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# Risk Communication and Community Engagement

Indicator Guidance for COVID-19

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Produced by the Collective Service for Risk Communication and Community Engagement (RCCE)  
in collaboration with the Inter-agency RCCE Data for Action Working Group.

## Acknowledgements

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The Collective Service Secretariat developed this guidance in close cooperation with the Collective Service core member agencies. The Global RCCE Data for Action Working Group was consulted throughout the development process, with members making substantial inputs to the guidance. The RCCE Data for Action Working Group is composed of participants from CDC, IFRC, Gates Foundation, GOARN, JUH, OXFAM, UK Med, INTERNEWS, UNICEF and WHO. The Collective Service Secretariat also liaised with the YES! - Global Collective Service Youth Engagement Subgroup, Global Collective Service Community Engagement in Low Resource Settings Subgroup, Global Collective Service Migrants, Refugees, host communities and other vulnerable groups sub Working Group and the Global Collective Service Media Working Group to discuss and develop the indicator guidance. Consultations and engagement also took place with Collective Service colleagues working at regional level in Asia Pacific, Middle East and North Africa, East and Southern Africa, West and Central Africa, Europe and Central Asia and Latin America and the Caribbean.

### **Specifically we would like to thank the following contributors:**

Genevieve Hutchinson, BBC Media Action; Kaushiki Ghose, BBC Media Action; Rosie Jackson, CDAC Network; Christina Craig, CDC; Riley Wagner, CDC; Nancy Pattison Wong, CDC; Eva Niederberger, Collective Service for RCCE; Brian Mac Domhnaill, Collective Service for RCCE; Silvia Magnoni, Collective Service for RCCE; Vincent Turmine, Collective Service for RCCE; Ginger Johnson, Collective Service for RCCE; Caroline Austin, IFRC; Monica Posada, IFRC; Benjamin Noble, IFRC; Santiago Rodriguez, IFRC; Viviane Fluck, IFRC; Frida Archibold, IFRC; Ombretta Baggio, IFRC; Helen Rice, IFRC; Ida Jooste, Internews; Stijn Aelbers, Internews; James Sport, Internews; Hana Pasic, GYM; Kathryn Bertram, JHU; Tom Black, Gates Foundation; Jeni A. Stolow, GOARN; Sameera Suri, GOARN; Peter Winch, LSHTM Hygiene Hub; Caroline Muturi, OXFAM; Raissa Azzalini, OXFAM; Abie Bangura, OXFAM; Michelle Farrington, OXFAM; Anu Puri, UNICEF; Carla Daher, UNICEF; Charles-Antoine Hofmann, UNICEF; Rania Elesawi, UNICEF; Humberto Jaime, UNICEF; Amaya Gillespie, UNICEF; Mario Mosquera, UNICEF; Rudrajit Das, UNICEF; Tasmia Bashar, UNICEF; Sergiu Tomsa, UNICEF; Magdalena Isaurralde, UNICEF; Sebastian Carrasco, UNICEF; Jean Luc Yameogo, UNICEF; Deepa Risal Pokharel, UNICEF; Namita Niranjana Rao, UNICEF; Bezya Bukhet Cihan, UNICEF; Arianna Serino, Save the Children; Thomas Moran, WHO; Brian Riley, WHO; Corey Henderson, WHO; Taylor Warren,

WHO; Lisa Menning, WHO; Peggy Hanna, WHO; Phillipe Borremans, WHO; Simon Van Woerden, WHO; Supriya Bezbaruah, WHO; Angela Ormondi, WHO; Tina Purnat, WHO; Christine Czerniack, WHO; Diana Maddah, UK Med.

## The Collective Service

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The Collective Service is a collaborative partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), which has active support from the Global Outbreak Alert and Response Network (GOARN), and key stakeholders from public health and humanitarian sectors. It was launched in June 2020, after endorsement by the Inter-Agency Standing Committee Principals in April 2020, and with support from the Bill and Melinda Gates Foundation. The aim of the Collective Service is to ensure that the complementary strengths of all partners are supported to deliver the greatest impact, and to bring together a wide range of organizations involved in RCCE policy, practice and research to provide practical support to those delivering on the ground.

## Purpose and audience

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In this document the Collective Service provides interim indicator guidance for the M&E of risk communication and community engagement activities for COVID-19. The indicator guidance can be used to monitor progress in implementing activities and to evaluate the RCCE response to COVID-19. The indicator guidance has been written primarily for national RCCE. The guidance will be of interest to government, United Nations, NGOs and civil society academic and community actors. It can also be used for regional and global RCCE. The indicator guidance has been developed as a menu of indicators that can be chosen from to measure the results of an RCCE programme.

While this document has been written specifically for the response to COVID-19 it is hoped that it will provide a useful reference point for the development of indicator frameworks for RCCE responses to other disease outbreaks. It is recommended that technical M&E advice is sought when seeking to adapt this indicator guidance to other disease outbreaks.

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# Abbreviations

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<b>BeSD</b>	behavioural and social drivers
<b>C4D</b>	communication for development
<b>CDC</b>	Centers for Disease Control and Prevention
<b>COVID-19</b>	coronavirus disease
<b>GOARN</b>	Global Outbreak Alert and Response Network
<b>GYM</b>	Global Youth Mobilization
<b>HCW</b>	health care worker
<b>IDP</b>	internally displaced person
<b>IFRC</b>	International Federation of the Red Cross and Red Crescent Societies
<b>IoGT</b>	Internet of Good Things
<b>JHU</b>	Johns Hopkins University
<b>LSHTM</b>	London School of Hygiene and Tropical Medicine
<b>M&amp;E</b>	monitoring and evaluation
<b>MHPSS</b>	mental health and psychosocial support
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>PH</b>	public health
<b>R4DC</b>	Responsible Data for Children
<b>RCCE</b>	risk communication and community engagement
<b>SDG</b>	Sustainable Development Goals
<b>SOP</b>	standard operating procedure
<b>UNICEF</b>	United Nations Children's Fund
<b>UNSD</b>	United Nations Statistics Division
<b>WHO</b>	World Health Organization



# Chapter 1: Introduction and Background



# Risk Communication and Community Engagement

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From the start of the COVID-19 crisis, risk communication and community engagement (RCCE) has been recognized as a central pillar of the response. RCCE is essential to the successful delivery of both medical and non-medical interventions. It encompasses everything from behaviour change to countering misinformation and supporting community leadership. RCCE is a cross-cutting priority that requires a broad range of humanitarian and public health partners to work together with governments and affected communities. As the world tackles the upcoming challenges of the ongoing crisis, including the roll-out of an unprecedented global immunization campaign, RCCE is essential to success.

RCCE is composed of two broad work streams: risk communication and community engagement. Risk communication and community engagement are mutually supportive of each other in the effort to put communities at the heart of the response to COVID-19.

A key strategy of the Collective Service response to RCCE is to be data-driven. Monitoring and evaluation will be used to measure the success of all interventions in order to analyse situations periodically and make changes as necessary. Social science methods are applied to ensure there is a comprehensive knowledge of the communities affected by the disease and ensure their participation in all stages: preparation, readiness and response. This approach shows respect towards and accountability to the community, and at the same time it favours trust-building and the acceptance of public health measures.

## Collective Service RCCE Interim Indicator Framework

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In 2020 the Collective Service developed the [COVID-19 Behaviour Change Framework](#), which is rooted in the [UNICEF Behavioural Drivers Model](#). The Collective Service COVID-19 Behaviour Change Framework is organized around six socio-behavioural dimensions: Information and communication; Knowledge and understanding; Perceptions; Practices; Social environment; Structural. These

socio-behavioural dimensions provide a framework in which to understand how people's perception, knowledge, practices, social processes and structural factors impact on the uptake of positive health behaviours. The *COVID-19 Behaviour Change Framework* is accompanied by a set of indicators. These indicators measure social and behavioural aspects of RCCE for COVID-19 and are mostly at outcome level. To support data collection for these indicators the Collective Service developed a [question bank](#). The question bank is a menu of questions related to socio-behavioural factors and COVID-19. The questions have been developed by the RCCE Collective Service team in consultation with response partners and experts and are part of the RCCE CS global strategy. It can be used to develop operational social science research in a community setting (e.g., quantitative surveys, qualitative focus group discussions). It includes key questions in the dimensions of knowledge, perceptions, practices, social and structural factors. It is intended that partners will identify key areas for investigation according to their operational priorities, select the most relevant questions and update them to reflect national and subnational contexts.

In 2021 the Collective Service undertook to develop this document, *the Interim RCCE Indicator Guidance*, with the aim of providing an M&E framework with clear output and outcome indicators to support programme management.<sup>1</sup> It combines outcome indicators from the Collective Service COVID-19 *Behaviour Change Framework* with output, activity and input indicators. The output, activity and input indicators have been developed with particular reference to the UNICEF Minimum Quality Standards and Indicators for *Community Engagement*.<sup>2</sup> The guidance provides a complete indicator set for the M&E of RCCE activities. As well as the *Minimum Quality Standards and Indicators for Community Engagement* and the *COVID-19 Behaviour Change Framework* the following indicator frameworks were looked at: [Core Humanitarian Standards](#); WHO COVID-19 Strategic Preparedness and Response Plan Monitoring and Evaluation Framework; [Behavioural and Social Drivers of Vaccination](#); Monitoring and Evaluation Framework for the COVID-19 Response Activities in the EU/EEA and the UK, European Centre for Disease Prevention and Control; Monitoring and Evaluation Framework and Tools for Risk Communication and Community Engagement and COVID-19, READY; Humanitarian Response Plan for COVID-19, OCHA.

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1 The Collective Service, COVID-19 Global RCCE Response Strategy, IFRC, UNICEF, WHO, Geneva, 2020

2 UNICEF, Minimum Quality Standards and Indicators for Community Engagement, 2019

The Collective Service Secretariat developed this guidance in close cooperation with the Collective Service core member agencies. The Global RCCE M&E Working Group was consulted throughout the development process, with members making substantial inputs to the guidance. The RCCE M&E Working Group is composed of participants from CDC, IFRC, Gates Foundation, GOARN, JUH, OXFAM, UK Med, INTERNEWS, UNICEF and WHO. The Collective Service Secretariat also liaised with the YES! - Global Collective Service Youth Engagement Subgroup, Global Collective Service Community Engagement and Low Resource Settings Working Group, Global Collective Service Migrants, Refugees, host communities and other vulnerable groups sub Working Group and the Global Collective

Service Media Working Group to discuss and develop the indicator guidance. Consultations and engagement also took place with Collective Service colleagues working at regional level in Asia Pacific, Middle East and North Africa, East and Southern Africa, West and Central Africa, Europe and Central Asia and Latin America.

This guidance will be rolled out to country and regional level partners during 2021. In 2022 the Collective Service will undertake a review of the document. Based on the review the indicator guidance will be revised and final *RCCE Indicator Guidance for COVID-19* will be published thereafter.







# Chapter 2: RCCE Indicator Framework



This chapter explains the structure of the interim indicator guidance.

As a first step, in developing the interim indicator guidance, a generic theory of change for RCCE was elaborated. The theory of change was developed for a broad country-level RCCE programme for COVID-19. The theory of change identifies the key RCCE results that contribute to the aim of reducing morbidity and mortality from COVID-19. In Table 1 the results are classified into impacts, outcomes, outputs, milestones, activities and inputs.

The monitoring of assumptions is done to help ensure that the programme is relevant to and appropriate to the context. Examples of assumptions relevant to RCCE may include:

- » The public is able to access the commodities and services that are recommended by the response for tackling COVID-19
- » Continued government support is provided to implement and sustain recommended COVID-19 policies throughout the pandemic.

Assumptions will vary according to the context and according to the programme objectives. For this reason, indicators to monitor assumptions have not been included in this guidance.



