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UNICEF Eastern and Southern Africa Regional Office

Risk Communication and Community Engagement for Ebola Virus Disease Preparedness and Response

Lessons Learnt and Recommendations from Burundi, Rwanda, South Sudan, Tanzania and Uganda

Nairobi, Kenya
27–28 January 2020

REPORT OF A UNICEF REVIEW MEETING

Executive Summary

The prolonged outbreak of the Ebola Virus Disease (EVD) in the Democratic Republic of the Congo has had consequences for the countries neighbouring the affected provinces of North Kivu and Ituri. Over the past 18 months, UNICEF has supported four countries categorized as priority one (Burundi, Rwanda, South Sudan and Uganda), as well as Tanzania, in enhancing their readiness to respond to the imminent risk of cross-border EVD transmission.

Many lessons have been learnt, challenges tackled, and progress made during the longest-known preparedness effort for a public health emergency globally – some of which could be applied during other outbreaks, including the current coronavirus disease (COVID-19) pandemic.

This report explores the Risk Communication and Community Engagement (RCCE) undertaken for EVD preparedness in the priority countries and the main takeaways from these initiatives, based on a regional review and stocktaking meeting that UNICEF hosted in Nairobi, Kenya on 28–29 January 2020.

The following are key lessons learnt in the different countries:

- The prolonged period of community awareness regarding Ebola prevention resulted in message fatigue (a state of being exhaustion resulting from extended exposure to similarly themed messages). This calls for innovative strategies around messages, format and delivery platforms to keep audiences engaged while maintaining a high perception of risk during preparedness.
- Social science evidence reviews on cross-border dynamics between the Democratic Republic of the Congo and each of the neighbouring countries were crucial in informing the development of interventions addressing specific community issues in border locations.
- Strong coordination mechanisms for RCCE ensured optimization of resources, harmonization of public messages and clear division of labour among partners.
- The secondment of consultants to local government to provide direct support and mentoring counterparts in high-risk districts enabled skills transfer, contributing to systems strengthening and enhancing efforts for sustaining preparedness activities.
- The pairing of key community influencers with district technical officers during radio talk shows and call-in programmes ensured audience engagement, fostered trust and provided good opportunities to respond to rumours and provide feedback to the communities.
- The creation of the RCCE pillar of EVD preparedness and response ensured that due attention was given to its work, while the integration of RCCE into all pillars of EVD public health emergency preparedness/response ensured clear understanding of community perspectives, cross pillar technical support, while also allowing for feedback to other pillars from community interactions.
- Too much community feedback without corresponding mechanisms to respond leads to a "feedback blot."

Participants at the meeting also discussed recommendations for sustaining current preparedness activities and informing future ones. They include:

- Community feedback should be systematically collated, analysed and presented to/fed into the national task forces to ensure that concerns implicating other pillars can be responded to and acted upon.
- RCCE preparedness plans should be scenario-based to provide clear guidance for a nuanced transition of activities between preparedness and response.
- Cross-border collaboration and coordination between neighbouring countries should be strengthened to ensure the harmonization of messages and community engagement interventions. The free movement of people and the unique geographical and sociocultural dynamics of border communities calls for specific cross-border RCCE strategies, initially, these can piggy back on already strong surveillance cross border engagements.
- Community engagement interventions for EVD and other public health emergencies should consider health workers and support staff as priority audiences for engagement. Surveys from different countries showed limited knowledge and awareness of prevention measures among these groups.
- Social science research/anthropology should be incorporated into RCCE preparedness efforts to understand the unique contextual and social dynamics (beyond knowledge), in order to inform strategy and message design as well as inform response efforts through other pillars.
- Specific strategies should be developed for urban communities. Rural communities were more likely to be aware of EVD prevention measures than their urban counterparts.
- RCCE should be integrated into and a core part of the global health security agenda. There should be a review of RCCE aspects of the Joint External Evaluation tools to ensure that they are more comprehensive. Further, RCCE key partners should be deliberately included in all International Health Regulations (2005) processes – such as Joint External Evaluations, joint monitoring missions, joint assessment missions, after-action reviews.
- Establish/strengthen a regional coordination mechanism for RCCE, with systematic inclusion of international non-governmental organizations (NGOs) as key collaborative partners.
- Develop a toolkit for community feedback that can be adapted to different country contexts during outbreak preparedness and response.

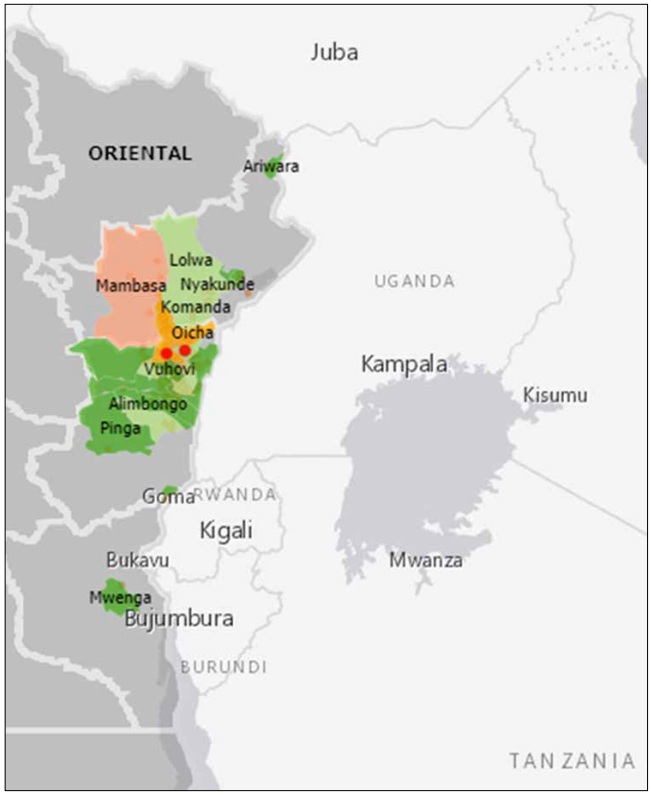
ACRONYMS

ACSM	Advocacy Communication and Social Mobilisation	**NAPHS**	National Action Plan for Health Security
EVD	Ebola Virus Disease	**RCSMCE**	Risk Communication Social Mobilisation and Community Engagement
KAP	Knowledge Attitude and Practice	**SSHAP**	Social Science in Humanitarian Action Platform
LC	Local Council		
NTF	National Task Force	**VHT**	Village Health Team

Introduction

On 1 August 2018, the Ministry of Health of the Democratic Republic of the Congo declared an outbreak of EVD in the Mabalako health zone of the Beni Territory in North Kivu Province. The outbreak was declared a Public Health Emergency of International Concern in July 2019, with a high overall risk of spread in the region. Burundi, Rwanda, South Sudan and Uganda were categorized as priority one countries for scaling up EVD readiness, while Angola, the Central African Republic, the Congo, Tanzania and Zambia were designated as priority two. The criteria for these categorizations were mainly proximity to the affected area and high volume of travel to and from it.

