Risk Communication and Community Engagement

Indicator Guidance for Ebola

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# Acknowledgements

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## The Collective Service

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 risk communication and community engagement (RCCE) policy, practice and research to provide practical support to those delivering on the ground.

## Purpose and audience

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

**Contents**

[Acknowledgements 2](#_heading=h.30j0zll)

[The Collective Service 2](#_heading=h.1fob9te)

[Purpose and audience 2](#_heading=h.3znysh7)

[Abbreviations 4](#_heading=h.tyjcwt)

[Chapter 1: Introduction and Background 5](#_heading=h.1t3h5sf)

[Risk Communication and Community Engagement 5](#_heading=h.4d34og8)

[Collective Service RCCE Interim Indicator Framework for Ebola 5](#_heading=h.2s8eyo1)

[Chapter 2: Indicator Framework 6](#_heading=h.3rdcrjn)

[List of Indicators 3](#_heading=h.35nkun2)

[How to apply the indicator guidance 5](#_heading=h.ihv636)

[Chapter 3: Data Collection 8](#_heading=h.44sinio)

[Ethics 8](#_heading=h.2jxsxqh)

[Data sources 9](#_heading=h.32hioqz)

[Disaggregation and frequency 10](#_heading=h.1hmsyys)

[Chapter 4: Indicators 12](#_heading=h.4i7ojhp)

[The practice of recommended public health measures 12](#_heading=h.2xcytpi)

[Social solidarity 13](#_heading=h.1ci93xb)

[Trust in authorities 14](#_heading=h.3whwml4)

[Accountability to the community 14](#_heading=h.2bn6wsx)

[Community-led response 16](#_heading=h.qsh70q)

[Knowledge of risk information on Ebola 17](#_heading=h.3as4poj)

[Information reach 19](#_heading=h.1pxezwc)

[Participation in response management 21](#_heading=h.49x2ik5)

[Community engagement 22](#_heading=h.2p2csry)

[Community Feedback 24](#_heading=h.41mghml)

[Capacity-building 26](#_heading=h.147n2zr)

[Coordination mechanism 27](#_heading=h.2grqrue)

[RCCE planning 27](#_heading=h.vx1227)

# Abbreviations

BeSD behavioural and social drivers

C4D communication for development

CDC Centers for Disease Control and Prevention

COVID-19 coronavirus disease

EVD ebola virus disease

GOARN Global Outbreak Alert and Response Network

GYM Global Youth Mobilization

HCW health care worker

IDP internally displaced person

IFRC International Federation of the Red Cross and Red Crescent Societies

IoGT Internet of Good Things

JHU Johns Hopkins University

LSHTM London School of Hygiene and Tropical Medicine

M&E monitoring and evaluation

MHPSS mental health and psychosocial support

MICS Multiple Indicator Cluster Survey

PH public health

R4DC Responsible Data for Children

RCCE risk communication and community engagement

SDG Sustainable Development Goals

SOP standard operating procedure

UNICEF United Nations Children’s Fund

UNSD United Nations Statistics Division

WHO World Health Organization

# Chapter 1: Introduction and Background

## Risk Communication and Community Engagement

Risk communication and community engagement (RCCE) has been recognized as a central pillar of public health responses. 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 ownership and 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.

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 Ebola.

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 for Ebola

In 2021 the Collective Service undertook to develop [*Interim RCCE Indicator Guidance for COVID-19*](https://www.rcce-collective.net/resource/risk-communication-and-community-engagement-indicator-guidance-for-covid-19/), with the aim of providing an M&E framework with clear output and outcome indicators to support programme management.[[1]](#footnote-0) The *Interim RCCE Indicator Guidance for COVID-19* draws on the UNICEF *Minimum Quality Standards and Indicators for Community Engagement*[[2]](#footnote-1)and the [*Collective Service COVID-19 Behaviour Change Framework*](https://www.rcce-collective.net/resource/covid-19-behaviour-change-framework/)*.* The current document adapts [*Interim RCCE Indicator Guidance for COVID-19*](https://www.rcce-collective.net/resource/risk-communication-and-community-engagement-indicator-guidance-for-covid-19/)to the needs of an Ebola response.

# Chapter 2: Indicator Framework

This chapter explains the structure of the indicator guidance.

As a first step, in developing the indicator guidance, a generic theory of change for RCCE was elaborated. The theory of change was developed for a local-level RCCE programme for Ebola. The theory of change identifies the key RCCE results that contribute to the aim of stopping the transmission of Ebola. In Table 1 the results are classified into impacts, outcomes, outputs, activities and inputs. The theory of change described here is as broad as possible so as to allow actors to choose the results most relevant to their context.

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 Ebola e.g. vaccines
* Continued government support is provided to implement and sustain recommended Ebola policies throughout the outbreak.

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.

Please note that the theory of change described here below is a static version of what happens in a response. In practice, for RCCE, the theory of change will describe the situation at one moment. This may change quickly. For example, research on barriers may identify that families are nervous of sending their loved ones to travel to distant health centres. This is recognized as a barrier and the theory of change will have to be adapted and new strategies developed. USAID describes this as an ‘emergency helix’.