**TABLE 1 | RCCE THEORY OF CHANGE FOR COVID-19**

<b>Impact</b>	Transmission, morbidity and mortality from COVID-19 is reduced						
	The community, particularly the most vulnerable members, accesses services and practises key public health recommendations						
<b>Outcome</b>	Social norms support the uptake of public health recommendations						
	The self-efficacy of individuals is strengthened to support the uptake of public health recommendations						
	The community acts in solidarity to support the uptake of public health recommendations						
	The community has trust in the public health response to COVID-19						
	The response is community-led & accountable to the public				The community understands public health information & recommendations		
	The RCEE systems are strengthened to respond to public health emergencies						
<b>Output</b>	The community participates in decision-making on the public health response		Communities, particularly the most vulnerable members, are engaged in the public health response			Accurate risk information is communicated to the public	
	The legal and policy framework supports RCCE for COVID-19	Mechanisms for community participation in decision-making are established	Supports are provided to enable community members to play an active role in service delivery	Local service workers engage & inform people in their communities	Media & in-person platforms are created for community public health dialogue	Accurate risk communication prepared by media & public health	Infodemic and health misinformation is managed
<b>Activity</b>	Community feedback mechanism link community with government, media and other actors						
	Social & behavioural research conducted		Message monitoring is established			Rumour monitoring is established	
	Cooperation with community-based partners is strengthened						
	Training to build the capacity of partners is provided						
	Technical assistance to support the implementation of RCCE is provided						
	Advocacy to promote the uptake and implementation of RCCE is conducted						
<b>Input</b>	Evidence-based national RCCE COVID-19 response plan is developed						
	RCCE needs assessment is conducted						
	National and local RCCE coordination mechanism is operating						
	Staff with competence in core RCCE skills are in place						
	A sufficient budget for the RCCE programme is allocated						

The indicators in this document have been chosen so as to measure the results of this theory of change. Each indicator refers to a result statement in the theory of change. For example, the result number 6 in Table 1, 'The community has trust in the public health response to COVID-19', has the corresponding indicator 'percentage of individuals who trust authorities and partners leading the COVID-19 response'. Where possible, several indicators are suggested for each result. This is so actors can choose the indicators that are most appropriate to their context. Actors may choose to use several indicators to measure a single result.

Indicators for this guidance were chosen for their relevance, coherence and reliability. Where possible indicators were aligned with key global documents, namely the Collective Service *Behaviour Change Framework* and the UNICEF *Minimum Quality Standards and Indicators for Community Engagement*. The indicators that relate to vaccination are drawn from the WHO document [Behavioural and Social Drivers of Vaccination](#). An extensive review of the literature was also made to find other RCCE indicators. Some new indicators are being used to measure results where no existing indicators were found that could be successfully adapted.

Data availability is an important consideration when choosing indicators. RCCE data availability varies considerably across time and place. Rather than restrict the framework to indicators for which data is currently available it was decided to include indicators for which data is not currently available but which we recommend be prioritized in the development of data collection methods.

During a pandemic the information needed to manage the response changes over time. For example, at the early stages of a response the focus may be on ensuring the population has the information needed to avoid contracting the virus. At a later stage the focus may change to engaging with the public on vaccination. It is recommended that once an indicator is selected it is maintained in the programme monitoring framework and updated throughout the response. New indicators can be added to a programme monitoring framework as the situation evolves; for example, once a vaccine becomes available indicators on vaccine acceptance can be added.

The risk information on infectious diseases delivered to the public can vary over time and between government areas. For example, the advice on what is a safe physical distance for people to maintain from one another may change as the scientific understanding develops. Governments may also adopt different health recommendations according to their context or policy preferences. This

presents some challenges in aggregating data. To deal with this, broadly defined indicators are used in this guidance. For example, instead of an indicator 'Percentage of people who maintain a social distance of 1.5 metres' we have an indicator on 'Percentage of individuals who report practising recommended measures to protect themselves from COVID-19'. The second indicator will use the health recommendation of the relevant government as a reference. These broadly defined indicators will also allow for comparison between countries and geographic areas on the percentage of people who practise locally recommended measures.

Please note that in the theory of change RCCE is necessary to the achievement of the impacts of a reduction in transmission, reduction in morbidity and a reduction in mortality from COVID-19. RCCE is understood to contribute to these impacts. Guidance on indicators to measure impact results is provided by the WHO [Strategic Preparedness and Response Plan](#).

Please also note that not every result in the theory of change has an indicator to measure it in this guidance. The indicator selection focused on key RCCE results. Further, there are some results that are not included here for measurement as further work is needed on the data collection methodology before they can be included in this guidance. The format of the indicator guidance is described in Table 2.

## List of Indicators

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Table 3 shows the full list of indicators in this guidance.

## Core Indicators

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In Table 4 a set of core indicators for the M&E of RCCE is presented. The set includes indicators for both risk communication and community engagement results. The indicators measure outcome and output level results. These core indicators can be regarded as a basic indicator set to track progress across RCCE. The Collective Service recommends these indicators be considered for inclusion in all COVID-19 M&E indicator frameworks. Using this core indicator set will also improve coherence in reporting and analysis within and between countries.

TABLE 2 | **DESCRIPTION OF INDICATOR GUIDANCE FORMAT**

<b>Indicator</b>	The full name of the indicator
<b>Result</b>	The full name of the result that the indicator will monitor
<b>Result level</b>	The level of the result – see theory of change (the impact, outcome etc.)
<b>Reference</b>	The document the indicator was taken from
<b>Purpose</b>	The rationale for the use of this indicator
<b>Definition</b>	A technical definition of the indicator
<b>Disaggregate</b>	Recommends how the data for the indicator should be disaggregated
<b>Computation</b>	How to calculate the final figure for the indicator
<b>Frequency</b>	How often the data should be collected, analysed and reported
<b>Data sources</b>	Recommends the type of data that should be used for the indicator
<b>Limitations</b>	Considerations to be made when using the indicator



**TABLE 3 | LIST OF RISK COMMUNICATION AND COMMUNITY ENGAGEMENT INDICATORS**

Level	Indicators	Page
Outcome	<b>The practice of recommended public health measures</b>	24
	Percentage of individuals who report practising recommended measures to protect themselves from COVID-19	24
	Percentage of individuals who report practising recommended measures to stop COVID-19 transmission in their community	26
	Percentage of individuals who immediately seek medical care if they have COVID-19 symptoms	28
	Percentage of individuals who will get a COVID-19 vaccine if it is available to them	30
	<b>Observance of social norms</b>	31
	Percentage of the population who expect most people in their community to observe social norms around COVID-19	31
	<b>Social solidarity</b>	33
	Percentage of individuals who think falling ill with COVID-19 leads to stigma	33
	Percentage of individuals that have received social support on COVID-19 from family, friends, or neighbours in the past three months	34
	<b>Trust in authorities</b>	35
	Percentage of individuals who trust authorities and partners leading the COVID-19 response	35
	<b>Accountability to the community</b>	37
	Percentage of individuals who think locally recommended measures for COVID-19 are fair	37
	Percentage of individuals who know how to provide feedback	38
	<b>Knowledge of risk information on COVID-19</b>	39
	Percentage of individuals who believe they are at risk of contracting COVID-19	39
	Percentage of individuals who know correct symptoms of COVID-19	40
	Percentage of individuals who know correct transmission routes of COVID-19	41
	Percentage of individuals who know how to protect themselves from COVID-19	43
	Percentage of adults/health workers who know where to get a COVID-19 vaccine for themselves	44
	<b>Information reach</b>	45
	Percentage of individuals who seek information about COVID-19 regularly	45
	Percentage of individuals who receive information through a communication channel they trust	46
	Percentage of individuals reached with public health information on COVID-19	47
	Percentage of individuals who are satisfied with the information content they receive on COVID-19	49

	<b>Participation in response management</b>	<b>50</b>
	Percentage of targeted areas where community members actively participate in the public health decision-making processes	50
<b>Output</b>	<b>Community engagement</b>	<b>52</b>
	Percentage of targeted community groups that promote public health recommendations to stop COVID-19	52
	Percentage of targeted areas where community members play an active role in the delivery of public health services to respond to COVID-19	53
	Percentage of targeted areas where community dialogues on public health are taking place	54
	Percentage of targeted areas where supports for community members to play an active role in the delivery of public health services to respond to COVID-19 are provided	55
	<b>Laws and policies</b>	<b>56</b>
	Percentage of targeted areas in which RCCE SOPs have been adopted by government partners	56
	Percentage of targeted areas where policies and procedures for the participation of local communities have been adopted	57
<b>Activity</b>	<b>Infodemic management</b>	<b>59</b>
	Capabilities to track and address infodemics and health misinformation are in place	59
	<b>Community feedback</b>	<b>61</b>
	Percentage of targeted areas where mechanisms are in place to capture and utilize community feedback	61
	Percentage of targeted areas where changes have been made to COVID-19 response plans based on community feedback	63
	<b>Research and needs assessment</b>	<b>64</b>
	Countries that carried out an assessment of behavioural and social drivers (BeSD) of COVID-19 vaccination acceptance and uptake	64
	<b>Capacity-building</b>	<b>65</b>
Number of participants in RCCE training sessions	65	
<b>Input</b>	<b>Coordination mechanism</b>	<b>66</b>
	An RCCE coordination mechanism is active and formally implemented	66
	<b>Plan and budget</b>	<b>67</b>
	A risk communication and community engagement plan for COVID-19 is adopted	67
	An adequate budget for risk communication and community engagement activities is available	68

TABLE 4 | LIST OF RECOMMENDED CORE INDICATORS

CORE INDICATORS	Page
Percentage of individuals who report practising recommended measures to protect themselves from COVID-19	24
Percentage of individuals who will get a COVID-19 vaccine if it is available to them	30
Percentage of individuals who know correct transmission routes of COVID-19	41
Percentage of targeted community groups that promote public health recommendations to stop COVID-19	52
Number of people reached with public health information on COVID-19	47



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## How to apply the indicator guidance

As noted above the advice is, where possible, to apply the Interim RCCE Indicator Guidance in conjunction with RCCE stakeholders and partners to support a coordinated response. Below is a brief description of how to apply this guidance for programming.

### • Develop a theory of change

As a first step, an RCCE theory of change should be developed. The theory of change presented in this document has been drafted as a broad outline that can be adapted to specific contexts. Results that are not relevant to a specific programme can be removed from the theory of change and other results can be added. It is vital to ensure that the theory of change remains logical and clear. Investing time and effort into developing the theory of change will be rewarded as it is the foundation of the M&E of the programme.



### • Choose indicators

Having identified the key results for the programme the next step is to choose indicators to measure them. Each indicator in this guidance refers to a result in the theory of change; for example result number 8 in Table 1, 'The community understands public health information and recommendations' has three indicators to measure it: 'Percentage of individuals who know correct symptoms of COVID-19'; 'Percentage of individuals who know correct transmission routes of COVID-19'; and 'Percentage of individuals who know how to protect themselves from COVID-19'. Each of these indicators measures a dimension of the result. The indicators that are most relevant to the programme should be chosen.

### • Choose means of verification

In this guidance a preferred means of verification or data source is identified for each indicator. Alternative data sources are also suggested. The means of verification should be chosen based on the context and resources of the programme. For some programmes it may be possible to conduct a high-quality survey and to conduct qualitative research for data triangulation. For other programmes, data collection options may be more limited. Consideration should also be given to the possibility of using specific mobile technologies for rapid data collection or monitoring of activities. In each case the objective is to provide as solid an evidence base as is practical in the context.

### • Decide on the frequency of reporting

The frequency of reporting on each indicator should be decided on. Data should be made available on indicators at the time when it is needed by programme managers. This may vary according to the circumstances of the response; for example at an early stage of a pandemic information may be needed more frequently than at a later stage. The frequency of reporting will also depend on the resources available to collect data and the operating context.

When all of these steps are completed there will be both a theory of change for the programme and an indicator framework to measure it. Data will need to be collected as per the chosen means of verification and the frequency. The most important step is to analyse, discuss and interpret the data that is available.

## Further Resources

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The following further resources are available on RCCE for COVID-19.

### • **Collective Service Helpdesk**

Technical support is available through the Collective Service Helpdesk. The Helpdesk aims to strengthen the capacity of national and local staff to collectively engage with affected communities. The Helpdesk draws on expertise with IFRC, GOARN, UNICEF and WHO to provide technical guidance and support to risk communication and community engagement (RCCE) practitioners. The Collective Service Helpdesk can be contacted for data queries and advice at: [helpdesk@rcce-collective.net](mailto:helpdesk@rcce-collective.net)

### • **Collective Service Dashboard**

The Collective Service actively reviews quantitative studies related to RCCE conducted in the field or at the global level by partners and academic communities. It undertaken extensive data matching so as to compile the data from these studies together in The [Collective Service Behavioural Indicators Dashboard](#). To date, over 340 quantitative studies are combined in the Dashboard. The Dashboard can be used to measure and track key social behavioural data on emergency responses at global, regional and country level. Individual dashboards are available for 187 countries.

### • **The Collective Service Social Science Training Package**

The Collective Service has developed a training package on using social science evidence for community engagement and communication activities. The training package consists of 7 modules and 24 sessions which cover the full spectrum of operationalising social sciences during an. To access training content please visit the Collective Service [Website](#).

