FINDING COMMUNITY-LED SOLUTIONS TO COVID-19:

An interagency guidance note on working with communities in high density settings to plan local approaches to preventing and managing COVID-19.

Produced by the interagency Risk Communication and Community Engagement (RCCE) technical working groups in East and Southern and West and Central Africa.

Purpose

This practical guidance note is intended for anyone involved in COVID-19 risk communication and community engagement (RCCE) efforts in complex and fragile settings in Africa, which includes refugee and internally displaced persons (IDP) camps and informal urban settlements.

A combination of high population density, poor housing, limited access to water and sanitation, overstretched or inaccessible health services and widespread poverty, increase the risk and impact of a COVID-19 outbreak in these settings. Refugees, IDPs and people living in informal urban settlements, which are often home to urban refugees and irregular migrants, are often stigmatized and excluded from national response plans. This can lead to high level of mistrust towards authorities and responders within these groups. This is further exacerbated by the fact that standard COVID-19 prevention measures, such as physical distancing and handwashing, will be more challenging and in some cases even impossible to implement in crowded camps and informal settlements.

This is why it is essential to work with communities in these settings to identify and support local, practical solutions to preventing the spread of infection and bringing the outbreak under control. Risk communication messages and community engagement approaches need to be adapted to acknowledge and address the challenges these communities face, or they risk causing frustration and the outright rejection of humanitarian response efforts.

This guidance note draws on and summarises content from a range of other guidance notes[1], many with a global focus or broader scope than RCCE, to focus on;

1. Challenges faced by people living in camps and informal settlements in following standard COVID-19 prevention measures

2. Risk communication and community engagement challenges in camps and informal settlements

3. Step-by-step guidance to work with communities to plan COVID-19 response measures, including practical examples of successful RCCE approaches and community-led solutions used in camps and informal settlements across Africa

4. Guidance on how to adapt standard COVID-19 prevention messages for these settings

5. Documents used to develop this guidance note

6. Useful resources to help you implement the recommendations in this guide

7. Acknowledgements

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[1] See annex 1 for a list of all resources used in the development of this guidance note.

1. Challenges faced by people living in camps and informal urban settlements in following standard COVID-19 prevention and control measures

The methods for reducing COVID-19 transmission are the same in any context; i.e. physical distancing, isolating cases, following contacts, and improved hygiene. However, in informal settlements and refugee and IDP camps there are acute challenges which can make it difficult for people to follow these measures including:

Population density: Urban informal settlements and refugee and IDP camps are often densely populated and overcrowded, making physical distancing or isolation of cases very difficult. In sub-Saharan Africa 55% of the urban population are estimated to be living in crowded informal settlements[2], while there are 18 million people living in refugee or IDP camps[3].

Household and social structures: Residents of informal settlements commonly live in large, multigenerational households, in cramped, poorly ventilated homes, sharing food and sleeping spaces. A study across 28 African countries found 59% of people said they lack physical space to isolate sick people[4]. This is reflected in community feedback: *"How can keep your distance if you are 15 people in one house?"[5]*. Children are often cared for by grandparents or older relatives, making shielding of vulnerable groups more difficult. Refugees and IDPs may live in inadequate emergency or transitional shelters, with a high proportion of child-headed households with less access to information and resources.

WASH: Access to water is inadequate and water points and toilets are usually shared and outside people's homes, which make physical distancing or isolation impossible.

Livelihoods: Many people in these settings will be employed in the informal sector, such as trading goods or driving motorbike taxis, with no opportunity to work from home or be paid when not working. With limited social safety nets, people may be forced to break physical distancing and quarantine rules; *"How can we respect the lockdown against corona virus when in our houses there is nothing to eat?"[4]* (DRC). Urban refugees living in countries with no right to work, will have even less opportunities for livelihoods.

Economic factors: Refugees, IDPs and people living in informal urban settlements often live hand-to-mouth with very limited savings. They are unable to stockpile food to see them through a lockdown or buy protective materials such as soap, hand sanitizer, extra water, or face masks. A survey by GeoPoll found 81% of respondents were concerned about having enough food to eat as a result of COVID-19[6].

Health system: Availability of formal health providers is low in many settlements. Multiple barriers prevent access to quality health care including cost, distance, prioritization of work and daily survival over lost time and money for treatments, visiting multiple informal providers to buy treatments, inadequate care at health facilities, poor experience of care, preference for traditional healers etc.