Figure 1: USAID SBC Emergency Helix[[3]](#footnote-2)

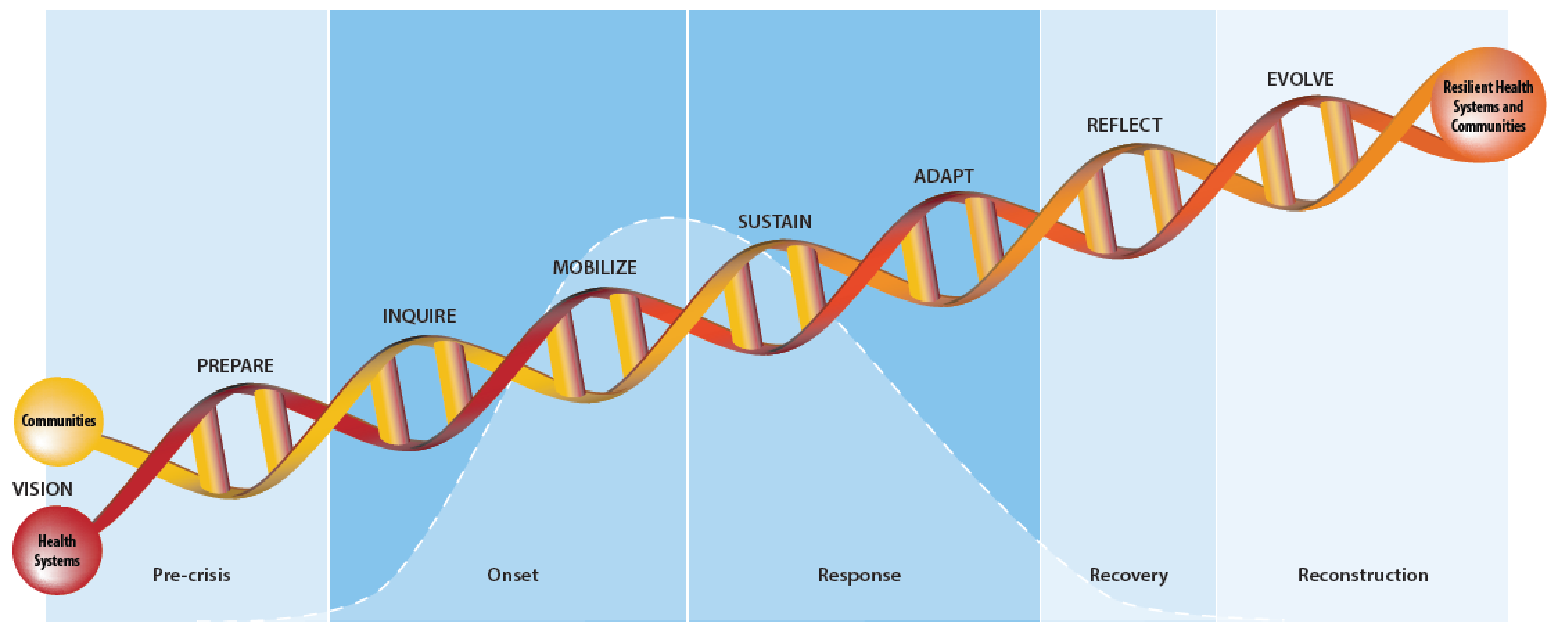


Table 1: RCCE Theory of Change for Ebola

| Impact | 1 Transmission of Ebola is stopped | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Outcome | 2 The community practices key public health recommendations | | | | | | | | | | | |
| 5 The community acts in solidarity to respond to Ebola | | | | | | | | | | | |
| 6 The community has trust in the public health response to Ebola | | | | | | | | | | | |
| 7 The response is accountable to the public | | 8 The response is community led | | | | | | | 9 The community understands public health information & recommendations | | |
| Output | 10 The RCEE systems are strengthened to respond to public health emergencies | | | | | | | | | | | |
| 11 The community participates in decision-making on the public health response | | | 12 Communities actively engage in the public health response | | | | | 13 Accurate risk information is communicated to the public | | | |
| 14 Supports for community participation in decision-making are established | 15 Supports to enable the community to conduct on-the-ground response activities are in place | | | | 16 Local service workers engage & inform people in their communities | 17 Media & in-person platforms are created for community public health dialogue | | | | 18 Accurate risk communication prepared by media & public health | 19 Infodemic and health misinformation is managed |
| Activity | 20 Community feedback mechanism link community with government, media and other actors | | | | | | | | | | | |
| 21 Social & behavioural is research conducted | | | | 22 Message monitoring is established | | | 23 Rumour monitoring is established | | | | |
| 24 Cooperation with community-based partners is strengthened | | | | | | | | | | | |
| 25 Training to build the capacity of the community and partners to respond to Ebola is provided | | | | | | | | | | | |
| 26 Technical assistance to support the implementation of RCCE is provided | | | | | | | | | | | |
| 27 Advocacy to promote the uptake and implementation of RCCE is conducted | | | | | | | | | | | |
| Input | 28 Evidence-based national RCCE Ebola response plan is developed | | | | | | | | | | | |
| 29 RCCE needs assessment is conducted | | | | | | | | | | | |
| 30 National and local RCCE coordination mechanism is operating | | | | | | | | | | | |
| 31 Staff with competence in core RCCE skills are in place | | | | | | | | | | | |
| 32 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 Ebola’, has the corresponding indicator ‘Percentage of individuals who trust authorities and partners leading the Ebola 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.