Two imported outbreaks reported in Kasese district of Uganda in June and August 2019 illustrated the continued risk of importation for neighbouring countries, especially Uganda which shares a long, porous border with DRC (around 2,698km km long), as well as Rwanda, which borders the city of Goma (North Kivu province) and Burundi, which borders Bukavu (south Kivu), areas that reported imported outbreaks. The quick and effective response in Uganda showed the value of investing in preparedness, including the added value of cross-border collaboration for public health emergencies. Without the significant financial, technical and institutional investments made, the disease could have easily spread, resulting in massive disruption and losses.



Map showing North Kivu/DRC and the preparedness countries

Background

UNICEF has worked with governments and implementing partners in the priority one countries to ensure that communities have comprehensive knowledge and are engaged on key protective behaviours for the prevention of EVD at individual and community level. Each country developed and implemented various RCCE interventions. These included surveys to establish community knowledge and perceptions, as well as the development of strategies and plans to guide implementation. The interventions used various approaches and channels to reach and engage different audiences. Community feedback mechanisms were instituted in high-risk locations

Through social science reviews and anthropological studies, UNICEF and its partners developed a better understanding of the local community's needs, fears and concerns. This helped in adapting the preparedness and response protocols based on socially and culturally acceptable contexts.

On 28–29 January 2020, over 30 participants from Burundi, the Democratic Republic of the Congo, Rwanda, South Sudan, Tanzania and Uganda attended a regional review and stocktaking meeting hosted by the UNICEF Eastern and Southern Africa Regional Office (ESARO) in Nairobi, Kenya.

Its purpose was to examine the progress that was made, the lessons learnt, the challenges that were encountered and the good practices that were used in RCCE for EVD preparedness in the priority countries. Participants also discussed recommendations for sustaining current preparedness activities and informing future ones.

The meeting included country presentations, a world café and panel discussions with UNICEF programme staff and representatives from the World Health Organization Nairobi hub , the International Federation of Red Cross and Red Crescent Societies and international NGOs based in Nairobi.

This report is a summary of the proceedings.

Opening Session

Charles Kakaire, the ESARO Communication for Development (C4D) specialist for emergencies, welcomed participants and noted that the meeting was the beginning of a process to share the lessons learnt from the longest-known preparedness effort for a public health emergency globally. These lessons will provide insight for future preparedness. Participants were urged to reflect on what this means for RCCE and the importance of documenting their experiences for potential replication.

Natalie Fol, the ESARO regional C4D adviser, noted that the meeting was a good learning opportunity and a chance to assess whether the region is better prepared for the next emergency. It is not clear if the current level of risk will warrant continued investment in preparedness and so it is important that creative approaches are used to convince donors to maintain their support.

The meeting was officially opened by ESARO Deputy Regional Director **Bo Viktor Nylund**. He noted that while the number of new infections in the Democratic Republic of the Congo is declining, there is a need to remain vigilant as the risk of importation remains high due to intense cross-border population movements. RCCE remains one of the most important pillars of preparedness for Ebola, as well as all public health emergencies. Regardless of context, communities need to be aware of the risk of contracting the disease and what they need to do to stay healthy – with or without Ebola. If communities are not properly engaged, outbreak control will fail. He thanked donors for their support of the preparedness efforts in the priority countries and government partners for the coordination and thought leadership.

The Department for International Development's humanitarian adviser, **Iesha Singh**, highlighted the UK government's commitment to taking early action and stressed that investment in building the resilience of countries, communities and people can save lives, protect livelihoods and safeguard development gains. Building resilience should focus on investing in health systems and looking at systematic efforts for longer-term solutions. The lack of a formal review means that it is challenging to objectively understand what has been comparatively achieved across the region. Related to this, she noted the need for well-defined minimum requirements for preparedness or operational readiness, as well as commonly agreed benchmarks. Other lessons identified included: the need to adapt to access issues in conflict/authoritarian settings and more broadly, capture feedback and ensure take-up by operational decision-makers developing models of collaboration between public health and wider humanitarian/development systems. The need to transition the preparedness interventions and identify what could be re/dual-purposed for other infectious disease responses beyond Ebola was stressed

Gabriele Fontana, the ESARO regional health adviser, emphasized the need to ensure that all preparedness efforts are aimed at broad systems strengthening. Lessons learnt from EVD should be used in all the other public health emergencies. The current coronavirus outbreak presents a perfect opportunity to test the preparedness mechanisms put in place for EVD over the past 18 months.

Ida-Marie Ameda, the ESARO Health specialist – public health emergencies, provided an overview of the EVD outbreak in DRC and imported outbreaks in Uganda, including key challenges in DRC and importation risks for neighbouring countries, cross border collaboration efforts including the Goma communique. The update also highlighted the UNICEF ESAR cross sectoral programmatic approach to EVD preparedness and how country offices were implementing it.

Achievements, Challenges and Lessons Learnt from EVD Preparedness in the Priority Countries

The meeting began with poster presentations of the countries' progress on the preparedness actions undertaken since August 2018. Country updates focused on the essential RCCE intervention areas, including national and subnational coordination of RCCE interventions; evidence generation through rapid surveys to establish EVD community knowledge and perceptions; mass media; social mobilization and community engagement interventions; development of communication materials and job aids; and mechanisms to collect and respond to community feedback on the preparedness efforts and other concerns.