Access to education: Schools and children in informal urban settlements and refugee and IDP camps are unlikely to have the equipment or internet access to be able to support online classes and limited space will mean physical distancing in the classroom would be difficult.

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[2] https://data.worldbank.org/indicator/EN.POP.SLUM.UR.ZS?locations=ZG

[3] UNHCR

[4] https://preventepidemics.org/covid19/perc/

[5] https://community.ready-initiative.org/uploads/short-url/s6ILSC7bRUMOg6kHNDKrUG02x7I.pdf

[6] https://www.geopoll.com/blog/coronavirus-in-sub-saharan-africa-food-security-covid-testing/

Transport: Those who rely on public transport, such as crowded minibuses or motorbikes, have limited possibility of physical distancing. *"It is hard to be 1 meter apart in public transport because they're overcrowded. Conductors wait till they pass roadblocks then they add passengers in the van"[4]* (Kenya).

Transient populations: Frequent voluntary and forced movement can make it challenging for contact tracing teams to systematically follow up contacts of confirmed cases and can lead to the importation of COVID-19 to new areas. Contact tracing teams may also not be trusted by communities and viewed as spies.

Cultural practices: This is not unique to camps or informal settlements, but the importance of religion, traditional burial practices and expected modes of greeting may make it difficult or socially unacceptable for people to adhere to measures like physical distancing.

CASE STUDY: Imposed quarantine fails in Liberia

Restrictions applied to entire areas, communities or cities have been used with mixed success. During the early phase of the Ebola outbreak in Liberia (2014-16), an area quarantine was imposed on West Point, a township in Monrovia home to 120,000 people. After the initial identification of confirmed cases, the Liberian army cut West Point off from the rest of the city, putting up razor wire and preventing population movement. Residents were informed that the area would be under quarantine for a minimum of 21 days but there was no public consultation. The community was unable to source adequate food and water, lost income as a result of not being able to access their workplaces and could not access healthcare. Limited resources were provided to isolate and care for suspected cases and contacts. When people reacted by attempting to escape the area, the army responded using live bullets. The quarantine did not help to contain transmission and was abandoned after 10 days. Following the event, President Ellen Johnson Sirleaf concluded that the quarantine had been a mistake, and asserted, "*Now I know that people's ownership, community participation, works better in a case like this. I think that experience will stay with us.*"

In other instances, however, community quarantine was more successful. In Bong County, for example, authorities engaged local leaders to inform the community about Ebola and secure their cooperation. Residents of Mawah village were restricted from moving in and out of the village and when concerns were raised about food and medicine shortages and the need for psychosocial support, these were rapidly addressed. Taking the time to involve community members and working through trusted local leaders ensured an effective response.

CASE STUDY: Local approaches to isolating sick people

The Acholi people in Uganda follow a set of rules in the event of a dangerous infectious disease. Their action is biomedically sound and involves isolating patients in a house on the edge of the community, with no visitors allowed except a previous survivor of the disease who will feed and care for the patient. Houses and villages with cases of the disease must identify themselves using long poles of elephant grass, and everyone in the village should limit their movements to within their own house or village. Prescriptive eating practices are also followed, particularly around meat. Such a system, based on prior experience, may work well in situations of strong community cohesion and where leaders are trusted and respected.

2. Risk communication and community engagement challenges in camps and informal settlements

The following issues will need to be considered when planning risk communication and community engagement approaches for camps and informal settings:

Language barriers: Most camps will host displaced persons from diverse countries of origins who speak multiple different languages. This necessitates RCCE activities and materials to be carried out in a range of different languages to be effective. This can also apply to informal urban settlements, which often house people from all over the country, including migrants and refugees.

Limited access to communication equipment: Limited financial means mean people living in these settings may have less access to communication equipment, such as phones, radios, TVs, and internet access. For refugees, there can be legal barriers such as requiring documentation to purchase a local SIM card. There can also be a gender divide in access to phones, TV, computers, and the internet.

Fewer options for face-to-face interactions: Congestion within camps and informal settlements makes organising any face-to-face RCCE activities challenging, as it will be hard to ensure physical distancing can be maintained, therefore more creative or digital solutions will need to be found.

Contested leadership: Governance structures may be contested and plural. For example, traditional community leaders operate alongside government or camp management, as well as criminal gangs, militia, or other groups. This can lead to differing and uncoordinated approaches to public health measures.