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 Ebola may change as the scientific understanding develops or as local barriers are better understood. 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 observe recommended burial practices’ the indicator ‘Percentage of individuals who report practising recommended measures to protect themselves from Ebola’is used. These broadly defined indicators also allow for comparison between countries and geographic areas on the percentage of people who practise locally recommended measures, for example it will allow comparison between areas where safe burial practices are a transmission risk and areas where they are not.

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 Ebola. RCCE is understood to contribute to these impacts.

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.

Table 2: Description of indicator guidance format

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

## List of Indicators

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

Table 3: List of risk communication and community engagement indicators

| **Level** | **INDICATORS** | **Page** |
| --- | --- | --- |
| Outcome | The practice of recommended public health measures |  |
| Percentage of individuals who report practicing recommended measures to protect themselves from Ebola (includes personal hygiene, attendance/behaviour at burials; safe sex) |  |
| Percentage of individuals who will get an Ebola vaccine if it is available to them |  |
| Social solidarity |  |
| Percentage of individuals who think falling ill with Ebola leads to stigma |  |
| Trust in the public health services |  |
| Percentage of individuals who trust authorities and partners leading the Ebola response |  |
| Accountability to the community |  |
| Percentage of individuals who think locally recommended measures for Ebola are fair |  |
| Percentage of individuals who know how to provide feedback |  |
| Community led response |  |
| Percentage of targeted areas where community members play an active role in the delivery of public health services to respond to Ebola |
| Knowledge of risk information |
| Percentage of individuals who believe they are at risk of contracting Ebola |  |
| Percentage of individuals who know correct symptoms of Ebola |  |
| Percentage of individuals who know correct transmission routes of Ebola |  |
| Percentage of individuals who know how to protect themselves from Ebola |  |
| Information reach |  |
| Percentage of individuals who receive information through a communication channel they trust |  |
| Percentage of individuals reached with public health information on Ebola |  |
| Participation in response management |  |
| Percentage of targeted areas where community members actively participate in the public health decision-making processes |  |
| Output | Community engagement |  |
| Percentage of targeted community groups that promote public health recommendations to stop Ebola |  |
|  |
| Percentage of targeted areas where community dialogues on public health are taking place |  |
| Supports for a community-led response |  |
| Percentage of targeted areas where supports are provided for a community-led response to Ebola |
| Activity | Community feedback |  |
| Percentage of targeted areas where mechanisms are in place to capture and use community feedback |  |
| Percentage of targeted areas where changes have been made to Ebola response plans based on community feedback |  |
| Capacity-building |  |
| Number of participants in RCCE training sessions |  |
| Input | Coordination Mechanism |  |
| An RCCE coordination mechanism is active and formally implemented |  |
| Plan and budget |  |
| A risk communication and community engagement plan for Ebola is adopted |  |
| Percentage of targeted areas where RCCE plans address barriers to the practice of public health recommendations |  |

## How to apply the indicator guidance

As noted above the advice is, where possible, to apply this 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. In Table 4 below an example is given of how the theory of change can be adapted to a response that focuses on safe burials and early presentation of cases. Results that are not relevant are removed and more detail is added to results that are relevant. It is important 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. The additional detail on results may require the indicators to be adapted.

**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 Ebola’; ‘Percentage of individuals who know correct transmission routes of Ebola’; and ‘Percentage of individuals who know how to protect themselves from Ebola’. 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 an outbreak 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.

Table 2: Example of an adaption of the generic theory of change

| Impact | 1 Transmission of Ebola is stopped | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Outcome | 2 The community practices key public health recommendations  **The community respects safe burial practices** The community supports early presentation of suspected Ebola cases | | | | | |
| 8 The response is community led  Community members manage burials to ensure Community members conduct and  safe practices are observed support contact tracing | | | 9 The community understands public health information & recommendations | | |
| Output | 10 The RCEE systems are strengthened to respond to public health emergencies | | | | | |
| 12 Communities actively engage in the public health response  Community groups advocate for Community groups engage members on  safe burial practices early presentation | | | 13 Accurate risk information is communicated to the public | | |
| 15 Supports to enable the community to conduct on-the-ground activities are in place  Financial support  Contract tracing mechanisms  SOPs on burials | 16 Local service workers engage & inform people in their communities  Engage on burials  Counseling on early presentation | 17 Media & in-person platforms are created for community public health dialogue | | 18 Accurate risk communication prepared by media & public health | 19 Infodemic and health misinformation is managed |

**Further Resources**

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 400 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 [Capacity Building](https://www.rcce-collective.net/capacity-building/) page on 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](https://www.icrc.org/en/doc/resources/documents/publication/p1067.htm).

UNICEF in collaboration with New York University, has developed the [Responsible Data for Children](https://rd4c.org/) (R4DC) 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](https://www.who.int/groups/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 Ebola’, 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 hand washing. 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 mechanisms are in place to capture and utilize community feedback’*,* 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 Ebola’ 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 a disease outbreak it is necessary to identify and characterize the factors that slow or accelerate transmission of Ebola and the populations that are most vulnerable to it. Disaggregation of data is needed to generate the information to do this.[[4]](#footnote-3) In this section detail is provided on disaggregation of indicators. For most population indicators disaggregation is recommended by age, sex and education. Other disaggregation using the definitions below can be considered, where feasible, particularly for the most vulnerable groups.