### • **Community Feedback**

The IFRC has produced a comprehensive set of guidance and tools to systematically use community insights to improve programmes, operations and accountability more broadly. It includes the first steps to setting up a basic feedback mechanism, guidance on how to conduct community perception surveys, how to analyse qualitative feedback comments, how to handle sensitive feedback, and ensure all feedback is handled responsibly. A wealth of guidance and tools are available at the Red Cross [Community Engagement Hub](#).

### • **The Collective Service Data for Action Handbook**

The Collective Service maintains a Data for Action Handbook. The purpose of the Handbook is to provide an outline description of the processes involved in the use of data for RCCE. The Handbook covers Social Science, Community Feedback, M&E, data utilization and Information Management. Links are provided to recommended resources in these areas. The Handbook is regularly updated by the Collective Service. A web version of the Handbook is currently being produced. In the meanwhile the Handbook can be accessed [here](#).



# Chapter 3: Data Collection



This section provides technical guidance on RCCE data collection, including on ethics, data sources and disaggregation.

## Ethics

This document does not seek to provide specific guidance on ethics for RCCE M&E. Rather, key resources are highlighted which may guide partners in RCCE M&E.

The IFRC uses its seven fundamental principles as the basis for the Movement's action at all times. The ethics of humanitarian action have been further articulated in the [Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief](#).

UNICEF in collaboration with New York University has developed the [Responsible Data for Children](#) (RD4C) initiative. The goal of the initiative is to develop field-informed, evidence-based, public goods tools and best practice guidance that empower front-line practitioners and programme managers to make informed decisions about children's data. RD4C includes guidance on how to design, support and implement programmes with these risks in mind, and how to promote appropriate data practices and systems. RD4C is cross-sectoral, working with all UNICEF sections.

In February 2020 the WHO established an international [Working Group on Ethics and COVID-19](#). The group develops advice on key ethical questions that WHO Member States need to address. The working group builds on the 2017 WHO Guidelines on Ethical Issues in Public Health Surveillance. This document, one of the first of its kind, is recommended as a useful reference for RCCE and the ethics of data collection.

## Data sources

For each indicator in this guidance a preferred data source is recommended. For example, for the indicator 'Percentage of individuals who report practising recommended measures to protect themselves from COVID-19', the recommended data source is from population surveys. Alternative data sources are also suggested. The alternative data sources can be used where the preferred data is not available. Taking the same indicator as an example, observational data can be used as a proxy for some public health measures such as mask wearing. For indicators related to administrative processes the



recommended data source is information from government or community counterparts. For example for the indicator 'Percentage of targeted areas where policies and procedures for the participation of local communities have been adopted', the recommended source is data from government offices and community representatives. However where this data is not available from government offices and community representatives, alternative data sources could be used. When using proxy data it is important to bear in mind that the data may not be as valid or reliable as the preferred data source.

One data source cannot be expected to provide all of the information needed to understand the result being measured. For this reason it is recommended to triangulate data sources when conducting analysis. Triangulation is where a question, for example 'Are people practising recommended measures to protect themselves from COVID-19?' is looked at from different points of view. This adds nuance and depth to the analysis. Triangulation can be done by analysing several sources of information; for example, combining survey data with observational data.

RCCE is community-led. Communities should take a lead in collecting data, analysing it, and participating in programme decision-making processes and by so doing help to ensure that the public health response is fit for purpose and accountable. Community participation can be used to measure whether the response is accountable. This information informs internal accountability processes. At the same time community participation is an act of accountability in itself. By participating the community learns about the results of the programme and is

better able to hold programme managers to account. It is strongly recommended that community representatives take part in the data collection, analysis and decision-making processes throughout.

## Disaggregation and frequency

To respond to the pandemic it is necessary to identify and characterize the factors that slow or accelerate transmission of COVID-19 and the populations that are most vulnerable to it. Disaggregation of data is critical to generating the information needed to do this<sup>3</sup>.

Disaggregating data by populations usually requires a

<sup>3</sup> PAHO, Why data disaggregation is key during a pandemic, 2021, <[iris.paho.org/bitstream/handle/10665.2/52002/Data-Disaggregation-Factsheet-eng.pdf?sequence=17](https://iris.paho.org/bitstream/handle/10665.2/52002/Data-Disaggregation-Factsheet-eng.pdf?sequence=17)>



large amount of data. For this reason, it is recommended where possible that larger-scale data collection is undertaken. This may involve pooling resources of several agencies together. For example, rather than conduct several small surveys it may be better to combine resources and conduct one large survey that allows for the disaggregation of data for key groups. Data collection templates can also be developed jointly with partners to facilitate shared analysis.

Bearing in mind the challenges that countries are experiencing in disaggregating data, we detail for each indicator a minimum disaggregation.

### Age

Disaggregation by the age categories 0–14, 15–24, 25–59; 60 plus is recommended for all of the population indicators.

### Sex

Disaggregation by the sex categories male, female is recommended for all of the population indicators.

### Education

The disaggregation of data by education should be made by: non formal, early learning, primary, lower secondary general education, upper secondary general education, technical and vocational. Where there is a policy interest education data can also be disaggregated by those with tertiary education.

### Geographic location

Data can be disaggregated both by the administrative areas of the country, for example by state, county, municipality, etc., and/or in terms of rural and urban.

Many of the indicators can be disaggregated by national government or subnational administrative areas. Subnational government administrative areas can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.

### Disability

Disaggregation of data by disability is recommended to be done in reference to the [Washington Group question sets](#).

## Migration

Data on refugees, migrants and IDPs should be disaggregated by 'native born' or 'foreign born'; i.e., born in the country or born outside of the country.

If further analysis is needed the data can be disaggregated by 'citizen' and 'non-citizen' (non-citizen includes stateless persons).

For countries that wish to analyse data by legal migration status the following categories can be used: refugees, asylum seeker, IDP, international migrants, and internal migrants. Country definitions of these categories should be used where available.<sup>4 5</sup>

## Virus variant

Countries may wish to disaggregate indicators by the variant of COVID-19 so as to better understand the different types of risk perception. This may allow for further understanding of community perception of risk, and where misunderstanding and misinformation may be linked. This document does not propose guidance on disaggregating indicators by the variant of COVID-19.

## Frequency

In this document guidance is provided on the frequency with which data should be collected for each indicator. It is recommended that data be collected with 'high frequency' or with 'moderate frequency'. This reflects how often data is needed for each indicator to successfully manage an RCCE programme. For example, it is recommended that data on the indicator 'Countries that carried out an assessment of behavioural and social drivers (BeSD) of COVID-19 vaccination acceptance and uptake' be collected at 'medium frequency' as frequent updates on whether a BeSD assessment has been conducted are not necessary to manage the programme. Conversely it is recommended that data on the indicator 'Percentage of individuals who report practising recommended measures to protect themselves from COVID-19' be collected with high frequency as countries will need to continually monitor community adherence to public health measures in order to control the spread of COVID-19.

4 UNICEF, Children on the Move Indicator Guidance, New York, 2020

5 UNSD, Technical Report on Monitoring Migration-related SDG Indicators DRAFT, January 2019, p. 7. See also UNSD, 'Defining migratory status in the context of the 2030 Agenda', 2017 <[//unstats.un.org/unsd/demographic-social/meetings/2017/new-york-egm-migration-data/Session%204/Session%204%20UNSD.pdf](https://unstats.un.org/unsd/demographic-social/meetings/2017/new-york-egm-migration-data/Session%204/Session%204%20UNSD.pdf)>

### Note on definition of 'community'

The term 'community' is used throughout this guidance. Defining 'community' may be difficult within the context of an epidemic response<sup>6</sup>. In this document people and communities are understood to mean any group of vulnerable, at-risk or crisis-affected people, recognizing the diversity of individuals that make up any community, the role that gender, age, disability, diversity and existing and evolving social, economic and power dynamics and patterns of inclusion or exclusion play in increasing the risks, vulnerabilities and marginalization of some groups of people within a community<sup>7</sup>.

### Note on using government health recommendations as a reference point

For many of the indicators it is recommended to use government risk information communication as the reference point. There may be some countries or regions where the government risk information communication may not be appropriate to use. In these cases, we recommend use of Collective Service risk information communication as the reference.

6 Bedson et al., 'Community engagement in outbreak response: lessons from the 2014-2016 Ebola outbreak in Sierra Leone', BMJ Global Health, 2019

7 IFRC, Community Engagement and Accountability Guide, 2021. <https://communityengagementhub.org/resource/ifrc-cea-guide/>



# Chapter 4: Indicators





# The practice of recommended public health measures

<b>Indicator</b>	<b>Percentage of individuals who report practising recommended measures to protect themselves from COVID-19</b>
<b>Result</b>	The community, particularly the most vulnerable members, accesses services and practises key public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework

**Purpose** This indicator measures the percentage of people who report practising measures to protect themselves as individuals from contracting COVID-19. Data from this indicator can be disaggregated to identify whether social groups, particularly the most vulnerable people, are taking action to reduce their personal risk of contracting COVID-19. Where a low proportion of the population, or particular social groups, are found not to be adopting recommended measures action should be taken immediately to analyse the reasons for this and to encourage greater uptake.

**Definition** For this indicator the government recommendations on measures to protect individuals from COVID-19 should be used. This indicator relates to measures that serve to directly protect an individual from COVID-19. Relevant measures include hand hygiene, wearing a mask, physical distancing, avoiding the touching of surfaces, avoiding crowded spaces, avoiding unventilated spaces.

It may be that in certain contexts the measures listed here may not be specific to personal protection. In this case adapting this guidance for the context is advised.

In many countries subnational government is mandated to recommend protective measures to the public. The recommendations of the mandated government agency should be used for the area in which the data is being collected.

For a person to be considered to be practising the recommended measures they should be practising all of the measures recommended by the government most or all of the time.

**Disaggregate** The minimum recommended disaggregation of this indicator is by: sex, age education and disability. The data should be disaggregated by the type of protective measure, as defined above.

Where there is a policy interest data may also be disaggregated by income or economic status, ethnic origin, geographic location, and migration.

**Computation** This indicator should be computed as a percentage.

Numerator: total of respondents aged 15 and above who report practising all of the recommended measures to protect themselves from COVID-19 most or all of the time.

Denominator: total of respondents aged 15 and above.



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**Frequency**

This indicator should be reported with high frequency.

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**Data sources**

The recommended data source for this indicator is population surveys.

Where population survey data is not available other types of data can be used. Data on observed behaviour can be used as a proxy for some measures such as mask wearing.

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**Limitations**

Understanding the drivers of social behaviour is critical to responding to a pandemic. The data from this indicator will not explain what motivates people to take certain actions. To attempt this, researchers would need to combine this indicator analysis with data on what motivates people to take protective measures, in particular by using qualitative research.

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<b>Indicator</b>	<b>Percentage of individuals who report practising recommended measures to stop COVID-19 transmission in their community</b>
<b>Result</b>	The community, particularly the most vulnerable members, accesses services and practises key public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework

**Purpose** This indicator measures the percentage of individuals who report practising recommended measures to reduce transmission of COVID-19 in their community. This indicator can reflect on the community's willingness to take action to protect one another. As such the indicator can also be understood as a measure of social solidarity. Data from this indicator can be disaggregated to identify whether social groups, particularly the most vulnerable, are taking action to reduce COVID-19 transmission. Where a low proportion of the population or particular social groups are found not to be adopting recommended measures to stop community transmission action should be taken to analyse the reasons for this and to encourage greater compliance with public health recommendations.

**Definition** For this indicator the government recommendations on measures to stop the transmission of COVID-19 in the community should be used. This relates to measures that are directed towards stopping community transmission such as remaining within recommended travel limits, avoiding non-essential travel, avoiding social events, covering coughs and sneezes with a bent elbow or tissue, and putting used tissues into a closed bin right away.

It may be that in certain contexts the measures listed here may not be specific to stopping community transmission. In this case adaption of this guidance to the context is advised.

In many countries subnational government is mandated to recommend protective measures to the public. The recommendations of the mandated government agency should be used for the area in which the data is being collected.

For a person to be considered to be practising the recommended measures to stop COVID-19 transmission in their community they should be practising all of the measures recommended by the government most or all of the time.

**Disaggregate** The minimum recommended disaggregation of this indicator is by: sex, age and education. The data should be disaggregated by the type of protective measure to stop COVID-19 transmission, as defined above.

Where there is a policy interest data may also be disaggregated by disability, income or economic status, ethnic origin, geographic location, and migration.

**Computation** This indicator should be computed as a percentage.

Numerator: total of respondents aged 15 and above who report practising all of the recommended measures to stop COVID-19 transmission in their community all or most of the time.

