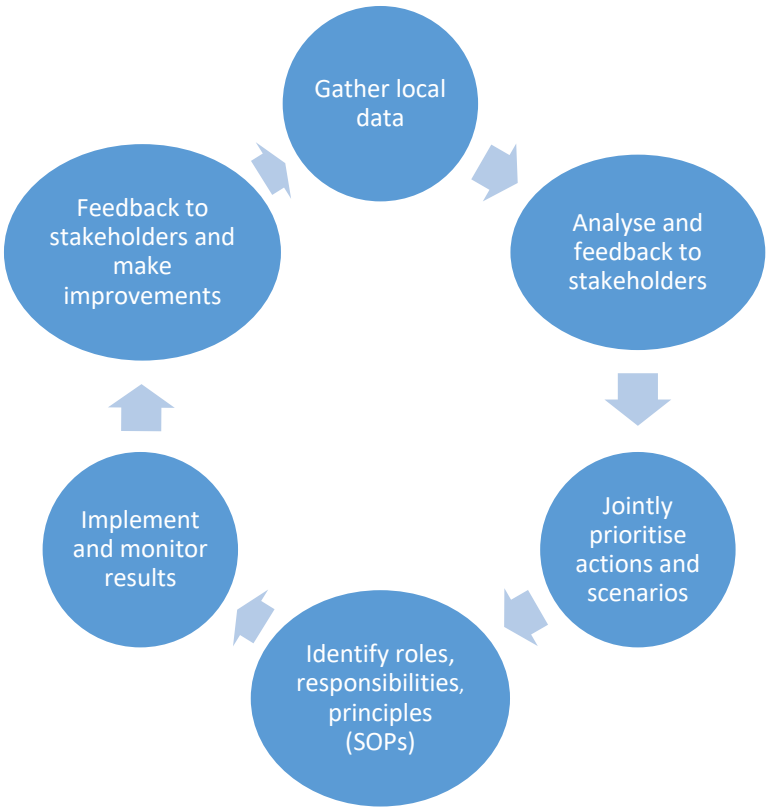

Fig A3.1. Key steps in the cycle of iteration involved in the adaptation of country programmes

ANNEX 4. RECOMMENDED ACTIONS FOR COUNTRY ADAPTATION

The table below provides ideas for country level action that must be adapted to be relevant at the local level. The process of adaptation is not usually linear, but rather consists of a cycle of iteration – testing and adjusting – according to feedback and context (see Annex 3).

OUTPUTS	RECOMMENDED ACTIONS
Regional objective 1. Localize the response to facilitate community-led responses and improvement of the quality and consistency of RCCE approaches	
Multisectoral and local partnerships are mapped	• Regularly map and identify units and departments across sectors, agencies and nongovernmental organizations to expand engagement at local level on COVID-19 primary and secondary impacts, such as for One Health, climate change and disaster reduction, noncommunicable diseases, travel health, and faith-based organizations in the context of the pandemic • Generate and pilot innovations that strive to include the voices of the most vulnerable and generate trust[1]
Resources for RCCE are mobilized for local action	• Map resources for RCCE to identify RCCE financial needs and in-kind support, and determine targets and potential donors • Cultivate long term relationships and partners to mobilize resources for RCCE on COVID-19 • Utilize community champions, minority voices and other local influencers in resource mobilization efforts • Fund monitoring and evaluation efforts
Community engagement and joint accountability agreements are in place	Engage communities to: • define inclusive and sustainable partnerships and platforms for the long term • define collaborative decision-making processes • negotiate shorter- and longer-term COVID-19 and non-COVID-19 priorities, roles and joint accountabilities, and ways of working among stakeholders, e.g. map 4Ws (who does what, where and when)
Regional objective 2. Strengthen evidence and innovation	
Localized, routine behavioural data and expanded evidence base in use	• Establish (at a minimum) age- and gender-disaggregated data and information collection mechanisms, including long term dynamic listening and rumour management systems, to provide rapid, regular, local, disaggregated behavioural (knowledge, attitude and practices) data, including on community expectations, perceptions, needs, and social, cultural, religious and political factors • Include core behavioural RCCE considerations in national situation analyses and core databases • Establish open source digital platforms/dashboards to share behavioural data, RCCE success stories, best practices and lessons learned • Collaborate with other sectors and partners to develop new ways of working and integrating RCCE across the response
Innovative approaches and digital health communication capacities are harnessed	• Develop a digital (social media) RCCE strategy and action plan to improve digital communication and engagement • Assess the effectiveness of the digital platform through measuring impact and population reach and engagement, and content analysis • Design and avail innovative and inclusive platforms to plan, review and collaborate on RCCE, such as virtual workshops, townhall meetings, social media and so on

[1] COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement, March 2020. Risk Communication and Community Engagement Working Group on COVID-19 Preparedness and Response in Asia and the Pacific; 2020 (https://reliefweb.int/sites/reliefweb.int/files/resources/COVID-19_CommunityEngagement_130320.pdf, accessed 6 September 2020).