Disaggregating data by populations usually requires a 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. The age categories recommended here can be adapted to the information needs of the response. For example, if there is a need to have data on children aged 0-17, then the age category 15-24 can be broken into the age categories 15-17 and 18-24. Children aged 0-17 can be computed with the age categories 0-14 and 15-17.

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](https://www.washingtongroup-disability.com/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.[[5]](#footnote-4) [[6]](#footnote-5)

**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 ‘*Percentage of targeted areas where mechanisms are in place to capture and utilize community feedback*’ be collected at ‘medium frequency’ as frequent updates on whether a feedback mechanism is in place are not necessary to manage the programme. Conversely it is recommended that data on the indicator ‘*Percentage of individuals reached with public health information*’ 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 Ebola. Depending on the information needs of the response ‘High frequency’ can be considered as monthly and ‘Medium frequency’ can be considered as quarterly.

**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.[[7]](#footnote-6) 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.[[8]](#footnote-7)

**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 when measuring, for instance, “practising recommended measures to protect themselves from Ebola” 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.

# Chapter 4: Indicators

## The practice of recommended public health measures

| **Indicator** | Percentage of individuals who report practising recommended measures to protect themselves from Ebola |
| --- | --- |
| **Result** | The community, particularly the most vulnerable members, accesses services and practises key public health recommendations |
| **Result level** | Outcome |
| **Purpose** | This indicator measures the percentage of people who report practising measures to protect themselves as individuals from contracting Ebola. 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 Ebola. 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 and address those for a greater uptake |
| **Definition** | For this indicator the government recommendations on measures to protect individuals from Ebola should be used. This indicator relates to measures that serve to directly protect an individual from Ebola. Relevant measures include: Avoid contact with blood and body fluids of people who are sick; Avoid contact with semen from a man who has recovered from EVD, until testing shows that the virus is gone from his semen; Avoid contact with items that may have come in contact with an infected person’s blood or body fluids; Avoid funeral or burial practices that involve touching the body of someone who died from EVD or suspect EVD; Avoid contact with bats, forest antelopes, and nonhuman primates (such as monkeys and chimpanzees) blood, fluids, or raw meat prepared from these or unknown animals (bushmeat).[[9]](#footnote-8)  For a person to be considered to be practising the recommended measures they should be practising all of the measures recommended by the government all all of the time. |
| **Disaggregate** | The minimum recommended disaggregation of this indicator is by: sex, age education and disability. Where there is an interest the data may be disaggregated by the type of protective measure, as defined above. |
| **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 Ebola all of the time.  Denominator: total of respondents aged 15 and above. |
| **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 for some measures such as observation of safe funeral practice. |
| **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. |

| **Indicator** | Percentage of individuals who will get an Ebola vaccine if it is available to them |
| --- | --- |
| **Result** | The community, particularly the most vulnerable members, accesses services and practises key public health recommendations |
| **Result level** | Outcome |
| **Purpose** | 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 an Ebola vaccine if it is available to them. Where a low proportion of the population or of certain population subgroups intend to get an Ebola vaccine efforts should be made to further analyse the reasons for this and to create the conditions and environment to encourage greater uptake. |
| **Definition** | This indicator refers to Ebola 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. |
| **Disaggregate** | The minimum recommended disaggregation of this indicator is by: sex, age and education. |
| **Computation** | This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who will get an Ebola vaccine if it is available to them.  Denominator: total number of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency once a vaccine is approved for use in the country. |
| **Data sources** | The recommended data source for this indicator is population surveys. |
| **Limitations** | None |

## Social solidarity

| **Indicator** | Percentage of individuals who think falling ill with Ebola leads to stigma |
| --- | --- |
| **Result** | The community acts in solidarity to support the uptake of public health recommendations |
| **Result level** | Outcome |
| **Purpose** | Stigma against those who have been infected by Ebola can lead to a reduction in health-seeking behaviours due to fear of possible onward transmission. This indicator measures the percentage of people who believe falling ill with Ebola will lead to stigma. Where there is significant stigma around falling ill with Ebola efforts should be made to better understand the reasons for this and to promote a culture of support and solidarity. |
| **Definition** | Stigma refers to negative attitudes and beliefs about those who have fallen ill with Ebola. To be counted as believing that falling ill with Ebola leads to stigma, individuals should identify at least one form of stigma that they believe will result from falling ill with Ebola. Please note that stigma is distinct from discrimination, which refers to the act of treating people differently because they have Ebola.[[10]](#footnote-9) |
| **Disaggregate** | The minimum recommended disaggregation of this indicator is by: sex, age and education. |
| **Computation** | This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who think that falling ill with Ebola leads to stigma.  Denominator: total of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The preferred data source is population survey. |
| **Limitations** | None |

## Trust in authorities

| **Indicator** | Percentage of individuals who trust authorities and partners leading the Ebola response |
| --- | --- |
| **Result** | The community has trust in the public health response to Ebola |
| **Result level** | Outcome |
| **Purpose** | To stop Ebola 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 Ebola. Where a low level of public trust in those leading the Ebola response is found, action should be taken to improve the relationship with communities and gain their trust. 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’. |
| **Definition** | This indicator measures the percentage of the population who trusts authorities and partners leading the Ebola response. |
| **Disaggregate** | 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, scientists etc., as relevant to the context. |
| **Computation** | This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who trust authorities and partners leading the Ebola response.  Denominator: total of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The recommended data source for this indicator is population surveys. |
| **Limitations** | In some contexts it may be too politically sensitive to ask questions on whether respondents trust in authorities and partners leading the Ebola 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](https://www.jstor.org/stable/4188769) 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 Ebola to avoid or reduce confusion with questions related to general perceptions of government. |