Over stretched community-based structures: Community based structures and groups are already providing much-needed support in ensuring continuity of services in refugee camps and informal settlements and may have limited additional capacity to support RCCE efforts. They may also be limited by movement restrictions, face challenges meeting face-to-face due to lack of personal protective equipment, or lack the skills and technology to communicate remotely.

Mistrust: Political and historical factors, such as discrimination and conflict, can create high levels of mistrust and even fear of authorities, state, or international responders. Urban refugees living in countries with encampment policies or migrants with unclear legal status, may prefer to remain hidden from authorities, which can leave them particularly vulnerable. If people do not trust the response, they may refuse to work with agencies and even react with hostility or violence, as well as ignore health advice, not follow measures like staying home, or refuse testing or treatment. There is already widespread community feedback across Africa that COVID-19 is not real, or just a tool to make money[7]. Violent responses are already being reported, for example protestors attacked a testing centre in Abidjan[8].

Social cohesion: Residents in camps and informal settlements have often come together from different places, backgrounds, and cultures. There will be pockets of wealth and deeper pockets of marginalization. This can add to social tensions and impact on people's willingness to work collectively.

Exclusion: Legal status, discrimination, and marginalization of refugees, IDPs, and those who live in informal settlements may mean they are not considered in national COVID-19 response plans, and so have less access to government announcements, health information, prevention guidance and materials. This lack of access to information can contribute to the spread of rumours and mis and dis-information.

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[7] https://community.ready-initiative.org/uploads/short-url/e1P3EQolxOlhBR5FXzvVrS1g5bk.pdf

[8] https://www.bbc.com/news/world-africa-52189144

Rapid spread of information: Crowded living conditions leads to increased social mixing, with information, including rumours and misinformation/disinformation, spreading rapidly from person to person. This can be of benefit if agencies tap into these informal communication networks but coupled with the challenges of lack of information and mistrust in these settings it also creates fertile breeding grounds for rumours and misinformation, which can quickly overshadow accurate health information.

Competing priorities: Refugees, IDPs and people living in informal settlements have many concerns to contend with, including other diseases, financial worries, worries about family left behind, and potential psychological trauma based on what they have left behind. This may lead people to prioritize other needs like work and daily survival, over what may not seem to them, to be a very serious illness.

Risk of stigma: Refugees, IDPs and residents of informal settlements are traditionally stigmatised, harassed or blamed for problems within a society and there is the risk these groups could be blamed for being the source of COVID-19 infections or importing it into the country. There are already examples suggesting discrimination against these groups has increased[9]. This stigma can have serious consequences, including violence, loss of income or exclusion from essential services and planning, as well as making it hard for responders to gain the trust and engage with these communities.

CASE STUDY: Micro entrepreneurs are finding ways to help their communities

Despite the negative impact of COVID-19 on the economy, many people are finding ways to help their community and earn an income at the same time by sewing face masks, making soap and hand sanitizer or providing motorbike delivery services for people who are self-isolating. Lenny shared his story through Shujaaz Inc Kenya: "I am in a group of 10 people who decided to start a hustle of selling liquid soap last year at around this time. We make the soap by ourselves then sell to the people in our community. Before the corona outbreak, we used to sell the soap at a higher price than now. For example, the half a litre which used to go for 70kshs now goes for 50kshs. We decided to reduce the price because the demand has been so high since the outbreak. I can say Corona has made us make more sales than previously. The reason why we chose to reduce the price was so that we could market ourselves more to our community and create the best customer relationship given that we have other competitors. So far it has been a good experience and I like the fact that we are helping people in this time of the outbreak and also saving as we plan for the future of our business after corona.

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[9] UNHCR community feedback collected in Uganda, Ethiopia, Tanzania, and South Sudan

3. Guidance for planning local solutions with communities

In settings where physical distancing, isolation and handwashing are challenging, response agencies must work with the community to find local, practical solutions to preventing the spread of infection. Informal settlements and camps can be highly organised, with a range of local groups and established community and leadership structures. These groups are well-placed to mount COVID-19 responses and feed into government disease surveillance structures and many already are. They also understand the unique challenges facing their community and how public health measures like physical distancing, surveillance systems such as contact tracing, and isolation could be adapted to work within their context.