Denominator: total of respondents aged 15 and above.

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**Frequency**

This indicator should be reported with high frequency.

**Data sources**

The recommended data source for this indicator is population surveys.

Where population survey data is not available other types of data can be used. Data on observed behaviour can be used as a proxy.

**Limitations**

Understanding the drivers of social behaviour is critical to responding to a pandemic. The data from this indicator will not explain what motivates people to take measures to stop COVID-19 transmission in their community. To attempt this, researchers would need to combine analysis of this indicator with data from qualitative research.

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Indicator	Percentage of individuals who immediately seek medical care if they have COVID-19 symptoms
<b>Result</b>	The community, particularly the most vulnerable members, accesses services and practises key public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework
<b>Purpose</b>	<p>In order to ensure that individual cases of COVID-19 are managed effectively and to reduce the transmission of COVID-19 individuals should seek medical care immediately once they have COVID-19 symptoms. This indicator measures the percentage of the population who seek medical care when they have COVID-19 symptoms. Where a low proportion of the population seeks medical care when they have COVID-19 symptoms action should be taken immediately to analyse the reasons for this and to encourage greater uptake.</p>
<b>Definition</b>	<p>Government advice on when a person should seek medical care for COVID-19 should be used for this indicator. As an example, CDC recommends people seek emergency medical care immediately if they have any of the following warning signs: trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; pale, grey, or blue-coloured skin, lips, or nail beds, depending on skin tone<sup>8</sup>. Self-reported measures of health-seeking behaviour triggered by COVID-19 symptoms can include calling a specific and dedicated hotline, consultation with medical staff, testing, and treatment.</p> <p>For this indicator the government recommendations on when and what medical care individuals should seek when they have COVID-19 symptoms should be referred to. In many countries subnational government is mandated to recommend to the public when and what medical care should be sought when an individual has COVID-19 symptoms. The recommendations of the mandated government agency should be used for the area in which the data is being collected.</p> <p>For a person to be counted they should report that they would seek medical care by taking at least one of the recommended measures if they have COVID-19 symptoms.</p>
<b>Disaggregate</b>	<p>The minimum recommended disaggregation of this indicator is by: sex, age and education. Countries are particularly encouraged to disaggregate this indicator by ethnicity and migration.</p> <p>Where there is a policy interest data may also be disaggregated by disability, income or economic status, and geographic location.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who report immediately seeking medical care if they have COVID-19 symptoms.</p> <p>Denominator: total of respondents aged 15 and above who have access to health facility.</p>

8 Centers for Disease Control and Prevention, 'What to do if you are sick', 2021 <[cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html](https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html)>

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**Frequency**

This indicator should be reported with high frequency.

**Data sources**

The recommended data source for this indicator is population surveys.

**Limitations**

This indicator as it is currently defined allows for comparison of the percentage of individuals who immediately seek medical care if they have COVID-19 symptoms. The indicator does not allow for analysis of health-seeking behaviour based on specific symptoms.

The interpretation of data on this indicator should take into consideration the context; for example, individuals may not seek medical care as medical care services are not accessible. Other issues may also be at play such as whether going to health centres is seen as a transmission risk. It is recommended that this indicator be interpreted along with other data such as that on access to health care.

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Indicator	Percentage of individuals who will get a COVID-19 vaccine if it is available to them
<b>Result</b>	The community, particularly the most vulnerable members, accesses services and practises key public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	<a href="#"><u>Behavioural and Social Drivers of Vaccination</u></a>
<b>Purpose</b>	The purpose of this indicator is to elicit what a respondent's intentions and decisions are towards the vaccine. This indicator measures the percentage of individuals who will get a COVID-19 vaccine if it is available to them. Where a low proportion of the population or of certain population subgroups intend to get a COVID-19 vaccine efforts should be made to further analyse the reasons for this and to encourage greater uptake.
<b>Definition</b>	This indicator refers to COVID-19 vaccines that are approved and safe to use. It includes people's wanting the vaccine or willingness to get it. It is assumed for the purpose of this indicator that no other vaccines will be offered to the public. This should be counted as a 'Yes or No' indicator.
<b>Disaggregate</b>	<p>The minimum recommended disaggregation of this indicator is by: sex, age and education.</p> <p>Where there is a policy interest data may also be disaggregated by disability, income or economic status, ethnic origin, geographic location, and migration.</p> <p>In some contexts, there may be an interest in disaggregating this indicator by the type of COVID-19 vaccine.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who will get a COVID-19 vaccine if it is available to them.</p> <p>Denominator: total number of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency once a vaccine is approved for use in the country.
<b>Data sources</b>	The recommended data source for this indicator is population surveys.
<b>Limitations</b>	It should be noted that while people may be motivated to get a COVID-19 vaccine they may face barriers to getting it – such as cost, difficulty getting time off work, challenges in travelling to the vaccination site, etc. In interpreting this indicator, people's motivation to get the vaccine should be understood as being different from their ability to get it.



# Observance of social norms

<b>Indicator</b>	<b>Percentage of the population who expect most people in their community to observe social norms around COVID-19</b>
<b>Result</b>	Social norms support the uptake of public health recommendations by the community
<b>Result level</b>	Outcome
<b>Reference</b>	UNICEF C4D MICS or DHS Indicators

## Purpose

People's behaviour is influenced by social norms. A social norm is that which people perceive others are doing or what they think others approve or disapprove of<sup>9</sup>. In a pandemic social norms help the community to establish and maintain the observance of certain behaviours. Social norms related to COVID-19 may include mask wearing in public, physical distancing, etc.

This indicator allows us to monitor the percentage of people who believe that most people in their community will observe social norms related to COVID-19. A low percentage indicates that the social norm is not established. In this case further efforts should be made to understand why the norm is not accepted by the community and to encourage uptake of the essential public health measures.

## Definition

For this indicator it is recommended to choose the norm that will most contribute to reducing the transmission of COVID-19 in the country. 'Community' should be understood as the population group that the individual lives within. The definition of 'community' can be adapted according to the context. (Please see Chapter 3 for further discussion on the definition of 'community'.) 'Observe' should be understood as those people who behave in a way that conforms with the social norm. For example, if the social norm is maintaining a physical distance from one another in public, then observance of the social norm means those who maintain a physical distance from other people in public. An individual is to be counted if they expect most people in their community to observe the social norm being referred to.

## Disaggregate

The recommended disaggregation of this indicator is by: sex, age and education.

Where there is a policy interest data may also be disaggregated for disability, income or economic status, ethnic origin, geographic location, and migration.

## Computation

This indicator should be computed as a percentage.

Numerator: total of respondents aged 15 and above who expect most people in their community to observe social norms around COVID-19.

Denominator: total of respondents aged 15 and above.

## Frequency

This indicator should be reported with high frequency.

9 Cialdini et al., 'Social influence, compliance and conformity', Annual Review Psychology, 2004

**Data sources**

The recommended data source for this indicator is population survey. For some social norms, such as mask wearing, observational data may be a preferable data source (see below).

**Limitations**

For this indicator countries will choose the social norm to be measured. The social norm being chosen is to be taken as an indication of the general observance of social norms in the country. It should be examined whether this is a reliable generalization in each context. It may be that the social norm chosen does not indicate a general observance of social norms around COVID-19. As always, the best approach is to triangulate this data with other sources of information.

It should also be noted that this indicator allows comparability between countries of 'observance of social norms' in general terms but it may not allow for comparison between specific social norms.

It should be borne in mind that social norms can change. For example, the social norms around physical distancing may change as the understanding of the transmissibility of COVID-19 improves.

The extent to which social norms are observed can vary between regions and between groups within a region. Some subgroups may have very different norms on specific behaviours.







## Social solidarity

Indicator	Percentage of individuals who think falling ill with COVID-19 leads to stigma
<b>Result</b>	The community acts in solidarity to support the uptake of public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework
<b>Purpose</b>	Social solidarity is one of the most powerful resources for tackling public health crises. Stigma against those who have been infected by COVID-19 can lead to a reduction in health-seeking behaviours. This indicator measures the percentage of people who believe falling ill with COVID-19 will lead to stigma. Where there is significant stigma around falling ill with COVID-19 efforts should be made to better understand the reasons for this and to promote a culture of support and solidarity.
<b>Definition</b>	Stigma refers to negative attitudes and beliefs about those who have fallen ill with COVID-19. To be counted as believing that falling ill with COVID-19 leads to stigma, individuals should identify at least one form of stigma that they believe will result from falling ill with COVID-19. Please note that stigma is distinct from discrimination, which refers to the act of treating people differently because they have COVID-19. <sup>10</sup>
<b>Disaggregate</b>	<p>The minimum recommended disaggregation of this indicator is by: sex, age and education.</p> <p>Where there is a policy interest data may also be disaggregated by disability, income or economic status, ethnic origin, geographic location, and migration.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who think that falling ill with COVID-19 leads to stigma.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	None

10 See for example, CDC, 'HIV Stigma and Discrimination', <[cdc.gov/hiv/basics/hiv-stigma/index.html](https://www.cdc.gov/hiv/basics/hiv-stigma/index.html)>

Indicator	Percentage of individuals that have received social support on COVID-19 from family, friends, or neighbours in the past three months
<b>Result</b>	The community acts in solidarity to support the uptake of public health recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	New indicator
<b>Purpose</b>	This indicator measures the percentage of the population that has received social support on COVID-19 from family members, friends or neighbours in the past three months. The indicator is useful for measuring whether individuals are receiving social support. It indicates whether there is a supportive culture or not. Where social support is not being received to deal with COVID-19, particularly by the most vulnerable people, then efforts should be made to promote social support. Analysing the type of social support received, and by whom, can inform RCCE approaches to supporting those most in need.
<b>Definition</b>	For the purposes of this indicator social support is understood to include emotional, instrumental, informational and appraisal support. <sup>11</sup> An individual who has received at least one of these four types of support in the last three months should be counted.
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age and education. Where there is a policy interest the data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.</p> <p>Countries may have an interest in disaggregating the data on social support received by the individual's experience of COVID-19 over the previous three months, for example whether the individual has undergone testing, treatment, or self-isolation.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who have received social support.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The recommended data source for this indicator is population surveys.
<b>Limitations</b>	This indicator measures whether a person received any social support from family, friends or neighbours. It does not measure whether individuals received sufficient social support.

11 See Glanz et al., 'Social Support', in Health Behavior and Health Education, 2008, <med.upenn.edu/hbhe4/part3-ch9-key-constructs-social-support.shtml>



## Trust in authorities

Indicator	Percentage of individuals who trust authorities and partners leading the COVID-19 response
<b>Result</b>	The community has trust in the public health response to COVID-19
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework
<b>Purpose</b>	To stop COVID-19 the community and public health authorities need to trust each other. This indicator measures the percentage of individuals who trust the public health response to COVID-19. Where a low level of public trust in those leading the COVID-19 response is found, action should be taken to improve the relationship with the public.
<b>Definition</b>	This indicator measures the percentage of the population who trusts authorities and partners leading the COVID-19 response.
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age and education. As community members may trust some authorities or partners and not others, it is recommended to disaggregate this data by government authorities, partners, health-care professionals, etc., as relevant to the context.</p> <p>Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who trust authorities and partners leading the COVID-19 response.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The recommended data source for this indicator is population surveys.

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## Limitations

In some contexts it may be too politically sensitive to ask questions on whether respondents trust in authorities and partners leading the COVID-19 response. Further, the data collected in these contexts may be unreliable as the respondent may not want to answer the question. In these contexts, an alternative to asking questions directly on trust is to use the Ohanian scale, which is used to measure source credibility. The Ohanian scale has three components: attractiveness (of the communicator); trustworthiness and expertise.

Another issue is that, when responding to a survey question on trust, participants may take it to refer to trust in the honesty of the 'authorities and partners' leading the response, or they may take it to refer to trust in the competence of those leading the response. Further, survey data on public trust in health authorities is often confounded with other issues related to public trust in government. This should be borne in mind when interpreting the data. The advice is to try to make the data collection as specific as possible to COVID-19 to avoid or reduce confusion with questions related to general perceptions of government.

It should also be borne in mind that mistrust in government in some countries may be based on a sound knowledge of government performance and may be a reflection of healthy critical thinking. This indicator should not be interpreted without considering the context.

Please note this indicator measures trust in the authorities leading the response. Trust in the source of information is measured by the indicator: 'Percentage of individuals who receive information through a communication channel they trust'.