## Accountability to the community

| **Indicator** | Percentage of individuals who think locally recommended measures for Ebola are fair |
| --- | --- |
| **Result** | The public health response is community led and accountable to the public |
| **Result level** | Outcome |
| **Purpose** | 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 Ebola. |
| **Definition** | For this indicator the locally recommended measures for Ebola 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. |
| **Computation** | This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who think locally recommended measures for Ebola 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 Ebola to avoid or reduce confusion with questions related to general perceptions of government. |

| **Indicator** | Percentage of individuals who know how to provide feedback |
| --- | --- |
| **Result** | The public health response is community led and accountable to the public |
| **Result level** | Outcome |
| **Purpose** | 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., Ebola 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. Please see the IFRC Feedback Toolkit and Community Engagement and Accountability Guide[[11]](#footnote-10) for more detail on Community Feedback Mechanisms. |
| **Definition** | 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:   1. Identify a community feedback mechanism organized by the mandated government agency or a partner; 2. Identify how feedback can be provided through a mandated community feedback mechanism. |
| **Disaggregate** | 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. |
| **Computation** | 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. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | 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. |
| **Limitations** | 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. |

## Community-led response

| **Indicator** | Percentage of targeted areas where community members play an active role in the delivery of public health services to respond to Ebola |
| --- | --- |
| **Result** | Communities, particularly the most vulnerable, are engaged in the public health response |
| **Result level** | Output |
| **Purpose** | 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 Ebola. This indicator measures whether the response is community led or not. 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 Ebola in the area.  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. |
| **Definition** | For this indicator community members should have played an active role in the delivery of public health services to respond to Ebola within the last month. Community members are defined as persons who are not employed as health professionals on the response to Ebola. 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 Ebola. 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, conducting surveillance, managing burials, responding to ‘community incidents’.  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** | Data can be disaggregated by geographic area |
| **Computation** | This indicator should be computed as a percentage.  Nominator: the number of targeted areas where community members play an active role in the delivery of public health services to respond to Ebola.  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 Ebola. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **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 community members have played an active role in the delivery of public health services to respond to Ebola. |
| **Limitations** | None |

## Knowledge of risk information on Ebola

| **Indicator** | Percentage of individuals who believe they are at risk of contracting Ebola |
| --- | --- |
| **Result** | The community understands public health information and recommendations |
| **Result level** | Outcome |
| **Purpose** | This indicator measures the percentage of individuals who believe they are at risk of contracting Ebola. 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 as communities with a lower risk perception may not follow public health measures sufficiently to stop Ebola. |
| **Definition** | For this indicator all individuals who believe they are at risk of contracting Ebola should be counted. |
| **Disaggregate** | The recommended disaggregation of this indicator is by: sex, age and education. |
| **Computation** | 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 Ebola.  Denominator: total number of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The preferred data source is population survey. |
| **Limitations** | None |

| **Indicator** | Percentage of individuals who know correct symptoms of Ebola |
| --- | --- |
| **Result** | The community understands public health information and recommendations |
| **Result level** | Outcome |
| **Purpose** | This indicator measures the percentage of people in the community who know symptoms of Ebola. Disaggregation of the indicator allows analysis of knowledge of Ebola 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. |
| **Definition** | Sudden onset of fever, intense weakness, muscle pain, headache and sore throat are typical signs and symptoms of Ebola. This is followed by vomiting, diarrhoea, rash impaired kidney and liver function and in some cases, both internal and external bleeding.[[12]](#footnote-11)  For this indicator the government information on Ebola symptoms should be used.  For an individual to be counted as having knowledge of the correct symptoms of Ebola 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. |
| **Disaggregate** | 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.  Where practical the data should also be disaggregated by knowledge of each symptom of Ebola. |
| **Computation** | This indicator should be calculated as a percentage  Numerator: total of respondents aged 15 and above who know correct symptoms of Ebola.  Denominator: total of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The preferred data source is population survey. |
| **Limitations** | None |

| **Indicator** | Percentage of individuals who know correct transmission routes of Ebola |
| --- | --- |
| **Result** | The community understands public health information and recommendations |
| **Result level** | Outcome |
| **Purpose** | Accurate public knowledge of transmission routes is needed to stop Ebola. This indicator measures the percentage of people in the community who know the correct transmission routes of Ebola. In countries where individuals do not have sufficient knowledge of the transmission routes of Ebola, risk communication efforts should be strengthened. |
| **Definition** | he virus spreads through direct contact (such as through broken skin or mucous membranes in the eyes, nose, or mouth) with:   * Blood or body fluids of a person who is sick with or has died from Ebola virus disease (EVD). * Objects contaminated with body fluids from a person who is sick with or has died from EVD. * Infected fruit bats or nonhuman primates. * Semen from a man who recovered from EVD.[[13]](#footnote-12)   For this indicator the government information on Ebola symptoms should be used. For an individual to be counted as having knowledge of the correct transmission routes of Ebola 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 Ebola. |
| **Computation** | This indicator should be calculated as a percentage.  Numerator: total of respondents aged 15 and above who know correct transmission routes of Ebola.  Denominator: total of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The preferred data source is population survey. |
| **Limitations** | None |