Lessons from previous humanitarian and health crises, including the West Africa and DRC Ebola outbreaks, have taught us that constructive and meaningful engagement with local communities and trusted leaders is essential for disease prevention measures to be adapted, accepted, well understood and successful. Impractical or enforced response measures and a lack of dialogue with communities instead leads to frustration, resistance, and non-compliance, which adds to the spread of infection. This section presents step-by-step guidance on how agencies can work with communities to identify and support local solutions to implementing COVID-19 prevention, mitigation, and response measures. The useful resources section at the end of this guide has links to materials and resources that can help you to implement the recommendations in this guide.

How to work with communities to find solutions

Step 1: Understand the community and their context

- Carry out an assessment, including a community mapping, to understand community structures, power dynamics, beliefs, capacities, and trusted and preferred channels of communication and sources of information. See the text box below for more guidance on the data you should collect.

- However, check first what data already exists about the community and if other organizations or groups are already working there to see who you can collaborate with.

- Assessments should allow time for open conversations and not rely only on survey questions, otherwise you miss gaining the depth of understanding needed to work effectively with these communities. Open consultations and listening is critical to ensure you 'do no harm'.

- The assessment should be community-led so it can tap into local knowledge and skills and build ownership of the findings. Hold a meeting first with community representatives to get their permission and guidance on the best way to carry out the assessment and work with local groups to collect the data. If face to face access is not possible, you may have to conduct these consultations via telephone. Build the capacity of community groups to collect disaggregated data and assess the needs of vulnerable groups such as persons with disabilities and the elderly. You can also collect data remotely using online tools but consider who might be excluded.

- Mistrust of the authorities may be high in camps and informal settlements and it could take time to gain people's trust and willingness to work with you and share honest feedback. This mistrust will be higher if people already have negative attitudes to COVID-19 because they have been adversely affected by measures such as lock-downs, or hold beliefs that the disease is not real, or a scheme to make money. In addition, COVID19 restrictions such as physical distancing can make it harder to build trust and therefore sustained engagement will be needed.

What data do you need to collect in order to work effectively with communities?

- **Basic demographic data** about the people living in the camp or settlement, disaggregated by age, gender, and other social characteristics and vulnerabilities, such as religion, disabilities, ethnic group or child or female-headed households.

- **Community structures** such as the community groups and social networks that exist and the formal and informal leaders and the level of trust people have in them. Both camps and informal settlements can be made up of several 'villages' which are not homogenous.

- **Community dynamics** mapping the level of social cohesion between groups, the different power dynamics, minority groups, gender norms and presence of criminal gangs.

- **Trusted sources of information and preferred communication channels** amongst different groups in the community, in general and in relation to COVID-19. What barriers do different groups face in accessing information e.g. language, equipment, free movement, literacy etc

- **People's knowledge, attitudes, practices, and perceptions** in relation to COVID-19 and the COVID-19 response, including the main fears, rumours, and misinformation in the community. What is the level of trust in the response in the community?

- **Capacities and current approaches** to implementing COVID-19 prevention measures and relevant support functions, like water provision, garbage collection or savings networks. How has the community managed health threats like this in the past? Discuss what impact a rapid increase in cases would have on the community to understand the support networks that exist, and how COVID-19 may debilitate them, or strengthen their relevance/role.

- **Main needs and challenges** faced by different groups in the community as a result of COVID-19 and public health measures. Do people have access to food, water, soap, healthcare? Are specific groups facing any protection risks, such as GBV or negative coping strategies?

- The assessments should include migrants in irregular situations, often in transit, and urban refugees in countries with encampment polices to ensure that assistance and protection needs are included for these often overseen subgroups of people.

- There is often a lack of formal data on informal settlements. However community-based groups such as [SDI (Slum/Shack Dwellers International)](https://) collect socio-demographic data about their settlements. In refugee and IDP settings, leaders, health structures and camp coordination and camp management structures will have records of residents. their community.

CASE STUDY: Communities take a lead in Ebola prevention and response in Liberia

During the 2014-2015 Ebola outbreak in Liberia, community leaders introduced new by-laws and taskforces to help stop the spread of the virus. Prevention efforts included, banning "strangers" from entering the community, prohibiting visitors from sleeping in one's home (for fear that they might be running from the presence of Ebola infection in their own home), and mandating a 21-day waiting period for those who wished to move into the community to ensure they were Ebola-free. Community task forces were established to enforce these rules, alert community members to cases of Ebola, manage reporting, and ensure those in quarantine and isolation were provided with food, water, and medicines. Block watch teams were also set up to go house-to-house to monitor the sick, refer new cases to health facilities, and identify efforts to conceal sickness or burials.