Key highlights from some of the countries include the use of street LED screen displays in Rwanda targeting transient populations, the anthropological study in Uganda which provided unique insights that informed preparedness, use of mobile caravans in high traffic points such as markets and bus stops in Burundi, airing/distribution on flash drives of *The story of Ebola* animated video in all Public Service vehicles, and local video theatres (Video Bandas/shacks) in Tanzania, and an extensive rumour tracking mechanism through the Integrated Community Mobilisation Network in South Sudan.

Please see Annex 1 for full details of the country interventions

Thematic Deep Dives

Rwanda – Mobilizing Media for EVD Preparedness

Rwanda used various mass media interventions to increase awareness about EVD prevention in the country. UNICEF partnered with the Rwanda Broadcasting Agency and a network of private radio stations to broadcast EVD prevention messages across all the radio stations. This ensured that key messages had an extensive reach across the country. This was reinforced by a network of journalists trained by the Rwanda Journalists Association who provided factual information about the disease.

Building on existing platforms, EVD prevention messages were incorporated into a local entertainment radio drama series called 'Itetero,' linking EVD prevention with early childhood development through the listening clubs for children and parents. Digital, outdoor LED screen displays were used at border towns to show EVD messages and short video clips, including a translated version of the video animation *The story of Ebola*. These screens effectively reached mobile populations at high-risk Points of Entry and in major towns.

South Sudan – Listening, Collecting and Responding to Community Feedback

South Sudan operates in a context of low literacy (27% above 15 years), multi-ethnic population, multiple disease outbreaks, a fragile health system, large nomadic population, insecurity and linked to this many media dark areas. To work optimally in this context, community engagement is undertaken through a countrywide network of social mobilizers – the Integrated Community Mobilization Network (ICMN). Mobilizers carry out community outreach activities, including routine collection of rumours and feedback from the community regarding the EVD prevention efforts.

Through the ICMN, community perspectives relating to the EVD prevention efforts and others topics are collected. Responses are then fed back into the community through radio programmes, community leaders and the mobilizers – either through community dialogues or individual routine home visits.

This mechanism was very instrumental in capturing and addressing sensitive community issues, many of which related to different pillars of preparedness efforts. Training, job aids and supportive supervision for the 2,500-member ICMN network ensured effective engagement, dialogue and the building of community trust. The work is not without challenges, which are mainly around systematic collection and management of feedback due to its sheer volume, multiple outbreaks which divert attention and the fact that some of the high-risk EVD states[1] are inaccessible due to ongoing conflict.

There are opportunities for enhancing this work and they include: an initiative supported by the Centers for Disease Control and Prevention to strengthen the EVD community feedback system and funding from World Bank – together these are being used to enhance the system to respond to all other health emergencies beyond Ebola, as part of systems strengthening.

Burundi – Engaging Communities for EVD Prevention

UNICEF, in collaboration with Burundi's Ministry of Health and Red Cross Society, conducted interpersonal communication and community engagement activities in all high-risk provinces.[2] The approach used included: capacity building of all stakeholders including community leaders, tradi-practitioners, community relays, fisherfolk, health workers, transporter association, women and youth association; use of a mix of media, social mobilization and advocacy and interpersonal communication.

Red Cross mobilizers conducted community outreach in schools, in markets and on public transport and carried out house-to-house visits, reaching target audiences in high-risk locations. Community health workers conducted outreach in health facilities and through key influential leaders in high-risk provinces, ensuring effective engagement of communities.

Roadshows were conducted using mobile caravans facilitated by the Ministry of Health to increase community awareness about EVD prevention, using edutainment formats. Caravan activities targeted busy locations within the high-risk provinces. A key lesson learned was the role of strong collaboration between government and partners in establishing the subcommittee for RCCE, developing a strategic approach and implementing it down to community level. The RCCE committee would like to put in place a community feedback mechanism and, working with the surveillance pillar, involve community leaders in community-based disease surveillance.

Uganda – Establishing a Multilevel Coordination Mechanism for Effective EVD Prevention

Coordination is key to effective preparedness. The existence of several actors in the RCCE pillar requires an effective coordination mechanism to optimize resources, harmonize public messages and clarify who is doing what where to ensure equitable coverage of pillar activities.

The RCCE pillar is part of the Public Health Emergency Operation Centre's national task force and is chaired by the Ministry of Health Health Promotion Department.

RCCE activities were coordinated through the Ministry of Health in the Risk Communication, Social Mobilization and Community Engagement (RCSMCE) Subcommittee.

1 Jubek, Yei River State, Morobo, Kajo-Keji, Torit, Nimule, Yambio, Tambura, Maridi and Wau
2 Priority 1 (6 health districts): Bujumbura North, Cibitoke, Isale, Mpanda, Mabayi, Bujumbura Center
Priority 2 (14 health districts): Rumonge, Kabezi, Bubanza, Bugarama, Bujumbura South, Kayanza, Ngozi, Buye, Kiremba, Vumbi, Kirundo, Busoni, Giteranyi, and Muyinga). These were prioritized because of cross border movement between Rwanda and Tanzania.

The elaborate mechanism is composed of several sub-working groups to ensure effective division of labour. It was replicated at the subnational level through district-level RCSMCE technical working groups in the affected areas.

Partner coordination during the EVD preparedness and response enabled the development of a harmonized national EVD prevention strategy and plan, as well as the production of standardized messages and development of information, education and communication (IEC) materials. Coordination ensured joint supportive supervision, the development of standard operating procedures and the alignment of all RCCE partner activities in the high-risk districts. The national task force held weekly coordination meetings during the preparedness phase. The frequency of these meetings was increased to twice daily during the response phase. Some of the best practices include: standardised approach to materials messaging and production; development and use of harmonised tools by national and district level committees; scaling up community engagement via trusted persons and strategic integration of committee work into other sectoral activities including health (village health teams), schools (school outreaches), child protection (parasocial workers) among others.

See Annex 2 for illustration of how the RCCE coordination mechanism in Uganda functioned.