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## Accountability to the community

<b>Indicator</b>	Percentage of individuals who think locally recommended measures for COVID-19 are fair
<b>Result</b>	The public health response is community led and accountable to the public
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Behavioural Change Framework

**Purpose** Humanitarian standards emphasize that responses to an emergency should be relevant and appropriate. Humanitarian actors must ensure that they are accountable to the community for the appropriateness and relevance of their actions. The participation of members of the community in the public health response to COVID-19 helps to ensure that the response is accountable to the wider public. Consideration should be given to making pandemic response plans, performance indicators, performance data, epidemiological and social data available in local languages for public review and discussion where possible. Public health and other authorities should also be willing to engage with the public through both formal governmental structures and through communication channels such as public debates, local media and other platforms as appropriate to the context. This indicator measures the percentage of people who think locally recommended public health measures are fair. If a large proportion of the population or particular social groups do not think the public health measures are fair it is a matter of concern. It may lead to a decline in public compliance with the measures. Further engagement will be needed with the public to discuss the response and a whole-of-society approach to controlling COVID-19.

**Definition** For this indicator the locally recommended measures for COVID-19 should be used. This may refer to measures recommended by the national government. In many countries subnational government is mandated to recommend protective measures to the public. The recommendations of the mandated government agency should be used for the area in which the data is being collected.

**Disaggregate** The recommended disaggregation of this indicator is by: sex, age and education. Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.

**Computation** This indicator should be computed as a percentage.  
Numerator: total of respondents aged 15 and above who think locally recommended measures for COVID-19 are fair.  
Denominator: total of respondents aged 15 and above.

**Frequency** This indicator should be reported with high frequency.

**Data sources** The preferred data source for this indicator is population survey.

**Limitations** Belief in the fairness of recommended public health measures may be confounded with other issues related to public trust in government. This should be borne in mind when interpreting the data. The advice is to try to make the data collection as specific as possible to COVID-19 to avoid or reduce confusion with questions related to general perceptions of government.

Indicator	Percentage of individuals who know how to provide feedback
<b>Result</b>	The public health response is community led and accountable to the public
<b>Result level</b>	Outcome
<b>Reference</b>	IFRC Feedback Toolkit and Community Engagement and Accountability Guide <sup>12</sup>
<b>Purpose</b>	One of the means to ensure accountability and strengthen community engagement is establishing feedback mechanisms for the community. Feedback mechanisms are not specific to a particular topic or sector. Community members should be able to voice their concerns and have them related to the appropriate topic, e.g., COVID-19 and sector, e.g. public health, through the feedback mechanism. While establishing these mechanisms is a necessary step, it is not sufficient in itself. It is also necessary to inform the community about them and to explain how they can be accessed and used. Data from community feedback mechanisms should inform programme decision-making, enabling course correction and community engagement strategies. Disaggregation of the indicator allows analysis of knowledge of complaint and feedback mechanisms among the most vulnerable groups, particularly those who may have a disability. Disaggregation by language is encouraged as language can be a major barrier to receiving information. Where the community does not know how to provide feedback, efforts should be made to better disseminate the information.
<b>Definition</b>	For a definition of community feedback mechanism please see the indicator: 'Percentage of targeted areas where mechanisms are in place to capture and utilize community feedback'. For an individual to be counted as having knowledge of how to make a complaint or provide feedback the individual should be able to: <ul style="list-style-type: none"> <li>» Identify a community feedback mechanism organized by the mandated government agency or a partner;</li> <li>» Identify how feedback can be provided through a mandated community feedback mechanism.</li> </ul>
<b>Disaggregate</b>	The recommended disaggregation of this indicator is by: sex, age, education and disability. The data should also be disaggregated by the preferred language for receiving communication of the person. <p>Where there is a policy interest data may also be disaggregated by income/economic status, ethnic origin, geographic location, and migration.</p>
<b>Computation</b>	This indicator should be computed as a percentage. Nominator: The percentage of the individuals who know how to provide feedback. Denominator: Total of respondents aged 15 and above.
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	The preferred data source for this indicator is population survey. The use of qualitative data to complement the analysis of the quantitative data is encouraged.
<b>Limitations</b>	Please note that to collect data on this indicator feedback mechanisms should be in operation in the geographic area and at the time of data collection.

12 IFRC Feedback Toolkit, 2021 <https://communityengagementhub.org/resource/cea-toolkit/> and IFRC, Community Engagement and Accountability Guide, 2021 <https://communityengagementhub.org/resource/ifrc-cea-guide/>



## Knowledge of risk information on COVID-19

Indicator	Percentage of individuals who believe they are at risk of contracting COVID-19
<b>Result</b>	The community understands public health information and recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Socio-Behavioural Framework – Perceptions
<b>Purpose</b>	Perceiving that one is at risk is a necessary condition for taking action to reduce that risk. This indicator measures the percentage of individuals who believe they are at risk of contracting COVID-19. In countries where there are a high percentage of individuals who do not have an accurate understanding of the risks that they face efforts need to be stepped up to communicate risk information.
<b>Definition</b>	For this indicator all individuals who believe they are at risk of contracting COVID-19 should be counted.
<b>Disaggregate</b>	The recommended disaggregation of this indicator is by: sex, age and education. Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.
<b>Computation</b>	This indicator should be computed as a percentage.  Numerator: total number of respondents aged 15 and above who believe they are at risk of contracting COVID-19.  Denominator: total number of respondents aged 15 and above.
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	This indicator measures the percentage of individuals who believe they are at risk of contracting COVID-19. It does not measure their perceptions of the level of risk that COVID-19 poses for them.

Indicator	Percentage of individuals who know correct symptoms of COVID-19
<b>Result</b>	The community understands public health information and recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service COVID-19 Behaviour Change Framework
<b>Purpose</b>	<p>Knowledge of the correct symptoms of COVID-19 is important if a person is to act to stop the onward transmission of COVID-19 and to protect their own health. This indicator measures the percentage of people in the community who know symptoms of COVID-19. Disaggregation of the indicator allows analysis of knowledge of COVID-19 symptoms among the most vulnerable groups, particularly those who may have a disability. Disaggregation by language is encouraged as language can be a major barrier to receiving information and developing accurate knowledge. In countries where individuals do not have sufficient knowledge of the symptoms of COVID-19, risk communication efforts should be strengthened.</p>
<b>Definition</b>	<p>The most common symptoms of COVID-19 are fever, dry cough and tiredness. Less common symptoms are aches and pains, sore throat, diarrhoea, conjunctivitis, headache, loss of taste or smell, a rash on skin, or discolouration of fingers or toes. The most serious symptoms are difficulty breathing or shortness of breath, chest pain or pressure, loss of speech or movement.</p> <p>For this indicator the government information on COVID-19 symptoms should be used. Where subnational government is mandated to communicate risk information, the information communicated by the mandated government agency should be used for the area in which the data is being collected.</p> <p>For an individual to be counted as having knowledge of the correct symptoms of COVID-19 the individual should be able to identify the key symptoms listed by the mandated government agency in its public health guidance. If the mandated government agency has not produced a list of key symptoms the organization leading the data collection should do so for the purposes of this indicator.</p>
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age, education and disability. The data should also be disaggregated by the preferred language for receiving communication of the person.</p> <p>Where practical the data should also be disaggregated by knowledge of each symptom of COVID-19.</p> <p>Where there is a policy interest data may also be disaggregated by income or economic status, ethnic origin, geographic location, and migration.</p>
<b>Computation</b>	<p>This indicator should be calculated as a percentage</p> <p>Numerator: total of respondents aged 15 and above who know correct symptoms of COVID-19.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.



<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	Knowledge of the correct symptoms of COVID-19 should not be assumed to be a predictor in itself of behaviour change. For analysis of behaviour change it is recommended to consider the data for this indicator within the conceptual framework of the Behaviour and Social Drivers approach.

<b>Indicator</b>	<b>Percentage of individuals who know correct transmission routes of COVID-19</b>
<b>Result</b>	The community understands public health information and recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Socio-Behaviour Change Framework

**Purpose** Accurate public knowledge of transmission routes is needed to stop COVID-19. This indicator measures the percentage of people in the community who know the correct transmission routes of COVID-19. In countries where individuals do not have sufficient knowledge of the transmission routes of COVID-19, risk communication efforts should be strengthened.

**Definition** Current evidence suggests that the virus spreads mainly between people who are in close contact with each other, typically within one metre (short-range). A person can be infected when aerosols or droplets containing the virus are inhaled or come directly into contact with the eyes, nose or mouth. People may also become infected by touching surfaces that have been contaminated by the virus when touching their eyes, nose or mouth without cleaning their hands.<sup>13</sup>

For this indicator the government information on COVID-19 symptoms should be used. Where subnational government is mandated to communicate risk information, the information communicated by the mandated government agency should be used for the area in which the data is being collected.

For an individual to be counted as having knowledge of the correct transmission routes of COVID-19 the individual should be able to identify the key transmission routes listed by the mandated government agency in its public health guidance. If the mandated government agency has not produced a list of key transmission routes the organization leading the data collection should do so for the purposes of this indicator.

**Disaggregate** The recommended disaggregation of this indicator is by: sex, age, education and disability. Where practical the data should also be disaggregated by knowledge or each transmission route of COVID-19. Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, and migration.

<sup>13</sup> See WHO, 'Coronavirus disease (COVID-19): How is it transmitted?', 2020, <[who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted](https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted)>

<b>Computation</b>	<p>This indicator should be calculated as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who know correct transmission routes of COVID-19.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	Knowledge of the transmission routes of COVID-19 should not be assumed to be a predictor in itself of behaviour change. For analysis of behaviour change it is recommended to consider the data for this indicator within the conceptual framework of the Behaviour and Social Drivers approach.



Indicator	Percentage of individuals who know how to protect themselves from COVID-19
<b>Result</b>	The community understands public health information and recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Socio-Behaviour Change Framework
<b>Purpose</b>	Knowledge of how to protect oneself and the community is essential to reduce mortality and morbidity caused by COVID-19. This indicator measures the percentage of individuals who know how to protect themselves from COVID-19. In countries where individuals do not have sufficient knowledge of how to protect themselves from COVID-19, risk communication efforts should be strengthened.
<b>Definition</b>	<p>To protect oneself from COVID-19 the WHO recommends the following preventative measures: regular handwashing with soap and water, or cleaning with alcohol-based hand rub; maintain at least one metre distance with an individual who is coughing or sneezing; avoid touching of the face; cover your mouth and nose when coughing or sneezing; stay home if you feel unwell; refrain from smoking and other activities that weaken the lungs; practise physical distancing by avoiding unnecessary travel and staying away from large groups of people.<sup>14</sup></p> <p>For this indicator the government information on protective measures for individuals for COVID-19 should be used. Where subnational government is mandated to communicate risk information, the information communicated by the mandated government agency should be used for the area in which the data is being collected.</p> <p>For an individual to be counted as having knowledge of how to protect himself from COVID-19 the individual should be able to identify the key preventative measures listed by the mandated government agency in its public health guidance. If the mandated government agency has not produced a list of key preventative measures the organization leading the data collection should do so for the purposes of this indicator.</p>
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age, education and disability. Where practical the data should also be disaggregated by knowledge of each preventative measure, for example handwashing, wearing a mask, etc.</p> <p>Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, and migration.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who know how to protect themselves from COVID-19.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	Knowledge of how to protect oneself from COVID-19 should not be assumed to be a predictor in itself of behaviour change. For analysis of behaviour change it is recommended to consider the data for this indicator within the conceptual framework of the Behaviour and Social Drivers approach.