Step 2: Engage community leaders and groups to identify local solutions

- Based on assessment findings, identify which leaders, community groups and representatives you need to meet with to start planning local solutions to managing COVID-19. See the box below for a list of the issues to discuss depending on the context and stage of the epidemic.

What prevention measures might you need to discuss and adapt?

- **Physical distancing:** can be difficult to achieve in crowded settings and needs to be implemented in a way that does not put people at risk of further harm, for example by preventing them from earning a daily income if they rely on this to survive. Discuss with leaders and groups ways to encourage non-contact greetings between residents, options for reducing physical contact in shops, restaurants and markets, or ways to reduce the flow of people in busy places or at busy times. For example, by establishing one-way pedestrian systems, painting markings on the ground where people queue, organising tables and chairs in places where people eat to allow safe distances, prohibiting standing in groups, or staggering the times different groups can leave their homes or access communal facilities.

- **Religious gatherings:** engage religious leaders to find alternatives to mass religious gatherings, ensuring people's religious needs are still met e.g. services via radio or online.

- **Public gatherings:** should be avoided so work with leaders and community groups to find new ways to deliver activities that do not involve bringing large groups together. For example, through WhatsApp or Facebook groups.

- **Handwashing:** work with leaders and groups to increase the number of handwashing facilities and encourage more frequent handwashing amongst residents. Support local groups to build and install handwashing facilities and supply these with soap and water in key locations, such as water pumps, latrines, transport hubs, markets, and places of worship.

- **Personal behaviours:** the simplest and cheapest prevention method is to not touch the eyes, nose and mouth, and move away from others and cover the mouth and nose with flexed elbow or tissue when coughing and sneezing, so discuss with leaders and groups approaches to encourage these behaviours amongst all residents.

- **Transport:** enclosed environments such as cars, minibus taxis and buses are high risk settings. Discuss with public transport operators how they can reduce risks. For example, by limiting passenger number to allow for more distance between people, keeping windows open to allow for better ventilation and requiring all passengers to wear face masks.

- **Detection, reporting and referral system for suspect cases:** discuss with the leadership of the community and local authorities how to establish local mechanisms to detect and report individuals who could have COVID-19 to the designated health authority as early as possible.

- **Isolation of cases:** or suspected cases of COVID-19 can be difficult in crowded settings where many people may live in one dwelling, especially if Government facilities are not sufficient (or feared). Work with community leaders to identify local options for isolating people who have tested positive from the rest of the population. This includes options for ensuring people's basic needs are met during quarantine and care givers receive PPE.

- **Burial practices:** discuss with communities how burial and funeral practices can be adapted to reduce the spread of infection, while still meeting local cultural, social, and religious needs as much as possible. This was a major source of tension during the Ebola response in West Africa when bodes were not treated and buried according to local norms. This created resistance and was a motivating factor for people to not report cases.

- Examples of groups you need to meet include;
  - <u>Refugee and IDP camps:</u> refugee/IDP leaders, faith leaders and groups, refugee volunteer groups such as, women's groups, community health workers, youth, elderly, persons with disabilities, LGBTI community members, minority groups, sector community committees, social influencers, NGOs, UN agencies, camp management and government.
  - <u>Informal urban settlements:</u> formal, informal, and religious leaders, including gangs, women and youth groups, faith groups, social influencers, local authorities, police or armed forces, service providers, social protection groups, professional livelihood, associations, health groups or workers, disaster relief committees, advocacy groups, local authorities and government

- Discuss with groups and representatives how the planning process should work. A local COVID-19 task force or committee could be established to oversee planning and implementation, but ensure it represents the community fairly and is well trusted by the population.

- Be aware of any potential bias, including which groups may be deliberately or inadvertently excluded from the planning process. In refugee and IDP settings, an Age Gender and Diversity Lens (AGD) can be used to ensure diverse groups are included in the identification of issues.

- Explain to community leaders and groups why prevention measures are important and how they work to stop the spread of COVID-19. Understanding the rationale behind different prevention measures like physical distancing and handwashing, will build buy-in and help these groups to identify local solutions that will still achieve the desired public health impact.