Tanzania – Generating Evidence to Inform Strategy Design and Message Adjustment

A knowledge, attitudes and practices (KAP) survey was commissioned to establish community knowledge and perceptions in eight districts located within the four EVD high-risk regions of Dar es Salaam, Kigoma, Mwanza and Rukwa.

Key findings: EVD awareness was very high among communities, but that comprehensiveness was very low when it came to their knowledge of the disease. Comprehensive knowledge was higher in rural areas than urban. More awareness was also recorded among children who were in school than among out-of-school children.

The survey findings informed the development of an RCCE strategy and plan for the prevention interventions. An anthropological study is underway to identify unique contextual and cultural dynamics specifically related to health-seeking behaviour and burial practices in the high-risk regions.

Similar studies in neighbouring priority countries, such as Uganda, have provided new insights into the role of certain groups and the nature of the engagement that is needed. Boda boda (motorcycle) taxis need to be involved as key allies in preparedness – both for risk communication (to engage their clients), surveillance (more knowledge about the locations of the sick and dead) and for safe and dignified burial (high motivation to carry the dead, as they come with a higher charge).

Sectoral Reflections and Synergies from Water, Sanitation and Hygiene, Nutrition and Child Protection

Ida-Marie Ameda (Health specialist – emergencies) moderated a session on using a cross sectoral approach EVD preparedness and response. The panellists were from UNICEF ESARO and included: Ndeye Marie Diop child protection in emergencies specialist, Marjorie Volege Nutrition in emergency specialist, Pierre Fourcassie WASH Humanitarian specialist and Akshay Sinar Humanitarian Programme Monitoring Specialist. The focus of the discussion was synergies with RCCE teams, lessons learned from this engagement during EVD preparedness and response and opportunities. The top three points included the: (i) importance of using social science knowledge to inform and appropriately focus preparedness and response efforts; (ii) ensuring any materials, messages and approaches involving health workers, the social workforce, community health workers and communities, need to be developed together with RCCE and formally tested before use and finally, (iii) need for dedicated funding for interventions (at least 20 to 30% of the budget), an adequate and well trained workforce and indicators for measuring progress to enable full functionality of RCCE as a critical function during all public health emergencies.

Learning from Partners: Reflections from World Health Organization, OXFAM and Save The Children

Miriam Nanyunja, senior technical adviser for preparedness at the World Health Organization's sub regional Nairobi hub, noted that RCCE is everyone's business and highlighted that there is need to organise a training for responders from all pillars on the basics of RCCE.

The increasing number of infections among health workers points to challenges with behaviour change, particularly when it comes to infection prevention and control among health workers. Consideration should be given to targeting RCCE at health workers as first responders, in addition to the community.

There are many partners involved in RCCE; hence, there is a need for coordination within the technical working groups to harmonize the contributions of the different partners.

Cross-border collaboration on RCCE is necessary to ensure similar messaging in the border communities, which are homogenous and highly mobile. She highlighted the importance of ensuring that RCCE is involved in all IHR

related processes and the global health security agenda, given its importance in response to ever increasing numbers of public health emergencies.

Margaret Asewa from Oxfam and **Nicola Brown** from Save the Children noted that the field presence of NGOs in most high-risk districts makes them better placed to support RCCE activities using their existing community structures.

Strategic engagement and collaboration with NGOs as key partners rather than implementing agencies was noted as key to sustaining preparedness and response interventions for EVD and other public health emergencies.

The absence of a regional-level coordination mechanism for RCCE was noted as a challenge for fundraising efforts and the alignment of partner activities.

General Participant Reflections on EVD Preparedness Efforts

What went well	What went less well
Existence of partnerships to scale up community engagement	Lag in community feedback and rumour tracking across all the preparedness countries
Involvement and goodwill of national governments	NGOs seen as implementing partners and not collaborators in the EVD preparedness activities
Radio communication – reassuring during the outbreak phase (radio interactive talks)	Message fatigue resulting from the prolonged exposure to EVD prevention messages
Cross-border collaboration, e.g. between Uganda and Democratic Republic of the Congo, which enabled synchronisation of border activities	Short-term funding for EVD preparedness
	Feedback blot – too much bad news

Transitioning from Preparedness to Response: Lessons from Uganda

After 11 months of preparedness, Uganda confirmed its first cases of EVD in June 2019. The cases – three members of the same family from the Democratic Republic of the Congo – were identified and isolated at the point of entry. The outbreak provided an opportunity to test the preparedness mechanisms that had been put in place.

Tabley Bakyaita, Uganda's assistant commissioner for health promotion, described how the transition was managed. A scenario-based RCCE preparedness plan provided a clear framework for transitioning to the response. The implementation plan described key actions for preparedness/prevention as long as there were no EVD cases (scenario one); activities that would be taken during a localized outbreak (scenario two); and interventions for an outbreak in multiple locations (scenario three).

During the outbreak, scenario two interventions were immediately activated. They included the activation of standard operating procedures for social mobilization and community engagement, as well as the deployment of RCCE teams as part of the rapid response teams to Kasese district which was reporting cases, and surrounding districts which were at high risk of transmission.

Prepositioned and on-air public messages were immediately adjusted to reflect the heightened risk and the start of the response phase. The subnational RCCE coordination mechanism in the outbreak-affected district was activated, with direct linkages and guidance from the national RCCE subcommittee.

Other activities carried out during the outbreak phase included the following:

- Coordination meetings of the RCCE subcommittee were convened twice daily to jointly review scenario two activities and compile situational reports;
- A WhatsApp group was established for RCCE subcommittee members, providing regular updates on who was doing what where and allowing real-time coordination between the subnational and national RCCE subcommittees;
- The inventory of implementing partners was updated and personnel was deployed to Kasese District – the location of the outbreak – to work with the district team on immediately activating community outreach visits;
- All key media focal points and implementing partners were issued with a set of basic EVD facts and talking points to ensure consistency of message;
- The frequency of the radio spots and other messages was increased and talk shows were rescheduled with talking points adapted to fit the current context;
- Scaled-up online media engagement was done across all platforms, providing regular updates, responding to questions and dispelling rumours;
- Standard operating procedures and guidelines of engagement were provided to ensure a coordinated approach, micro-plans were developed, and community outreach activities were scheduled;
- Harmonized training of all village health teams and local leaders was launched, featuring orientation on basic messages, communication skills and community-based surveillance;

- Risk communication staff were joined to other pillar teams (e.g. vaccination; surveillance; psychosocial; water, sanitation and hygiene/infection prevention and control) before community visits to ensure use of proper communication approaches, uniform messaging and engagement with communities;
- EVD messages in the local languages of the affected communities were reprinted and rapidly distributed/ disseminated, with permission for partners to reprint for their areas of operation.