14 See WHO, 'Coronavirus disease (COVID-19)', 2021, <[who.int/health-topics/coronavirus#tab=tab\\_2](https://www.who.int/health-topics/coronavirus#tab=tab_2)>

<b>Indicator</b>	<b>Percentage of adults / health workers who know where to get a COVID-19 vaccine for themselves</b>
<b>Result</b>	The community understands public health information and recommendations
<b>Result level</b>	Outcome
<b>Reference</b>	<a href="#">Behavioural and Social Drivers of Vaccination</a>
<b>Purpose</b>	<p>This indicator measures the percentage of adults and health workers who know where to get a COVID-19 vaccine for themselves. The indicator allows for analysis of knowledge of where to get a vaccine among health workers and the adult population. Health workers face a risk of exposure to COVID-19 through their work. Health workers also, by working directly with patients, may present a risk of spreading infection. Vaccination for health workers should be a priority in all countries. Knowledge of where to get a vaccine can vary among the adult population. Knowledge may be significantly lower among those who face barriers to accessing information. Data from this indicator can be used to tailor risk communication and community engagement campaigns to both the adult population and health workers, with a focus on promoting information about the location and timing of vaccination services.</p>
<b>Definition</b>	<p>This indicator refers to COVID-19 vaccines that are approved and safe to use. It is assumed for the purpose of this indicator that no other vaccines will be offered to the public.</p> <p>To be counted a respondent should know where to go for vaccination, i.e., knows that the facility or vaccination clinic exists and where it is located.</p> <p>For this indicator the national definition of ‘health worker’ should be used where available. Health workers include the roles of doctor, nurse, paramedic or first responder, allied health, community health worker, traditional healer, other health worker. The WHO provides an <a href="#">international standard classification of health worker</a> which can also be referenced.</p>
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age and education.</p> <p>Disaggregation of this indicator by disability and migration is encouraged.</p> <p>Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin and geographic location.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Numerator: total of respondents aged 15 and above who know where to get a COVID-19 vaccine for themselves.</p> <p>Denominator: total of respondents aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency once a COVID-19 vaccine is available in country.
<b>Data sources</b>	The preferred data source is population survey.
<b>Limitations</b>	None

Indicator	Percentage of individuals who seek information about COVID-19 regularly
<b>Result</b>	Accurate risk information is communicated to the public
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Socio-Behaviour Change Framework
<b>Purpose</b>	To protect their health and to stop the transmission of COVID-19 it is important that individuals regularly seek information about COVID-19. This indicator measures the percentage of individuals who seek information about COVID-19 regularly. This indicator is a measure of whether the community is sufficiently engaged in seeking risk information. Where a low percentage of the community or certain social groups are not regularly seeking information efforts should be made to re-engage with the population.
<b>Definition</b>	As the pandemic evolves so too will the information needs of the community. In general at the early stages of a response the information needs of the community are greater and the community may be advised to seek information with greater frequency. As the community learns about COVID-19 and the recommended measures, including vaccination, the frequency with which the community is advised to seek information may change. As such, countries should define what 'regularly' means at each stage of the pandemic.
<b>Disaggregate</b>	The recommended disaggregation of this indicator is by: sex, age and education. Where there is a policy interest data may also be disaggregated by the topic that individuals seek information on. The data can be further disaggregated by income or economic status, ethnic origin, geographic location, disability, and migration.
<b>Computation</b>	This indicator should be calculated as a percentage.  Numerator: total of individuals aged 15 and above who regularly seek information on COVID-19.  Denominator: total of individuals aged 15 and above.
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The recommended data source for this indicator is population survey.  Data from website traffic and media monitoring sources may be used as a proxy data source.
<b>Limitations</b>	None

<b>Indicator</b>	<b>Percentage of individuals who receive information through a communication channel they trust</b>
<b>Result</b>	Accurate risk information is communicated to the public
<b>Result level</b>	Output
<b>Reference</b>	Collective Service Socio-Behaviour Change Framework
<b>Purpose</b>	No matter how well planned or applied, risk communication community engagement interventions will fail if people do not trust the information source. Therefore, establishing and maintaining trust is arguably the first and most important step in effective RCCE. This indicator measures the proportion of the population who receive information through a communication channel they trust. Where the population, or a part of it, does not receive information through a communication channel it trusts efforts should be made to work with the communication channels that people do trust and strengthen the sharing of accurate information through them.
<b>Definition</b>	This indicator refers to individuals who have (1) received information on COVID-19 in the last three months through a communication channel AND (2) who trust the information from that communication channel. Both of these conditions should be met for a person to be counted as having received information through a communication channel they trust. Communication channels may include health-care workers, family, friends, community leaders, newspapers, radio, TV and online sources including social media and/or messaging apps, etc.
<b>Disaggregate</b>	The recommended disaggregation of this indicator is by: sex, age and education. The data should also be disaggregated by the communication channel. The suggested categories for communication channels are: national media channels (countries should name them), community health workers, politicians and religious leaders, among others relevant to the context. Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.
<b>Computation</b>	This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who report trusting the communication channel through which they receive COVID-19 related information.  Denominator: total of respondents aged 15 and above who have received information on COVID-19 in the last quarter.
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	The recommended data source for this indicator is population survey.  Social media monitoring could also be used to monitor public discourse on the trustworthiness of communication channels. As social media may not be representative of the population, this data is best used in combination with data from population surveys.
<b>Limitations</b>	In some contexts, community members may be reluctant to openly answer questions on whether they receive information through a communication channel they trust. In these contexts, an alternative to asking questions directly on trust is to use the Ohanian scale, which is used to measure source credibility. The Ohanian scale has three components: attractiveness (of the communicator); trustworthiness; and expertise.

Indicator	Percentage of individuals reached with public health information on COVID-19
<b>Result</b>	Accurate risk information is communicated to the public
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	<p>Communicating accurate risk information to the public is necessary to help people to identify local-level solutions and to adopt and sustain key preventive measures. This indicator counts the number of people who have been reached with accurate risk information on COVID-19. It is a measure of the reach of our public health messaging. Disaggregation of the indicator allows analysis of whether information is reaching the most vulnerable groups, particularly those who may face barriers to accessing information. Disaggregation also allows identification of the channels by which population groups are receiving different types of information. The data from this indicator can help adjust methods of communication, particularly if key social groups are not receiving the information they need to protect themselves from COVID-19.</p>
<b>Definition</b>	<p>This indicator measures the percentage of individuals in the population who have been reached by public health information on COVID-19. The frequency with which we plan to reach people with information will change according to the circumstances of the pandemic. The country should define the time period for the indicator; i.e., whether individuals have been reached with information in the last week, fortnight, month, etc.</p> <p>For this indicator the government recommendations on what public health information should be communicated to the public should be used. Where subnational government is mandated to communicate risk information, the recommendations of the mandated government agency should be used for the area in which the data is being collected.</p> <p>As the pandemic evolves the information that should be communicated to the public will change over time. It is important to continue to update the data collection tools to reflect changes in the public health information, for example by updating survey questions on information received on preventative measures at the early stage of the pandemic to information on vaccine availability at later stages of the pandemic.</p>
<b>Disaggregate</b>	<p>The recommended disaggregation of this indicator is by: sex, age, education, and disability. The data should also be disaggregated by the communication channel through which individuals have been reached, including the language of communication. If practical, the data should also be disaggregated by the type of information (on preventative measures, access to services, vaccines, etc.). Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, and migration.</p>
<b>Computation</b>	<p>This indicator should be calculated as a percentage.</p> <p>Numerator: total of individuals aged 15 and above who have been reached by risk information on COVID-19 (within the specified time period).</p> <p>Denominator: total of individuals aged 15 and above.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.

## Data sources

The preferred data source is population survey.

Media monitoring methods can also be used where survey data is not available. For media monitoring the following metrics should be used:

Social media: number of impressions per post;

Web: number of unique page views;

TV and radio: number of people reached through TV or radio;

Print: number of people reached through print or online.

Please note that data reported through media monitoring should be understood as the number of persons who have been reached with public health information through a specific media channel, for example the number of people reached by a radio station, etc. Many of the people reached by a channel, for instance a radio station, will also have been reached by other media, for example a website. Adding the number of people reached by each channel is not a valid measure of total reach as it is expected to involve double counting.

## Limitations

Indicators on the number of people reached by information are widely used in RCCE. Indicators on reach should be used with their limitations in mind. For example, although a person may have been 'reached' by a type of media one does not know exactly what that means. One does not know, for example, if the person has understood the message. Secondly, even where information has been received and understood it may not lead to a change in behaviour as other behavioural and social drivers may influence the behaviour of the person.<sup>15</sup>

15 UNICEF, *The Behavioural Drivers Model: A Conceptual Framework for Social and Behaviour Change Programming*, Jordan, 2019





Indicator	Percentage of individuals who are satisfied with the information content they receive on COVID-19
<b>Result</b>	Accurate risk information is communicated to the public
<b>Result level</b>	Outcome
<b>Reference</b>	Collective Service Socio-Behaviour Change Framework
<b>Purpose</b>	Risk information should be communicated in a way that the public can understand and apply to their personal and community circumstances. This indicator measures the percentage of individuals who are satisfied with the information content they have received on COVID-19. If the public is not satisfied with the information further analysis should be conducted to understand the reasons why. Efforts should be made to adjust the information content so that it is satisfactory to the public.
<b>Definition</b>	This indicator measures whether individuals are satisfied with the information content they have received on COVID-19. The indicator measures content that has been received from all information channels in the last quarter.
<b>Disaggregate</b>	The recommended disaggregation of this indicator is by: sex, age and education. The data should also be disaggregated by the communication channel through which the information was received and the language in which the information was received. Where there is a policy interest data may also be disaggregated for income or economic status, ethnic origin, geographic location, disability, and migration.
<b>Computation</b>	<p>This indicator should be calculated as a percentage.</p> <p>Numerator: total of individuals aged 15 and above who are satisfied with the information content they have received on COVID-19 within the last quarter.</p> <p>Denominator: total of individuals aged 15 and above who have received information on COVID-19 within the last quarter.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	<p>The preferred data source is population survey.</p> <p>Some media monitoring methods may include information on information satisfaction.</p>
<b>Limitations</b>	None



## Participation in response management

<b>Indicator</b>	<b>Percentage of targeted areas where community members actively participate in the public health decision-making processes</b>
<b>Result</b>	The community, particularly its most vulnerable members, participated in decision-making on the public health response
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	Community participation is vital to ensure accountable, adaptive and appropriate responses which put people at the centre and support community-led solutions. Communities should be given recognized roles to provide input on the management of the response. <sup>16</sup> This indicator measures the percentage of targeted areas where participatory decision-making processes have been active within the last quarter. Where participatory decision-making processes are not active efforts should be made to reinvigorate them. The participation of communities in public health decision-making will help to ensure community engagement and support.
<b>Definition</b>	<p>Active participatory decision-making for COVID-19 is where community members are involved in decision-making on the planning and implementation of activities. Trusted community leaders should be identified to participate in the process.<sup>17</sup> Action to support and foster leadership from among the most disadvantaged is necessary for a truly participative process. The definition of what constitutes 'community participation' should be made at country level. It is recommended that a strong definition of community participation is adopted where practical. The definition of what constitutes 'active participation' of community members in the public health decision-making process should be made at country level. 'Active participation' could, for example, be defined as: community members being present with the possibility to input into decisions related to the planning, design, implementation and management of the COVID-19 response in the administrative area within the last three months.</p> <p>The targeted area can be defined as appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	Data can be disaggregated by geographic area
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where community members actively participate in public health decision-making processes.</p> <p>Denominator: the total number of areas targeted for community members to actively participate in public health decision-making processes.</p>

16 See WHO, COVID-19: How to select, implement and adjust public health and social measures, Coronavirus update 44, 2020, <[who.int/docs/default-source/coronaviruse/risk-comms-updates/update44-public-healthand-social-measures.pdf?sfvrsn=1bcdd00f\\_5](https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update44-public-healthand-social-measures.pdf?sfvrsn=1bcdd00f_5)>

17 UNICEF, Minimum Quality Standards and Indicators for Community Engagement, 2019

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**Frequency**

This indicator should be reported with medium frequency.

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**Data sources**

The preferred means of collecting data for this indicator is through a participatory process involving both community members and officials of the public health response. Both community members and officials of the public health response should agree as to whether the definition of participation above, has been met for the public health response to COVID-19 in their area.