| **Indicator** | Percentage of individuals who know how to protect themselves from Ebola |
| --- | --- |
| **Result** | The community understands public health information and recommendations |
| **Result level** | Outcome |
| **Purpose** | This indicator measures the percentage of individuals who know how to protect themselves from Ebola. In countries where individuals do not have sufficient knowledge of how to protect themselves from Ebola, risk communication efforts should be strengthened. |
| **Definition** | This indicator relates to measures that serve to directly protect an individual from Ebola. Relevant measures include:   * Avoid contact with blood and body fluids of people who are sick; * Avoid contact with semen from a man who has recovered from EVD, until testing shows that the virus is gone from his semen; * Avoid contact with items that may have come in contact with an infected person’s blood or body fluids; * Avoid funeral or burial practices that involve touching the body of someone who died from EVD or suspect EVD; * Avoid contact with bats, forest antelopes, and nonhuman primates (such as monkeys and chimpanzees) blood, fluids, or raw meat prepared from these or unknown animals (bushmeat).[[14]](#footnote-13)   For this indicator the government information on protective measures for individuals for Ebola should be used.  For an individual to be counted as having knowledge of how to protect himself from Ebola 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. |
| **Disaggregate** | 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. |
| **Computation** | This indicator should be computed as a percentage.  Numerator: total of respondents aged 15 and above who know how to protect themselves from Ebola.  Denominator: total of respondents aged 15 and above. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | The preferred data source is population survey. |
| **Limitations** | None |

## Information reach

| **Indicator** | Percentage of individuals who receive information through a communication channel they trust |
| --- | --- |
| **Result** | Accurate risk information is communicated to the public |
| **Result level** | Output |
| **Purpose** | No matter how well planned or applied, risk communication and community engagement interventions will fail if people do not trust the information source and channels. 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 and source 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. |
| **Definition** | This indicator refers to individuals who have (1) received information on Ebola within a defined period of time through a communication channel. The period of time should be defined by the response management on the basis of how often people in communities affected by Ebola should be receiving risk information 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. |
| **Disaggregate** | 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 (should be named), community media channels (should be named), social media, web pages (main websites should be named), SMS/Whatsapp/Similar platforms, Megaphones/Crieurs, Religious ceremonies, community health workers, politicians. |
| **Computation** | 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 Ebola related information.  Denominator: total of respondents aged 15 and above who have received information on Ebola in the last month. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | 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. |
| **Limitations** | 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 Ebola |
| --- | --- |
| **Result** | Accurate risk information is communicated to the public |
| **Result level** | Output |
| **Purpose** | This indicator counts the number of people who have been reached with accurate risk information on Ebola. 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 Ebola. |
| **Definition** | This indicator measures the percentage of individuals in the population who have been reached by public health information on Ebola. 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.  For this indicator the government recommendations on what public health information should be communicated to the public should be used.  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. |
| **Disaggregate** | 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.) |
| **Computation** | This indicator should be calculated as a percentage.  Numerator: total of individuals aged 15 and above who have been reached by risk information on Ebola (within the specified time period).  Denominator: total of individuals aged 15 and above. |
| **Frequency** | 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 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.  SMS/Whatsapp/Similar platforms: Number of telephone numbers messages are sent to  Megaphones/Crieurs: Estimate of reach  Religious ceremonies: Estimate of attendance at ceremonies where public health messages are delivered  Community Health Workers  Political leaders  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.[[15]](#footnote-14)  Please see the IFRC guidance on counting people reached [here](https://preparecenter.org/wp-content/sites/default/files/checklist5countingpeople280618.pdf). |

## Participation in response management

| **Indicator** | Percentage of targeted areas where community members actively participate in the public health decision-making processes |
| --- | --- |
| **Result** | The community, particularly its most vulnerable members, participate in decision-making on the public health response |
| **Result level** | Output |
| **Purpose** | 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.[[16]](#footnote-15) 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. |
| **Definition** | Active participatory decision-making for Ebola is where community members are involved in decision-making on the planning and implementation of activities. Trusted community leaders should be engaged with to encourage the participatin of the community. Action to support and foster leadership from among the most disadvantaged helps to ensure a truly participative process.[[17]](#footnote-16)  The definition of what constitutes ‘active participation’ of community members in the public health decision-making process should be made at country level. It is recommended that a strong definition of community participation is adopted where practical. ‘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 Ebola response in the administrative area within the last month.*  The targeted area can be defined as appropriate to the context; for example, local government administrative areas or health administrative areas could be used. |
| **Disaggregate** | Data can be disaggregated by geographic area |
| **Computation** | This indicator should be computed as a percentage.  Nominator: the number of targeted areas where community members actively participate in public health decision-making processes.  Denominator: the total number of areas targeted for community members to actively participate in public health decision-making processes. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | The preferred means of collecting data for this indicator is through a participatory process involving both community members, officials and implementing partners 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 Ebola in their area and defined-included the definition in the RCCE response plan. |
| **Limitations** | None |