Reflections from the Democratic Republic of the Congo

Karen Greiner, the UNICEF senior adviser for C4D in Goma, noted that there have been major shifts in the response in the Democratic Republic of the Congo to address community concerns.

These have included updates to content – adjusting the formats of public information materials from fewer posters and messages to more tools and resources for responders such as job aids or conversation/ community dialogue guides – and the reconstitution of rapid intervention teams to include community, traditional, religious and women's leaders.

There has also been a shift in focus on strengthening community systems, which led to the reactivation of Community Action Cells (CAC) as platforms for community mobilization and engagement. Action plans from the cells create opportunities for non-Ebola investments and initiatives with potential for greater impact on communities.

Studies from the Social Science Cell (a pillar focussed on social science research) found low self-reported rates of Ebola knowledge among health workers, coupled with high transmission in informal healthcare settings. In response, C4D supported the development of tools for traditional healers (in collaboration with the Infection Prevention and Control Commission), as well as tools to strengthen health workers' ability to describe and recognize symptoms in infants.

Challenges were noted relating to the amount of feedback collected, with limited ability and capacity to respond effectively.

Sharon Reader, Community Engagement and Accountability Adviser at the International Federation of the Red Cross and Red Crescent Societies, presented the community feedback mechanism that her organization has deployed in the Democratic Republic of the Congo to collect community perceptions about the response, including suggestions for interventions. Over 500,000 feedback comments have been received since August 2018.

Feedback is collected by volunteers during the community interactions they have as part of their normal outreach work. They simply record in free text what people are saying, the questions they ask or the suggestions they make. At the end of every day, the volunteers share their handwritten with their supervisors. It is then coded and analysed, with support from the Centers for Disease Control and Prevention. The results are widely shared with responders on a weekly basis.

One challenge that was noted is the need to act on the collected feedback at a wider level, which has not happened so far.

Reader said the International Federation of the Red Cross and Red Crescent Societies' key actions have been the translation of feedback into concrete action, support for the setup of community feedback working groups in all locations and the development of a community feedback system guide and toolkit for future operations.

Key Lessons Learnt

In Tanzania and Uganda, KAP studies showed that rural audiences were more likely to be aware of EVD prevention mechanisms than their urban counterparts. While additional research may be needed to explain this trend, this highlights the need to develop urban-specific strategies to ensure wider reach and engagement of urban populations.

As part of systems strengthening, UNICEF recruited and seconded RCCE consultants to the high-risk regions/ districts/provinces to provide direct support and mentoring to local government counterparts. This ensured capacity strengthening for the local governments, enabled skills transfer and contributed to better efforts in sustaining preparedness activities.

In order to build community trust and dispel potential misinformation, deliberate efforts were made to pair technical officers with key community influencers during radio talk shows and call-in programmes. This ensured audience engagement, fostered trust and provided good opportunities to give feedback to the communities. The radio talk shows and call-in programmes also provided powerful platforms for responding to rumours.

Surveys in the preparedness countries showed that schoolchildren were more likely to be aware of EVD prevention mechanisms than their out of school counterparts. While this might have demonstrated effectiveness of the school-based activities, it also highlights the need for intensified community engagement activities targeting out-of-school children.

Health workers in many of the preparedness countries also exhibited limited knowledge and awareness of basic EVD

information, as well as infection prevention and control. This points to the need to consider them as a primary target audience for EVD awareness and infection prevention and control interventions.

Social science research was crucial in shaping the preparedness interventions. Evidence reviews on cross-border dynamics between the Democratic Republic of the Congo and the priority one countries provided insights into the nuances at border locations, which were contextualized as part of the preparedness and response efforts. Similarly, an anthropological study in Uganda helped to unearth unique contextual issues that would have otherwise been missed with the KAP surveys. Findings from the study were used to inform the messaging and RCCE strategy, as well as other pillars of preparedness.

Recommendations

Community feedback should be systematically collated, analysed and presented to/fed into the national task forces to ensure that concerns implicating other pillars can be responded to and acted upon.

RCCE preparedness plans should be scenario-based to provide clear guidance for a nuanced transition of activities between preparedness and response.

Due to the mobile nature of border communities and their unique contextual environment – including cross-border livelihood means, media consumption and community mobilization platforms – there is a need to develop specific strategies for engaging audiences on either side of the border. RCCE implementers could follow the example of immigration and customs departments that collaborate at ports of entry. The East African cross-border surveillance network was identified as one good practice mechanism for cross-border collaboration.

Community engagement interventions for EVD prevention and other infectious diseases should consider health workers and support staff – such as cleaners, security guards and food handlers – as priority audiences for engagement, due to their high risk of exposure and limited knowledge on the identification of symptoms and the key preventive and personal protective measures.

Social science should be a key aspect of RCCE prevention actions to facilitate a better understanding of unique contextual and social dynamics, which have implications for community engagement and may not be picked up by knowledge or perception surveys.

The quality of communication materials was identified as a key area of improvement, as audience attention is linked to the attractiveness of the materials. They should be catchy to attract the attention of the intended audiences.

RCCE should be mainstreamed as a core element of the International Health Regulations. This would ensure the systematic inclusion of key elements in all outbreak preparedness and response mechanisms, such as joint external evaluations, after-action reviews, joint assessment missions and joint monitoring missions.

While RCCE coordination mechanisms exist at country level, coordination remains weak at regional level. There is need to establish a regional coordination mechanism for RCCE, with systematic inclusion of international non-governmental organizations (NGOs) as key collaborative partners.

RCCE should be integrated into and as core part of the global health security agenda. The inclusion of RCCE in all International Health Regulations processes – such as joint monitoring missions, joint assessment missions, after-action reviews, etc. – should be advocated.