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**Limitations**

None

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## Community engagement

Indicator	Percentage of targeted community groups that promote public health recommendations to stop COVID-19
<b>Result</b>	Communities, particularly the most vulnerable, are engaged in the public health response
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	The evidence from recent pandemics has shown that community engagement is key to ensuring an effective, whole-of-society response. This indicator measures the percentage of targeted community groups that have promoted public health recommendations to stop COVID-19 within the last quarter. Where targeted community groups are not active in the effort to stop COVID-19 it may be necessary to re-engage with community groups.
<b>Definition</b>	Community groups may include sports organizations, social groups, local religious organizations or congregations. The community groups that are being targeted for the promotion of public health recommendations to stop COVID-19 should be identified in the RCCE plan. To be counted, the community group should have taken actions to promote public health measures within the last quarter, such as disseminating key messages on COVID-19 to members, organizing discussion groups, etc.
<b>Disaggregate</b>	This data can be reported nationally – counting national-level community groups – or for subnational areas – counting subnational-level community groups.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted community groups that are promoting public health messages to stop COVID-19 in the geographic area.</p> <p>Denominator: the total number of community groups that were targeted to promote public health messages to stop COVID-19 in the geographic area.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or community counterparts.
<b>Limitations</b>	None

Indicator	Percentage of targeted areas where community members play an active role in the delivery of public health services to respond to COVID-19
<b>Result</b>	Communities, particularly the most vulnerable, are engaged in the public health response
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	<p>Public health responses are more effective when community members play an active role in the delivery of services. This indicator measures the percentage of targeted areas where community members play a role in the delivery of public health services to respond to COVID-19. Where the community is not playing an active role, it may be necessary to re-engage with the community to encourage engagement. Alternatively it may be necessary to examine if community leadership is being constrained by the organization of the public health response to COVID-19 in the area.</p> <p>To analyse the role of the community in the public health response this indicator can be used in conjunction with the indicators on community participation in decision-making and community participation in promoting public health recommendations.</p>
<b>Definition</b>	<p>For this indicator community members should have played an active role in the delivery of public health services to respond to COVID-19 within the last quarter. Community members are defined as persons who are not employed as health professionals on the response to COVID-19. An 'active role' is defined as community members having a specific responsibility in the delivery of a service or activity. A broad range of services or activities may be included. The service or activity should be listed within the response plan to COVID-19. These may include community-level shielding initiatives, helping to get to the hospital promptly – for example through fuel provision in remote areas, food donations for the most vulnerable, young people helping the elderly to get to vaccination sites, community contact tracing, reporting outbreak alerts, etc.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	Data can be disaggregated by geographic area
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where community members play an active role in the delivery of public health services to respond to COVID-19.</p> <p>Denominator: the total number of areas targeted for community members to play an active role in the delivery of public health services to respond to COVID-19.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	The preferred means of collecting data for this indicator is through a participatory process involving both community members and officials of the public health response. Both community members and officials of the public health response should agree as to whether community members have played an active role in the delivery of public health services to respond to COVID-19.
<b>Limitations</b>	None

Indicator	Percentage of targeted areas where community dialogues on public health are taking place
<b>Result</b>	Communities, particularly their most vulnerable members, are engaged in the public health response
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	<p>A whole-of-society response is needed to meet the challenge of COVID-19. RCCE seeks, through an understanding of the social environment, to create a space for community dialogues that promote attention and listening to different viewpoints without bias. Learning from these dialogues will help to adapt public health approaches. Community dialogues should be open to all of the community, including business, religious, social, sport, youth, government, political and private representatives. The participation of public health leaders is especially welcome in community dialogues. Special efforts should be made to include the most vulnerable members of the community. This indicator measures the number of communities where active, formal dialogues on COVID are taking place regularly. In communities where these dialogues are not regularly taking place there may be a need to re-activate the community engagement process.</p>
<b>Definition</b>	<p>Community dialogues are here defined as processes that bring community members together to allow the open discussion of local public health concerns. The community dialogues can take place online or in person. Community dialogues of various formats can be counted so long as they are open to all community members and facilitate discussions related to COVID-19. Existing community dialogues or forums that include discussion related to stopping COVID-19 can be counted. To be counted as being active the community dialogues should take place at least once a quarter in the targeted area.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	This indicator can be disaggregated by subnational area.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where community dialogues on public health are taking place.</p> <p>Denominator: the total number of targeted areas for community dialogue on public health.</p>
<b>Frequency</b>	This indicator should be reported with high frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or community counterparts.
<b>Limitations</b>	None

<b>Indicator</b>	<b>Percentage of targeted areas where supports for community members to play an active role in the delivery of public health services to respond to COVID-19 are provided</b>
<b>Result</b>	Supports are provided to enable community members to play an active role in service delivery
<b>Result level</b>	Output
<b>Reference</b>	New indicator
<b>Purpose</b>	For community members to play an active role in the public health response to COVID-19 support is needed. The support needed will differ according to the context and response plans. In general support should be put in place to ensure that community engagement is well-organized, is sustainable throughout the response, and is targeted on the most vulnerable people. This indicator measures whether support is in place to enable community members to play an active role in the delivery of public health services responding to COVID-19.
<b>Definition</b>	<p>Support for community members to play an active role in the delivery of public health services may include activities such as registration, training, guidance, material supports, etc. To be counted the area should be providing these supports at the time of data collection.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	This indicator can be disaggregated by subnational area.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where support is in place to enable community members to play an active role in the delivery of public health services responding to COVID-19.</p> <p>Denominator: The total number of targeted areas to provide for supports for community members to play an active role in the delivery of public health services to respond to COVID-19.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency throughout the response.
<b>Data sources</b>	The preferred means of collecting data for this indicator is through a participatory process involving both community members and officials of the public health response. Both community members and officials of the public health response should agree as to whether the targeted support is in place to enable community members to play an active role in the delivery of public health services.
<b>Limitations</b>	None



## Laws and Policies

Indicator	Percentage of targeted areas in which RCCE SOPs have been adopted by government partners
<b>Result</b>	The legal and policy framework supports RCCE for COVID-19
<b>Result level</b>	Activity
<b>Reference</b>	New indicator (see Minimum Quality Standards and Indicators for Community Engagement, UNICEF, C.13.3)
<b>Purpose</b>	<p>The RCCE experience during the Ebola outbreak in West Africa underlined the importance of partner organizations adopting SOPs for RCCE.<sup>18</sup> This indicator measures the percentage of targeted areas in which RCCE SOPs have been adopted by government partners. Where RCCE SOPs are not being adopted by government partners, efforts should be made to engage with counterparts and to provide the assistance necessary for the adoption of the SOPs.</p> <p>Please note that this indicator can be used to complement the Sustainable Development Goals Indicator 16.10.2: Number of countries that adopt and implement constitutional, statutory and/or policy guarantees for public access to information.</p>
<b>Definition</b>	<p>An RCCE SOP should be understood as a set of step-by-step instructions to help workers carry out routine operations on community engagement and risk communication. RCCE SOPs should specifically relate to risk communication or community engagement in a pandemic or disease outbreak. To be counted as an RCCE SOP it should specify a set of actions and standards for community engagement or risk communication. All relevant government partners can be counted. For an area to be counted as having adopted RCCE SOPs at least one government partner in the administrative area has to have adopted at least one RCCE SOP.</p> <p>Please note that government areas can be defined according to local or national circumstances; for example, health administrative areas could be used where appropriate.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	This data can be disaggregated by government administrative area.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas in which RCCE SOPs have been adopted by government partners.</p> <p>Denominator: the total number of areas targeted for the adoption of RCCE SOPs.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency throughout the response

<sup>18</sup> Gillespie et al., 'Social Mobilization and Community Engagement Central to the Ebola Response in West Africa', Global Health, 2016



<b>Data sources</b>	Data for this indicator can be collected through government counterparts.
<b>Limitations</b>	None

<b>Indicator</b>	<b>Percentage of targeted areas where policies and procedures for the participation of local communities have been adopted</b>
<b>Result</b>	Mechanisms for community participation in decision-making on the management of the response to COVID-19 are established
<b>Result level</b>	Output
<b>Reference</b>	New indicator (see <a href="#">Minimum Quality Standards and Indicators for Community Engagement</a> , UNICEF)

**Purpose** In many countries the planning framework for responding to public health emergencies does not include policies and procedures for participation of local communities. Establishing these policies and procedures will enable public participation and community engagement. This indicator is a measure of the adoption of policies and procedures for the participation of local communities. It reflects the extent to which the government is putting in place participatory mechanisms.

**Definition** The definition of the appropriate policies and procedures for the participation of local communities should be decided by countries. At a minimum, policies and procedures for the participation of communities should consider the following:

- » Recognize meaningful participation as a right and as being essential for informed decision-making and collective self-determination.
- » Detail the proposed level of participation in a gender-sensitive, age-sensitive, and contextually appropriate manner and in line with planning activities.
- » Ensure that the participation of communities is linked to key elements of design and management of activities.
- » Ensure recognized participatory methods and approaches are employed to ensure the participatory processes are effective.
- » Ensure that community engagement approaches are locally relevant, gender, age, and culturally appropriate and in languages and formats that are understood by all members of the community.<sup>19</sup>

The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.

**Disaggregate** This data can be disaggregated by government administrative area.

19 Adapted from UNICEF, Minimum Quality Standards for Community Engagement, 2019, see A.1.1

<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where policies and procedures for the participation of local communities have been adopted.</p> <p>Denominator: the total number of areas targeted for the adoption of policies and procedures for the participation of local communities.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government offices. If possible, community representatives should take part in the data collection process.
<b>Limitations</b>	This indicator measures whether participatory mechanisms have been established or not. It does not measure the quality of the participation.





# Infodemic management

<b>Indicator</b>	<b>Capabilities to track and address infodemics and health misinformation are in place</b>
<b>Result</b>	Rumour monitoring mechanism for COVID-19 is established
<b>Result level</b>	Activity
<b>Reference</b>	See WHO SPRP May 2021

## Purpose

An infodemic can intensify or lengthen outbreaks when people are unsure about what they need to do to protect their health and the health of people around them. With growing digitization – an expansion of social media and internet use – information can spread more rapidly, which can help to fill information voids more quickly but can also amplify harmful messages. The purpose of this indicator is to monitor whether capabilities to track and address infodemics and health misinformation are in place. This indicator can be used both at national and subnational level. Where these capabilities are not in place countries are encouraged to redouble their efforts in infodemic management.

Please note that this indicator is adapted from the WHO, May 2021 SPRP indicator: ‘Proportion of countries that have capabilities to track and address infodemics and health misinformation’. For further resources on infodemic management please see the WHO Infodemic Management webpage.

## Definition

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. Infodemic management is the systematic use of risk- and evidence-based analyses and approaches to manage the infodemic and reduce its impact on health behaviours during health emergencies. It aims to ensure people have access to factual information in a timely manner that is easily understood, so that they may rapidly adopt behaviours to protect health and the health of others during an epidemic. Infodemic management must be backed up by science, must rely on evidence-based interventions, and must make use of best practices, including sharing experiences and continuous learning.

An area should be scored as having capability to track and address infodemics and health misinformation in place according to the following scale:

- » Yes, there is a unit within Ministry of Health or equivalent
- » Yes, there is a unit within government but in another Ministry
- » Yes, there is a unit within a partner agency
- » No there is not a unit, but staff within a government ministry or partner agency are completing these tasks
- » No unit, no staff completing these tasks within a government ministry or partner agency, but planning on setting up a unit within a government ministry or partner agency
- » No unit, no staff completing these tasks within a government ministry or partner agency, not planning on setting up a unit within a government ministry or partner agency
- » Don't know

<b>Disaggregate</b>	This indicator can be disaggregated by government administrative area.
<b>Computation</b>	Please choose from the appropriate category in the definition above.
<b>Frequency</b>	This indicator is aimed for reporting on a quarterly basis.
<b>Data sources</b>	Data for this indicator can be collected through government or RCCE counterparts.
<b>Limitations</b>	None





# Community feedback

<b>Indicator</b>	<b>Percentage of targeted areas where mechanisms are in place to capture and use community feedback</b>
<b>Result</b>	Community feedback mechanisms link community with government, media and other actors
<b>Result level</b>	Activity
<b>Reference</b>	New indicator (see IFRC Feedback Toolkit and Community Engagement and Accountability Guide <sup>20</sup> and <a href="#">Minimum Quality Standards and Indicators for Community Engagement</a> , UNICEF)

## Purpose

One of the pillars of Accountability to Affected Populations is strengthening listening approaches and setting up secure means for affected communities to provide feedback about their experiences and perspectives on services, programmes and responses, about a specific topic or issue related to the response. Feedback can include public health concerns or questions about rumours, perceptions and other concerns. Feedback may also include questions about the behaviour and conduct of staff and volunteers. This includes serious complaints about sexual exploitation and abuse (SEA) and corruption, and sensitive feedback linked to violence or protection concerns. Feedback can be received informally through conversations between community members and staff and volunteers, or more formally through channels such as a telephone hotline, complaints desk or community committee (see 'Definition' below). Please note that feedback mechanisms are not specific to a particular topic or sector. Community members should be able to voice their concerns and have them related to the appropriate topic, e.g., COVID-19 and sector, e.g., public health, through the feedback mechanism. What matters most is that feedback is acted on and responded to. Community feedback approaches ensure that communities and individuals can express their beliefs, access needed information, obtain answers to questions and raise concerns or complaints as needed. It strengthens community inclusion and enables an improved response to the needs of the community. Community feedback can be relayed through government and non-governmental channels. It is also important that community feedback is linked to media, both as a means to inform the media of the reality in the community and as a means of social accountability. This indicator measures whether mechanisms are in place to capture community feedback.