## Community engagement

| **Indicator** | Percentage of targeted community groups that promote public health recommendations to stop Ebola |
| --- | --- |
| **Result** | Communities, particularly the most vulnerable, are engaged in the public health response |
| **Result level** | Output |
| **Purpose** | This indicator measures the percentage of targeted community groups that have promoted public health recommendations to stop Ebola within a defined period of time. The period of time should be defined by the response management on the basis of how often community groups should be expected to promote public health messages to stop Ebola. Where targeted community groups are not active in the effort to stop Ebola it may be necessary to re-engage with community groups. |
| **Definition** | Community groups may include sports organizations, social groups, local religious organizations, congregations etc. The community groups that are being targeted for the promotion of public health recommendations to stop Ebola should be identified in the RCCE plan. To be counted, the community group should have taken actions to promotepublic health measures within the last month, such as promoting key messages and community dialogues on Ebola , organizing discussion groups, door to door visits, etc. |
| **Disaggregate** | This data can be reported counting local community groups. |
| **Computation** | This indicator should be computed as a percentage.  Nominator: the number of targeted community groups that are promoting public health messages to stop Ebola in the geographic area.  Denominator: the total number of community groups that were targeted to promote public health messages to stop Ebola in the geographic area. |
| **Frequency** | This indicator should be reported with high frequency. |
| **Data sources** | Data for this indicator can be collected through government or community counterparts. |
| **Limitations** | None |

| **Indicator** | Percentage of targeted areas where supports are provided for a community led response to Ebola |
| --- | --- |
| **Result** | Supports to enable the community to conduct on-the-ground response activities are in place |
| **Result level** | Output |
| **Purpose** | For community members to play an active role in the public health response to Ebola 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 Ebola. |
| **Definition** | 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, subsidies etc. To be counted the area should be providing these supports at the time of data collection.  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 indicator can be disaggregated by sub-national area. |
| **Computation** | This indicator should be computed as a percentage.  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 Ebola.  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 Ebola. |
| **Frequency** | This indicator should be reported with medium frequency throughout the response. |
| **Data sources** | The preferred means of collecting data for this indicator is through a participatory process involving both community members, officials and implementing partners 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. |
| **Limitations** | None |

## Community Feedback

| **Indicator** | Percentage of targeted areas where mechanisms are in place to capture and utilize community feedback |
| --- | --- |
| **Result** | Community feedback mechanisms link community with government, media and other actors |
| **Result level** | Activity |
| **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 and/or complaints 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., Ebola-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. (see IFRC Feedback Toolkit and Community Engagement and Accountability Guide[[18]](#footnote-17) and [Minimum Quality Standards and Indicators for Community Engagement](https://www.unicef.org/mena/media/8401/file/19218_MinimumQuality-Report_v07_RC_002.pdf.pdf), UNICEF for further information) |
| **Definition** | 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, IoGT, others), interactive messaging platforms (Facebook, Twitter, WhatsApp), focus group discussions, participation in research on community insights, written communications (email, letters), Q&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&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:   * The mechanism is open to all persons to safely use and that it can be used by vulnerable people and special needs groups. * A systematic and transparent mechanism is established through which people can register dissent and raise issues. * 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. * Communities are informed of the findings from monitoring, evaluation and learning activities, on what has been the follow-up and communities have access to data.   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.  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 indicator can be disaggregated by government administrative area. |
| **Computation** | This indicator should be computed as a percentage.  Nominator: The number of targeted areas where mechanisms are in place to capture and use community feedback.  Denominator: The total number of areas targeted to put mechanisms in place to capture and use community feedback. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | Data for this indicator can be collected through government or RCCE counterparts (including implementing partners). Community members should be consulted as to whether the community feedback mechanisms are actually in place. |
| **Limitations** | None |

| **Indicator** | Percentage of targeted areas where changes have been made to Ebola response plans based on community feedback |
| --- | --- |
| **Result** | Community feedback mechanism is established |
| **Result level** | Activity |
| **Reference** | New indicator |
| **Purpose** | 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. |
| **Definition** | For a targeted area to be counted as having made changes to Ebola 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 a month.  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 indicator can be disaggregated by government administrative area. |
| **Computation** | This indicator should be computed as a percentage.  Nominator: the number of targeted areas where changes have been made to Ebola response plans based on community feedback within a defined period.  Denominator: the total number of areas where community feedback mechanisms are in place. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **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. 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. |
| **Limitations** | 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. |

## Capacity-building

| **Indicator** | Number of participants in RCCE training sessions |
| --- | --- |
| **Result level** | Activity |
| **Result** | Training to build capacity of partners is provided |
| **Reference** | New Indicator |
| **Purpose** | 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. |
| **Definition** | 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. |
| **Disaggregate** | 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. |
| **Computation** | This is a numeric count of the total number of times individuals have participated in an RCCE training session in the last quarter. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | 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. |
| **Limitations** | 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

| **Indicator** | An RCCE coordination mechanism is active and formally implemented |
| --- | --- |
| **Result** | National and local RCCE coordination mechanism is operating |
| **Result level** | Input |
| **Purpose** | 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.[[19]](#footnote-18) 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. |
| **Definition** | 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. |
| **Disaggregate** | This indicator can be disaggregated by government administrative area. |
| **Computation** | This indicator is a ‘Yes or No’ indicator |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | Data for this indicator can be collected through government or RCCE counterparts. |
| **Limitations** | None |