Proposed Actions for Improving Preparedness

Data for Action (Country level)

- Identify credible institutions to support RCCE-related surveys
- Develop a roster of individuals and institutions available for short-term deployment to carry out social science/ anthropological work
- Develop a social science module for RCCE practitioners to equip them with basic knowledge, enabling them to play an effective oversight and quality assurance role during their interactions with the social science researchers
- Present key findings from surveys and social science research to national task forces, with clear follow-up actions to be monitored by the incident management team
- Establish collaborative arrangements with national statistics and/or research institutions to support rapid surveys and assessments
- Create a repository of modules and ready-to-use tools, as well as guidelines for RCCE research, to allow quick adaptation

Coordination (Regional level)

- Establish a regional coordination mechanism for Risk Communication and Community Engagement
- Reinforce the strategic positioning of RCCE as part of all International Health Regulation processes
- Develop a toolkit for community feedback which can be adapted to country context
- Develop guidance for Urban RCCE strategies for Public Health Emergencies
- Facilitate discussions and engagements around Cross border coordination

Next Steps for 2020 Country Preparedness

Burundi

- Undertake KAP study to establish the effectiveness of interventions
- Reinforce cross-border coordination with the Democratic Republic of the Congo
- Finalize the standard operating procedures for RCCE

Rwanda

- Provide technical support to the Ministry of Health through the deployment of consultants to high-risk districts
- Conduct a second KAP survey
- Identify and utilize mechanisms for community feedback
- Revise partnership materials and content, focusing on job aids for community health workers

South Sudan

- Revise the 2020 plan to strengthen RCCE beyond EVD, with a focus on the National Action Plan for Health Security, capacity building and subnational coordination mechanisms
- Transition/adapt the EVD community feedback mechanism into a multi-hazard mechanism for tracking community feedback for all Public Health Emergencies beyond EVD

Tanzania

- Establish subnational coordination mechanisms for RCCE
- Establish a mechanism for collecting rumours and analysing feedback from the community
- Finalize and standardize training materials for community mobilizers
- Establish clear mechanisms for monitoring RCCE activities, with clear linkages to the Health Management Information System

Uganda

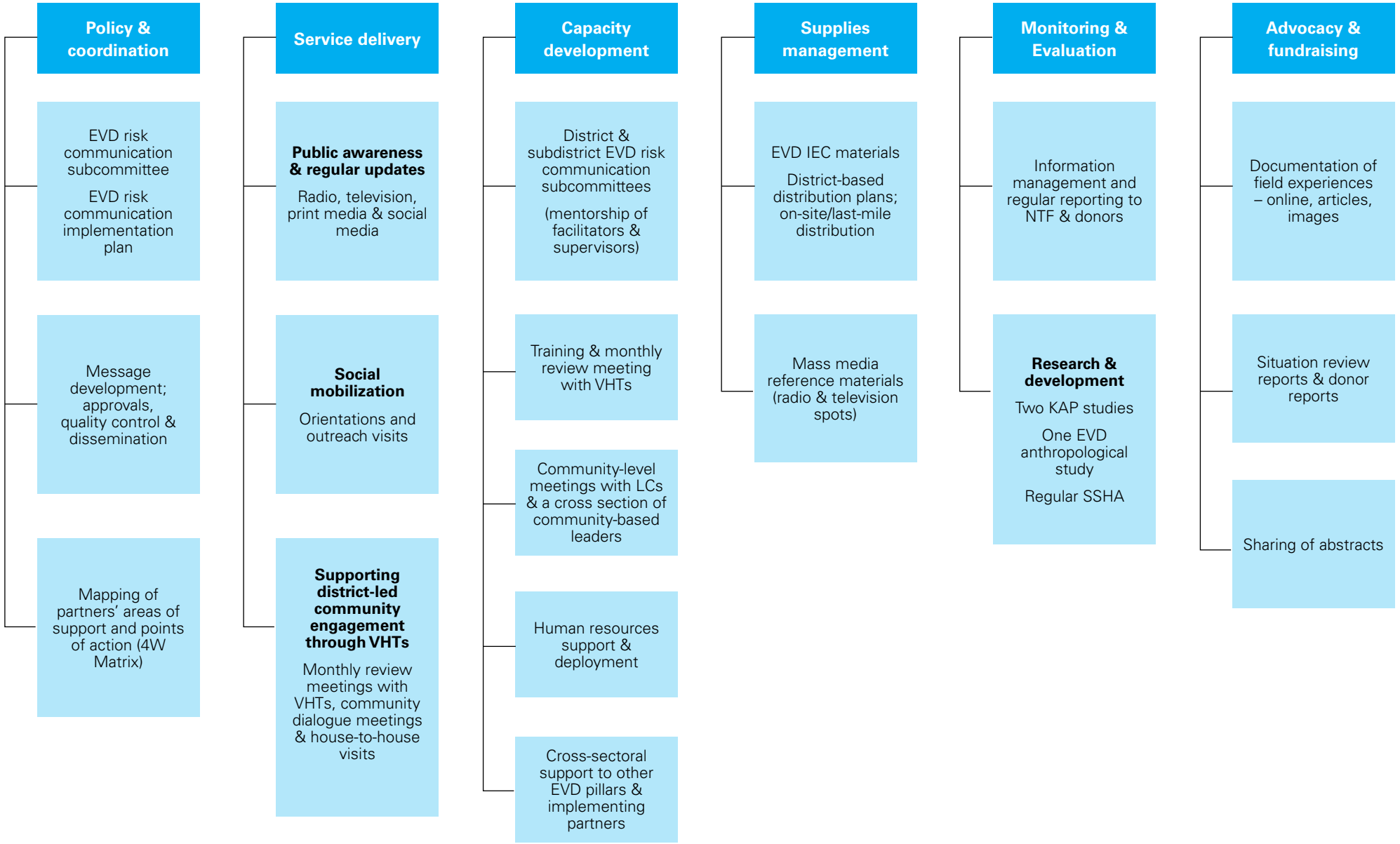
- Revise the RCCE strategy based on the results of the second KAP
- Develop a specific RCCE strategy for urban communities
- Organize regular cross-border coordination meetings with neighbouring countries