Lessons and best practices are shared and applied	• Share positive case studies and success stories from communities • Establish a multidisciplinary RCCE research taskforce to support documentation of experience and operational research to inform evidence-based planning and response • Identify local and international academic partners and research institutions to guide the research agenda for COVID-19 RCCE and build regional capacity • Conduct impact assessment studies and develop publications addressing the effectiveness of RCCE and innovative approaches
Regional objective 3. Enhance local capacity	
Community systems are enhanced	• Develop long-term plans and strategic approaches to increase engagement of communities • Facilitate capacity-building workshops to enhance capacity and collaboration among communities, authorities and other providers • Coordinate with national authorities to ensure laws and legislation support engagement with communities • Establish a regional RCCE technical support facility, with national equivalents, to provide an accessible roster of RCCE experts and trainers, and share materials in support of behaviour change-informed interventions • Regional RCCE Interagency Working Group to share lessons learned, as well as guidance, tools and templates for public/outbreak communication messaging, materials development and training to support community engagement efforts and capacity-development across the Region • Liaise with academic institutions and other providers to establish capacity-building options for RCCE for COVID-19 in the medium and long term
People-centred, agile RCCE plans are utilized	• Establish RCCE benchmarks, protocols and processes for managing changes in the level of public health threat and corresponding changes required in the response • Institutionalize community engagement as part of the collaborative approach to evidence-based multisectoral RCCE plans for COVID-19, including engaging stakeholders in periodic reviews of plans • Develop participatory rapid risk assessment tools for RCCE for different settings and populations • Conduct local capacity needs assessment • Develop capacity-building training and training-of-trainers packages for a range of levels of community engagement • Develop digital and other quick reference guides for transparent sharing of information about planning and resource allocation • Build RCCE capacity to enhance functional and technical capabilities, including interpersonal communication counselling, community engagement and motivation skills for frontline workers.
New COVID-safe social norms are developed	• Engage with communities and authorities to negotiate new norms for living with the threat of COVID-19, including for a wide range of activities beyond health care, such as for schools[1,2], marketplaces and other workplaces, shopping, worship[3], tourism, hospitality and transportation, as well as cultural and social activities, such as everyday greetings[4], private parties and weddings. • Share community examples and case studies of success

[1] Coronavirus disease (COVID-19): Schools [website]. Geneva: World Health Organization; 2020 (https://www.who.int/news-room/q-a-detail/q-a-schools-and-covid-19, accessed 6 September 2020).

[2] Guidance on returning to school safely during the COVID-19 pandemic [website]. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (http://www.emro.who.int/health-topics/corona-virus/back-to-school.html, accessed 6 September 2020).

[3] Safe Eid al Adha practices in the context of COVID-19: Interim guidance, 25 July 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/333454, accessed 6 September 2020).

[4] Myth busters: Should I avoid shaking hands because of the new coronavirus? [website]. Cairo: WHO Regional Office for the Eastern Mediterranean; 2020 (http://www.emro.who.int/health-topics/corona-virus/myth-busters.html, accessed 6 September 2020).