## RCCE planning

| **Indicator** | A risk communication and community engagement plan for Ebola is adopted |
| --- | --- |
| **Result** | Evidence-based national RCCE Ebola response plan is developed |
| **Result level** | Input |
| **Purpose** | 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 Ebola has been adopted. It is an indicator of RCCE operational readiness. |
| **Definition** | An RCCE plan should:   * Be informed by a needs assessment that identifies and includes the perspectives of the most vulnerable. * Define the coordination mechanism for the RCCE plan, establish roles and responsibilities for partners, including the role of the community in providing on-the-ground services as part of the response, identify how the community will participate in the management and decision-making processes, identify accountabilities between governments, partners and communities, and set milestones for coordination and improvement over time. * 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. * 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. * Define a social research agenda. * Detail a media collaboration plan. * Be costed for all major activities, including social science and M&E.   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. |
| **Disaggregate** | This indicator can be disaggregated by government administrative area. |
| **Computation** | This is a ‘Yes or No’ indicator |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | Data for this indicator can be collected through government or RCCE counterparts. |
| **Limitations** | None |

| **Indicator** | Percentage of targeted areas where RCCE plans address barriers to the practice of public health recommendations[[20]](#footnote-19) |
| --- | --- |
| **Result** | Evidence-based national RCCE Ebola response plan is developed |
| **Result level** | Input |
| **Purpose** | Addressing barriers to the practice of public health recommendations is central to the RCCE approach. Barriers can be identified through needs assessments or social research. Response plans should seek to address these barriers. Where response plans are not targeting identified barriers it is recommended to review them to ensure a focused, evidence-based approach to social behavior change. |
| **Definition** | For a definition of RCCE plans please see the indicator ‘*A risk communication and community engagement plan for Ebola is adopted*’.Barriers refer here to structural or social factors that negatively influence the practice of public health recommendations. Barriers may be structural, such as distance to a health facility, cost of transportation, limited availability of services at health facility etc or barriers may be social such as discrimination, social norms etc. The RCCE plan should identify specific barriers and a realistic set of actions to address the specific barriers. The indicator refers to the RCCE response plan at the time of data collection. |
| **Disaggregate** | This indicator can be disaggregated by government administrative area. |
| **Computation** | This indicator should be computed as a percentage.  Nominator: the number of targeted areas where the RCCE plan addresses at least on specific barrier to the practice of public health recommendations.  Denominator: the total number of areas targeted for RCCE plans to addresses at least on specific barrier to the practice of public health recommendations  Please note: If the targeted area does not have a response plan, the targeted area should be counted as not having an RCCE plan addresses at least on specific barrier to the practice of public health recommendations. |
| **Frequency** | This indicator should be reported with medium frequency. |
| **Data sources** | Data for this indicator can be collected through government or RCCE counterparts.  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 agree on whether the RCCE plan addresses at least on specific barrier to the practice of public health recommendations. |
| **Limitations** | This indicator does not measure whether the RCCE plans was implemented as written. |

1. The Collective Service, COVID-19 Global RCCE Response Strategy, IFRC, UNICEF, WHO, Geneva, 2020 [↑](#footnote-ref-0)
2. UNICEF, *Minimum Quality Standards and Indicators for Community Engagement*, 2020 [↑](#footnote-ref-1)
3. https://healthcommcapacity.org/wp-content/uploads/2017/02/The-SBCC-Emergency-Helix5-ksm.pdf [↑](#footnote-ref-2)
4. 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> [↑](#footnote-ref-3)
5. UNICEF, Children on the Move Indicator Guidance, New York, 2020 [↑](#footnote-ref-4)
6. UNSD, Technical Report on Monitoring Migration-related SDG Indicators DRAFT, January 2019, p. 7. See also UNSD, I’ll ‘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> [↑](#footnote-ref-5)
7. Bedson et al., ‘Community engagement in outbreak response: standards, approaches and lessons from the 2014-2016 Ebola outbreak in Sierra Leone’, *BMJ Global Health*, 2019 [↑](#footnote-ref-6)
8. IFRC, Community Engagement and Accountability Guide, 2021. <https://communityengagementhub.org/resource/ifrc-cea-guide/> [↑](#footnote-ref-7)
9. https://www.cdc.gov/vhf/ebola/prevention/index.html [↑](#footnote-ref-8)
10. See for example, CDC, ‘HIV Stigma and Discrimination’, <cdc.gov/hiv/basics/hiv-stigma/index.html> [↑](#footnote-ref-9)
11. 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/> [↑](#footnote-ref-10)
12. Frequently asked questions on Ebola virus disease, UNICEF [↑](#footnote-ref-11)
13. https://www.cdc.gov/vhf/ebola/transmission/index.html [↑](#footnote-ref-12)
14. https://www.cdc.gov/vhf/ebola/prevention/index.html [↑](#footnote-ref-13)
15. UNICEF, *The Behavioural Drivers Model: A Conceptual Framework for Social and Behaviour Change Programming*, Jordan, 2019 [↑](#footnote-ref-14)
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> [↑](#footnote-ref-15)
17. UNICEF, *Minimum Quality Standards and Indicators for Community Engagement*, 2019 [↑](#footnote-ref-16)
18. 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/> [↑](#footnote-ref-17)
19. WHO, [COVID SPRP Monitoring and Evaluation Indicator Guidance](https://www.who.int/publications/i/item/WHO-WHE-2021.07-eng), May 2021 [↑](#footnote-ref-18)
20. This indicator is adapted from the Breakthrough Action, indicator and guidance: Percentage of communities/committees with written action plans that documented overcoming at least one social or structural barrier to the practice of at least one health behavior. [↑](#footnote-ref-19)