Annex 1: Overview of individual country preparedness activities for EVD

RCCE work area	Country updates				
	Burundi	Rwanda	South Sudan	Tanzania	Uganda
Coordination	• National EVD communications sub commission activated • Subcommittees activated at province and district levels • Bimonthly meetings held • In process of developing standard operating procedures for EVD RCCE	• National EVD RCCE working group activated • Weekly meetings held • Standard operating procedures for EVD RCCE developed	• National EVD RCSMCE working group subcommittee activated • Weekly meetings held • Standard operating procedures for EVD RCCE developed	• RCCE working group activated • Biweekly coordination meetings held • Standard operating procedures for EVD RCCE developed	• RCCE working group activated • District task force activated in high-risk districts • Weekly coordination meetings held – turned daily during outbreak response • Activated standard operating procedures for viral haemorrhagic fevers exist
Evidence generation	• KAP survey conducted in high-risk regions • Compiled a Social science Evidence review on Cross-Border dynamics between Burundi and Democratic Republic of the Congo	• KAP survey conducted in high-risk districts • Compiled a Social science Evidence review on Cross-Border dynamics between Rwanda and Democratic Republic of the Congo	• KAP survey conducted in high-risk regions • Compiled two Social science Evidence reviews on cross-border dynamics between South Sudan, Uganda and Democratic Republic of the Congo and Bushmeat in the border areas of South Sudan and DRC	• Conducted a KAP survey conducted in three high-risk regions • Conducted an Anthropological study two high-risk regions of	• Two KAP surveys conducted in high-risk regions • Anthropological study in seven high risk districts to determine contextual factors • Conducted Social science Evidence review on Cross-border dynamics between Uganda and Democratic Republic of the Congo
Communication materials	Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools	Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools	Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools	Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools	• Held a workshop to review, and translate IEC materials into 8 languages • Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools
Mass media	Radio messages, talk shows, call-in programmes	• Ebola song and video • Radio messages and public service announcement • Outdoor LED screen displays in Kigali and border towns • Community radio station in border town with prizes for listeners • Live streaming of roadshows and other mobilization events • Radio drama series	• Radio messages, public service announcements	• Radio and Television, • *Story of Ebola* animation video recorded on flash drives and distributed through Public transport, and local cinemas, churches and schools • Partnership with BBC Media Action to train journalists on EVD reporting	• Held a workshop to review, and translate IEC materials into 8 languages • Variety of IEC materials printed, including Posters, banners, leaflets, job aids, flip charts and fact sheets for schools

RCCE work area	Country updates				
	Burundi	Rwanda	South Sudan	Tanzania	Uganda
Social mobilization and community engagement	Engagement of religious leaders	• Community health workers • Partnership with faith-based organizations • Engagement during *Umuganda* (national Community workday)	• Direct engagement through the integrated community mobilization network • Partnership with Catholic Missionaries	• Partnership with Tanzania Red Cross Society	• Partnership with Uganda Red Cross Society and Lutheran World Federation • Direct cash transfers to local governments (districts)
Community feedback and measuring results	• Radio • Toll free line	• Toll free line • Community radio with call-back logs	• Rumour tracking through the ICMN • Toll free lines	Toll freeline Rumour tracking and community feedback mechanisms under establishment linked to the Health Management Information System	• U-Report dashboard managed by the Uganda Red Cross Society • Radio talk shows • Community meetings • U-Report polls

Annex 2: The anatomy of an RCCE coordination mechanism in Uganda



Annex 3: Agenda

DAY ONE: TUESDAY 28, JANUARY

Opening, setting the scene and overview

Time	Session	Method	Presenters / Lead
8:30 - 9:00	Registration of participants		Mercy Ndegwa – Programme Associate
9:00 - 9:15	Welcome and opening	Plenary	Charles Kakaire, C4D Specialist, ESARO Natalie Fol, Régional Advisor, C4D, ESARO Bo-Victor Nylund, UNICEF ESARO DRD
9:15 – 9:30	Security briefing (UNDSS) - Duncan	Plenary	Duncan Kagio – Security Officer
9:30 – 9:40	Setting the scene (Introduction of participants, meeting objectives, common rules and other announcements)	Plenary	Charles Kakaire – C4D Specialist, ESARO
9:45-10:15	Overview of the EVD outbreak in DRC situation and ESAR guidance on EVD preparedness	Plenary présentation (20') and Q&A (10')	Gabriele Fontana, Regional Adviser, Health, ESARO Ida Marie, Health Specialist, ESARO
10:15-10:35	Reflections on investing in EVD preparedness in ESAR – UK Department for International Development (DFID)	Oral presentation (10') and Q&A (10')	Gema Redondo - Humanitarian Advisers – Uganda Ebola Preparedness and Response, and Iesha Singh, Humanitarian Adviser, Regional Ebola Response, UK

10:35 – 11:00 COFFEE BREAK

Deep-dive: achievements, challenges and lessons learnt from EVD preparedness in the priority countries

11:00-11:45	Market Place - Exhibition of Country Posters Each country presents a summary of their preparedness work on A1 Poster under the following dimensions: 1. Coordination 2. Evidence generation 3. Communication materials development 4. Mass media 5. Social mobilisation and Community Engagement 6. Community feedback and measuring results	Each country presents their summary in 7 minutes 10 minutes Q&A	To be determined by COs – One presenter per country