<sup>20</sup> IFRC Feedback Toolkit, 2021 <https://communityengagementhub.org/resource/cea-toolkit/> and IFRC, Community Engagement and Accountability Guide, 2021 <https://communityengagementhub.org/resource/ifrc-cea-guide/>

<b>Definition</b>	<p>Community feedback mechanisms can include data collected through conversations between community members and community workers and volunteers, during household visits, from hotlines, information centres, digital engagement platforms (U-Report, RapidPro, loGT, others), interactive messaging platforms (Facebook, Twitter, WhatsApp), focus group discussions, participation in research on community insights, written communications (email, letters), Q&amp;A forums, listening sessions, media call-ins (TV, radio programmes), community platforms, feedback booths, community meetings, health volunteer networks, etc. Data collection methods being used for M&amp;E and social science purposes can also be considered part of a community feedback mechanism. The focus of this indicator is on information being regularly collected, analysed, integrated into decision-making processes, and acted on. A community feedback mechanism should have procedures in place to ensure that:</p> <ul style="list-style-type: none"> <li>» The mechanism is open to all persons to safely use and that it can be used by vulnerable people and special needs groups.</li> <li>» A systematic and transparent mechanism is established through which people can register dissent and raise issues.</li> <li>» There are clear and functional lines of two-way communication for routine feedback so that relevant issues or concerns are relayed to the appropriate officials, at local or national level.</li> <li>» Communities are informed of the findings from monitoring, evaluation and learning activities, and communities have access to data.</li> </ul> <p>A targeted area can be counted as having a community feedback mechanism in place if it has at least one community feedback mechanism operating that meets all of these four criteria.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	<p>This indicator can be disaggregated by government administrative area.</p>
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: The number of targeted areas where mechanisms are in place to capture and use community feedback.</p> <p>Denominator: The total number of areas targeted to put mechanisms in place to capture and use community feedback.</p>
<b>Frequency</b>	<p>This indicator should be reported with medium frequency.</p>
<b>Data sources</b>	<p>Data for this indicator can be collected through government or RCCE counterparts. Community members should be consulted as to whether the community feedback mechanisms are actually in place.</p>
<b>Limitations</b>	<p>None</p>

Indicator	Percentage of targeted areas where changes have been made to COVID-19 response plans based on community feedback
<b>Result</b>	Community feedback mechanism is established
<b>Result level</b>	Activity
<b>Reference</b>	New indicator
<b>Purpose</b>	<p>Feedback mechanisms should operate as a communication channel between the wider community and the management of the public health response. The management of the response should review the information received through the feedback mechanism and where necessary adjustments to the response should be made. For example, feedback can be acted on and responded to, through changes in services or community engagement strategies, or sharing of factual and timely information through risk communication interventions to address rumours. This indicator measures whether community feedback mechanisms are being used to adjust the response. The indicator can be used to measure the integration of community feedback into response planning at subnational or national level.</p>
<b>Definition</b>	<p>For a targeted area to be counted as having made changes to COVID-19 response plans based on community feedback mechanisms the management of the public health response in the area should be able to refer to specific changes or adjustments that have been made to the response plan based on specific community feedback mechanisms within a defined period, for example within a period of six months.</p> <p>The targeted area can be defined as is appropriate to the context; for example, local government administrative areas or health administrative areas could be used.</p>
<b>Disaggregate</b>	This indicator can be disaggregated by government administrative area.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of targeted areas where changes have been made to COVID-19 response plans based on community feedback within a defined period.</p> <p>Denominator: the total number of areas where community feedback mechanisms are in place.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	<p>The preferred means of collecting data for this indicator is through a participatory process involving both community members and officials of the public health response. Officials of the public health response should provide information on whether community feedback has led to a change in the response plan. Representatives of the community should be consulted on whether they agree that their feedback has led to changes in the response plans.</p>
<b>Limitations</b>	<p>It should be noted that the link between community feedback and a change in a response plan may not be straightforward. This indicator is best used in combination with other information sources.</p>



## Research and needs assessment

<b>Indicator</b>	<b>Countries that carried out an assessment of behavioural and social drivers (BeSD) of COVID-19 vaccination acceptance and uptake</b>
<b>Result</b>	Social and behavioural research is conducted
<b>Result level</b>	Input
<b>Reference</b>	<a href="#">Behavioural and Social Drivers of Vaccination</a>
<b>Purpose</b>	<p>Routinely measuring the behavioural and social drivers of vaccination is vital to be able to adequately assess and address reasons for low uptake. Gathering and using quality data on the behavioural and social drivers (BeSD) of vaccination will enable programmes to design, target and evaluate interventions to achieve greater impact with more efficiency, and to examine and understand trends over time.</p> <p>This indicator measures the number of countries that have carried out an assessment of the behavioural and social drivers of COVID-19 vaccination acceptance and uptake. In countries where a BeSD assessment has not been carried out efforts should be made to put the resources in place for the conduct of the BeSD assessment.</p> <p>This indicator can also be used to monitor the use of BeSD for subnational vaccination campaigns.</p>
<b>Definition</b>	<p>A Behavioural and Social Drivers assessment is recommended to include the four domains that influence vaccine uptake, namely: what people think and feel about vaccines; social processes that drive or inhibit vaccination; individual motivations (or hesitancy) to seek vaccination; and practical factors involved in seeking and receiving vaccination.<sup>21</sup> For this indicator, a country can be counted as having conducted a Behavioural and Social Drivers assessment if they have included all four domains in the assessment. Our definition does not include the methods employed to conduct the assessment, which are best decided at country level. Please note that this indicator speaks to the generation and use of social data for vaccine uptake and should not be confused with the use of any one specific tool.</p>
<b>Disaggregate</b>	This data can be reported per country.
<b>Computation</b>	<p>This indicator should be computed as a percentage.</p> <p>Nominator: the number of countries that have conducted an assessment of behavioural and social drivers (BeSD) of COVID-19 vaccine uptake.</p> <p>Denominator: the total number of countries conducting vaccination campaigns for COVID-19.</p>
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or RCCE counterparts.
<b>Limitations</b>	None

21 UNICEF, WHO, Data for Action: Achieving high uptake of COVID-19 vaccines, Interim Guidance, February 2021





## Capacity-building

Indicator	Number of participants in RCCE training sessions
<b>Result</b>	Activity
<b>Result level</b>	Training to build capacity of partners is provided
<b>Reference</b>	New Indicator
<b>Purpose</b>	Building national and subnational RCCE capacity is essential if RCCE is implemented. This indicator measures the number of individuals who have been trained on RCCE approaches. This indicator can be used to monitor capacity-building at national and subnational levels.
<b>Definition</b>	This indicator counts the number of times individuals have participated in an RCCE training session in the last quarter. Please note this is a count of the number of times individuals have participated and not of the number of individuals (see Limitations below). An RCCE training session is defined as any training that includes substantial learning on RCCE. A training session is defined as a period of teaching, education, instruction or professional development. Each training session should be counted as one session regardless of how long the session is; i.e., if it is for one day or three days.
<b>Disaggregate</b>	Detailed data collection on the type of training provided is recommended. Data can be collected on the subject of the training, for example training in communication, media engagement, infodemic management, etc. Data on the number of participants who have been trained should be collected, with disaggregation, where appropriate by sex and the affiliation of the trainee, for example NGO, UN, government, etc. Data can also be collected on the language the training is conducted in and on what training resources are used.
<b>Computation</b>	This is a numeric count of the total number of times individuals have participated in an RCCE training session in the last quarter.
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government and RCCE counterparts. It is important to collect data from all partners who conduct RCCE training in the geographical area to ensure the data is comprehensive.
<b>Limitations</b>	Most data collection systems on training are not able to count the number of individuals who have participated in training sessions across multiple partners. For this reason this indicator does not count the number of individuals who have participated in RCCE training sessions. It counts the number of times individuals have participated in RCCE training sessions. For example if one person participates in three RCCE training sessions in the last quarter, this will be counted as three times individuals have participated in an RCCE training session.



## Coordination mechanism

<b>Indicator</b>	<b>An RCCE coordination mechanism is active and formally implemented</b>
<b>Result</b>	National and local RCCE coordination mechanism is operating
<b>Result level</b>	Input
<b>Reference</b>	New indicator
<b>Purpose</b>	Having RCCE coordination mechanisms in place helps to ensure that response organizations, governments and partners synchronize strategy and plans, and that health recommendations and guidance are consistent and timely and can be adapted for diverse realities, transmission scenarios and population needs. <sup>22</sup> This indicator measures whether an RCCE coordination mechanism is active and formally implemented. Where coordination mechanisms are not active and formally implemented support may be needed to either establish or re-activate the coordination mechanism.
<b>Definition</b>	The RCCE coordination mechanism should be led or co-led by governments and/or responsible bodies and should include representatives from government, multisectoral entities and civil society, and/or non-governmental organizations and local associations. To be considered formally implemented the coordination mechanism should have terms of reference that have been formally agreed by all participating members. To be considered active the coordination group should have met at least once during the last quarter.
<b>Disaggregate</b>	This indicator can be disaggregated by government administrative area.
<b>Computation</b>	This indicator is a 'Yes or No' indicator
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or RCCE counterparts.
<b>Limitations</b>	None

22 WHO, COVID SPRP Monitoring and Evaluation Indicator Guidance, May 2021



## RCCE plan and budget

<b>Indicator</b>	<b>A risk communication and community engagement plan for COVID-19 is adopted</b>
<b>Result</b>	Evidence-based national RCCE COVID-19 response plan is developed
<b>Result level</b>	Input
<b>Reference</b>	New indicator (See WHO COVID SPRP Indicator Guidance – Note May 20)
<b>Purpose</b>	<p>A risk communication and community engagement (RCCE) plan establishes the rationale and strategy to ensure that communities are at the centre of the response. The plan should be based on evidence gathered during the needs assessment and should reflect the expressed preferences of the community, paying particular attention to the needs of the most vulnerable. This indicator measures whether an up-to-date risk communication and community engagement plan for COVID-19 has been adopted. It is an indicator of RCCE operational readiness.</p>
<b>Definition</b>	<p>An RCCE plan should:</p> <ul style="list-style-type: none"><li>» Be informed by a needs assessment that identifies and includes the perspectives of the most vulnerable.</li><li>» Define the coordination mechanism for the RCCE plan, establish roles and responsibilities for partners, identify accountabilities between governments, partners and communities, and set milestones for coordination and improvement over time.</li><li>» Identify key audiences and influencers, define information provision (on both prevention, preparedness and response at individual, community and system level) and define activities to be implemented.</li><li>» Identify key methods for community engagement, including community influencers and networks and anticipate special information and engagement needs for people who are disabled or illiterate.</li><li>» Define a social research agenda.</li><li>» Detail a media collaboration plan.</li><li>» Be costed for all major activities, including social science and M&amp;E.</li><li>» The RCCE plan should be adapted according to the evolution of the pandemic and the transmission scenarios in the government administrative area. The RCCE plan should be updated at least once every six months.</li></ul>
<b>Disaggregate</b>	This indicator can be disaggregated by government administrative area.
<b>Computation</b>	This is a 'Yes or No' indicator
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or RCCE counterparts.
<b>Limitations</b>	None

<b>Indicator</b>	<b>An adequate budget for risk communication and community engagement activities is available</b>
<b>Result</b>	A sufficient budget for the RCCE programme is allocated
<b>Result level</b>	Input
<b>Reference</b>	New indicator (see Minimum Quality Standards and Indicators for Community Engagement, UNICEF, B.7.2/ D.16.4.)
<b>Purpose</b>	Resource mobilization and budgeting for community engagement should be based on a thorough and realistic analysis of the inputs required to achieve targets, including all personnel, coordination and operational costs. This indicator measures whether an adequate budget for risk communication and community engagement activities is available. It is an indicator of RCCE operational readiness.
<b>Definition</b>	<p>This indicator refers to a budget that has been allocated for RCCE activities; i.e., that the money is available to RCCE actors. Countries should define what is an adequate budget for RCCE activities based on local contexts and conditions. The following standards should be taken into consideration:</p> <ul style="list-style-type: none"> <li>» Identify the real costs of RCCE activities, including resources for labour, materials, transportation, and supplemental resources.</li> <li>» Anticipate the real costs staff and volunteers, including training, supervision, reporting, management, and salaries or incentives.</li> <li>» Ensure sufficient resources to support attendance and participation in sectoral, pillar, cluster, department, interagency and governmental meetings. This includes collaborative activities like information-sharing and liaising with regional and local actors.</li> </ul>
<b>Disaggregate</b>	This indicator can be disaggregated by government administrative area.
<b>Computation</b>	This is a 'Yes or No' indicator
<b>Frequency</b>	This indicator should be reported with medium frequency.
<b>Data sources</b>	Data for this indicator can be collected through government or RCCE counterparts.
<b>Limitations</b>	None