Feedback mechanisms for streamlining public communication and addressing misinformation are improved	• Create and promote RCCE national internal communication platforms for exchange of materials and expertise, working closely with pre-existing emergencies (conflict, natural disaster, food insecurity, etc.) • Collaborate with social media companies and communication and technical experts to establish information systems that secure consistency/accuracy in evidence, risk communication, rumour management, community engagement, campaigns and other interventions across the national response • Establish standard operating procedures to systematically guide and regularly update preventive messages, and manage rumours and the range of public health risks (COVID-19 and non-COVID-19) for various groups using local data (via the agreed process outlined above) • Conduct subnational (virtual) workshops to enhance capacity, local collaboration and responsible coverage among media, health promotion and other RCCE-related sectors • Regularly update training for high-level and technical spokespersons, especially given the high turnover of senior officials in some countries of the Region • Develop RCCE-specific interactive public communication channels, such as through hotlines, email, WhatsApp, Facebook and Instagram
Regional objective 4. Improve coordination at all levels	
Coordination mechanisms are enhanced, especially at subnational and local levels	• Develop standard operating procedures for increasing the RCCE contribution to incident management systems (IMS), emergency operation centres (EOCs), and so on • Facilitate local workshops and other inclusive ways of enhancing RCCE coordination among all concerned parties and integration of RCCE in COVID-19 emergency management systems such as EOCs, health sector and cluster coordination, and so on
RCCE is integrated across a localized COVID-19 response	• Activate country and regional level inter-agency working group/taskforce with defined roles and responsibilities (terms of reference) • Demonstrate the value of integrating RCCE plans into COVID-19 national preparedness and response plans • Update country briefs to prioritize RCCE on the national agenda for the next generation of COVID-19 action • Identify target groups who are at higher risk, such as migrants, internally displaced populations and the underserved • Develop and conduct advocacy initiatives for positioning and mobilizing resources dedicated to RCCE activities • Identify and engage regional RCCE champions for increasing awareness and mobilizing senior authorities and decision-makers across sectors, including faith-based leaders and organizations

ANNEX 5. PROPOSED KEY INDICATORS RELEVANT FOR THE COVID-19 PANDEMIC

Note: While IFRC, UNICEF and WHO convene the Regional RCCE Inter-agency Working Group, all partners are invited to participate in the monitoring and evaluation framework. Specific lead and support roles will be identified as part of the work of the Working Group.

Level	Indicator	Frequency	Means of verification
Activity	# trainings completed; # stakeholders trained	Monthly	National partner reports
Output	% people reached through the distribution of RCCE messaging; % people engaged through the distribution of RCCE messaging	Monthly	Social/media figures, national partner reports
Output	% communities with multisectoral partner maps, includes aggregation to % countries with national partner maps	Monthly	Partner reports
Output	% people providing feedback through Community Feedback and Response Mechanism/accountability platforms	Monthly	Partner reports
Outcome	% change in primary COVID-19-related knowledge, risk and other perceptions, attitudes and motivations, behaviours and practices (KAPB)** • disaggregated to local levels	Quarterly (rapid assessments) or longer cycles depending on country capacity	Surveys, polls
Outcome	% change in non-COVID secondary impacts-related KAPB**	Quarterly (rapid assessments) or longer cycles depending on country capacity	Surveys, polls
Institutional	# community feedback reports produced	Quarterly	Regional partner reports
Institutional	# joint accountability agreements between communities and government/other partners	Quarterly	Regional partner reports
System*	% countries collecting core KAPB indicators • disaggregated to local levels	Quarterly	Partner reports
System*	% countries recommending at least 3 out of 5 personal prevention measures		
System*	% countries with rumour management/community feedback mechanism on COVID-19	Quarterly	Regional partner reports
Systems*	% countries with national RCCE plans • % communities with local level RCCE plans	Quarterly	Country assessments
Systems*	% countries with a national RCCE coordination mechanism; % stakeholder satisfaction with coordination • % communities with local level RCCE plans	Quarterly	Country assessments
Systems	# policies, by-laws and regulations changed to support national response • to support local responses	Quarterly	Regional partner reports

Systems	% countries with standard operating procedures (SOPs) for RCCE at community level • % communities using SOPs	Monthly	Regional partner reports
Systems	% countries with RCCE represented in incident management team; % countries including RCCE in rapid response teams	Quarterly	Country assessments
Systems	% national resources allocated to RCCE • disaggregated to % resources allocated to local level	Quarterly	National plans, country assessments
Systems	% countries with access to an identified technical support facility/mechanism	Quarterly	Regional partner reports

[*] Corresponds to the recommended core global indicator.
[**] Core knowledge, risk and other perceptions, attitudes and motivations, behaviour and practices (KAPB) variables identified in the COVID-19 global risk communication and community engagement strategy (in press).

Risk communication and community engagement (RCCE) is a critical part of every country's response to the COVID-19 pandemic. As part of a coordinated response, effective RCCE can help countries continue to drive down COVID-19 cases while simultaneously learning to live with COVID-19 in the longer term. This short framework, produced by the World Health Organization (WHO), the International Federation of Red Cross and Red Crescent Societies (IFRC) and the United Nations Children's Fund (UNICEF) is intended to guide countries of the WHO Eastern Mediterranean Region, IFRC and UNICEF's Middle East and North Africa Regions in developing their approaches to RCCE.

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