Time	Session	Method	Presenters / Lead
11:45-13:00	Thematic deep dives on specific achievements: • Establishing multi-level coordination mechanism for effective EVD preparedness in Uganda • Mobilising the media for at scale EVD awareness in Rwanda • Engaging communities to prevent EVD in high risk areas in Burundi • Collecting and managing community feedback in South Sudan • Generating evidence to inform EVD preparedness in Tanzania	Plenary presentations (5X10') Interactive dialogue (20')	To be determined by COs – One presenter per country
13:00 - 14:00 LUNCH BREAK			
14:00 -14:40	Sectoral reflections on synergies and collaboration with Health, Nutrition, Child Protection, WASH, HARP	Panel discussion 5 x 5' Discussion (10')	Ida Marie Ameda – UNICE Health Emergencies Marjorie Volege – UNICEF Nutrition Specialist Marie Diop – UNICEF Child Protection Specialist Pierre Fourcassie – UNICEF WASH Specialist Akshay Sinha – UNICEF Emergencies Specialist
14:40 – 15:10	Learning from partners: WHO and INGO Coalition for EVD Preparedness	Plenary presentation (15'); Q&A (15')	Dr. Julius Wekesa - Manager, Outbreaks and Crisis Response - WHO Margaret Asewa – WASH coordinator - OXFAM Nicola (Nicki) Brown - Regional EVD Health Advisor - Save The Children
15:10-15:40	Country group discussion – What went well, less well and why? *Coffee/tea will be available at the back of the room*	Thematic group discussions	To be determined
15:40 – 16:20	Feedback on thematic discussion	Plenary	Rapporteur from each group
16:20- 16:30	Wrap up of Day 1: Key take-aways from the day?	Plenary	Charles Kakaire – C4D Specialist

DAY TWO: WEDNESDAY 29 JANUARY

Responding to EVD: experiences from DRC and Uganda

Time	Session	Method	Presenters / Lead
8:30 - 8:45	Main points from previous day; Introduction of the topics for the day	Plenary	Charles Kakaire – C4D Specialist
8:45 - 9:05	Transitioning from Preparedness to Response – *Reflections from Uganda*	Oral presentation (10') and Q&A (10')	To be determined by COs – One presenter only
9:05 - 9:45	Overview of RCCE Response in DRC: UNICEF and IFRC	Plenary presentations (2X 15') Discussion (10')	Karen Greiner – Senior Advisor, C4D - UNICEF DRC/Goma Sharon Reader - Community Engagement and Accountability (CEA) Lead - IFRC
9:45 – 10:15	- Reflections from Uganda on Cross border collaboration Example: DRC/Uganda RCCE meeting	Oral presentations (DRC: 15' – UCO: 5') and Q&A (10')	Uganda – Presenter to be determined
10:15 - 10:45 COFFEE BREAK			

Looking ahead for improved and sustained EVD preparedness in ESAR

10:45 -1 1:45	Thematic group discussion for improved interventions in 3 core areas: - Cross border collaboration - Evidence generation and use - Monitoring, reporting and documentation	Participants divided into core areas	To be determined
11:45 - 12:30	World Café	Groups rotate to see other Country colleagues' proposals	Rapporteur to be determined
12:30 - 13:00	Feedback from groups and agreement on priority focus areas for sustaining preparedness	Feedback in plenary	Rapporteur from each group
13:00 - 14:00 LUNCH BREAK			

Time	Session	Method	Presenters / Lead
14:00 - 14:45	What can we do better? Individual Country reflection and agreement on key areas of focus for 2020	Country group work	Rapporteur to be determined
14:45 – 15:15	Report back from countries	Feedback in plenary	Rapporteur from each country
15:15 - 16:10	Discussion on way forward/Next steps and commitments (RO, CO) *Coffee/tea will be available at the back of the room*	Plenary discussion	Charles Kakaire / Gabriele Fontana
16:10 - 16:30	Wrap up and closure	Plenary	Natalie Fol

Annex 4: List of Participants

N°	COUNTRY / AGENCY	NAME	FUNCTION
1.	Uganda	Miriam Lwanga	UNICEF C4D Specialist
2.		Susan Birungi Nyakoojo	Programme Officer, West Central Zonal Office
3.		Tabley Bakyaita	MOH – Assistant Commissioner, Health Promotion
4.	Rwanda	Maksim Fazlitdinov	UNICEF C4D Specialist
5	Burundi	Fatimata Balandi	UNICEF C4D specialist
6		BUKURU Pamphile	MOH - Chief IEC section
7.	South Sudan	Gopinath Durairajan	UNICEF Chief, C4D
8.		Aping Kuluel	UNICEF C4D officer
9.		Mary Obat	MOH – Director of Health Promotion and Education
10.	Tanzania	Hanna Woldemeskel	UNICEF C4D Specialist;
11.		Judith Bihondwa	Overall lead – EVD Preparedness
12.		Dr. Amalberga Kasangala	MoH - Assistant Director, Health Promotion Section
13.	DRC	Karen Greiner	UNICEF DRC/Goma – Senior Adviser, C4D
14.	Kenya	Surangani Abeyesekera	UNICEF C4D Specialist
15.		John Obisa	UNICEF C4D Specialist
16.	DFID	Gema Redondo / Iesha Singh (Remotely)	Humanitarian Adviser - Uganda Ebola Preparedness and Response
17.	ESARO	Natalie Fol	UNICEF Regional Adviser, C4D
18.		Gabriele Fontana	UNICEF Regional Adviser, Health
19.		Charles Kakaire	UNICEF C4D specialist (Emergencies)
20.		Massimiliano Sani	UNICEF C4D Specialist
21.		Kenneth Limwame	UNICEF C4D Specialist
22.		Fitsum Habtemariam	UN Volunteer
23.		Ida Marie Ameda	UNICEF Health Specialist (Emergencies)
24.		Marjorie Volege	Nutrition Specialist (Emergencies)
25.		Marie Diop Ndeye	UNICEF Child Protection Specialist (Emergencies)
26.		Pierre Fourcassie	UNICEF WASH Specialist (Emergencies)
27.	WHO	Dr. Miriam Nanyunja	Senior Technical Advisor, Preparedness; Eastern and Southern Africa
28.		Dr. Julius Wekesa	Manager, Outbreaks and Crisis Response, Eastern and Southern Africa
29.	IOM	Obat Andrew Peter	Senior Migration Health Emergency Response Officer - Africa and Middle East
30.	UNOCHA	Joy Maingi	Humanitarian Affairs Officer
31.	IFRC	Sharon Reader	Community Engagement and Accountability (CEA) Lead, Africa Region
32.	INGO Coalition – Save The Children	Nicola (Nicki) Brown	Regional EVD Health Advisor – Eastern and Southern Africa
33.	INGO Coalition – Oxfam	Margaret Asewa	WASH coordinator - Horn, East and Central Africa

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