- Work with the community to map the resources and capacities that are available in the community and identify any outstanding gaps that may require external support and resources.

- Agree roles and responsibilities of key stakeholders in implementing COVID-19 prevention and response measures, including community leaders, groups, organizations, local authorities and services and response agencies such as your own. Agree how implementation will be monitored throughout the response to ensure deliverables and accountability are achieved.

CASE STUDY: Displaced persons lead COVID-19 response

COVID-19 has placed a strain across all sectors, with the biggest impact felt by displaced persons on household income and livelihoods. Displaced women in Somalia, trained in tailoring, are now at the forefront of the COVID-19 response by supporting the production of masks. UNHCR negotiated for the Ministry of Health to work with these women to sew face masks. Similarly, in Dadaab refugee camp, community tailors have been mobilized and trained to make masks for persons of concern.

Displaced people have also worked closely with UNHCR and partners to ensure the continuity of services and prevent and respond to COVID-19 in camp and urban settings. In Dadaab, a 12-person committee (with meaningful representation of women) has been established in each camp comprising the following representatives; camp chairs, community peace and protection team, youth, religious leaders, community based rehabilitation and minority nationality members. Committees monitor delivery of services, collect feedback from community members and provide daily updates and reports to UNHCR. Airtime is provided to the committee members.

- Always consider the prevailing gender and cultural norms and the impact that any local solutions to managing COVID-19 will have on women, children, the elderly, people living with disabilities, and according to migration status. Ensure they don't increase the risk of violence, including sexual and gender-based violence and violence against children. Violent enforcement of measures is not justified under any circumstances, and this should be clearly communicated.

- Consider the impact prevention and response measures will have on people's livelihoods, access to essential services and mental health. Public health measures need to be balanced against other risks affecting communities, such as loss of income or food insecurity.

- For public health measures, such as physical distancing, to be accepted and successful, their negative impacts must be mitigated through other support interventions. For example, cash or voucher assistance for families to meet their basic needs while they cannot work, by providing food, water, hygiene materials and other basic items during periods of isolation or quarantine.

- Help to build links between communities and Government institutions, camp management and other responders to advocate for and mobilize additional resources to respond to COVID-19. For example, scaling up affordable water provision, safe sanitation, sewing face masks or installing handwashing stations.

CASE STUDY: Supporting communities to construct their own handwashing stations

Continuous risk communication has increased the knowledge of community members on key prevention methods, but low income households have questioned the practicality of these approaches to due to insufficient resources. Feedback such as this is common across Africa: *"Vulnerable households cannot respect handwashing as it is difficult for them to find water and buying soap or gel is not their priority"* (Madagascar). To address this challenge, Red Cross and Red Crescent National Societies have been supporting communities to find affordable, practical solutions.

In **Botswana**, teams of volunteers supported communities to construct traditional handwashing stations using poles and plastic containers, provided by the community. These were mainly placed at entrances to busy places to make it easy for individuals to wash their hands.

In response to requests for handwashing facilities, **Democratic Republic of Congo** Red Cross volunteers are supporting communities to manufacture locally designed portable handwashing stations using household water jerrycans that communities already use for collecting and storing drinking water. Simply cut a small hole at the base of the jerrycan and insert a plastic tap - which is easy to find at the local market. The handwashing station is easy to construct and at a very low cost. Communities are now constructing their own stations and washing their hands more regularly.

During their work in communities, **Malawi** Red Cross Society (MRCS) volunteers noticed that many families struggled to buy soap for handwashing due to financial constraints. The National Society did not have the means to provide soap to all households in need so the volunteers discussed with communities what practical strategies they could use to ensure good hand hygiene in their contexts. The idea of repurposing small pieces of soap left over from used bars to use for handwashing was suggested. Small pieces of soap are common in most households and can easily be saved up and used for handwashing. MRCS is now sharing this suggestion with other communities.

Step 3: Communicate prevention and response measures clearly and widely via trusted channels

- Once local solutions are agreed, they need to be communicated to the population, with opportunities for people to ask questions and provide feedback on potential challenges.

- Trusted community leaders, community health workers, influencers, role models and groups should be supported to lead risk communication and community engagement in their community. Train them on COVID-19 prevention and response, risk communication and community engagement approaches, interpersonal skills, and how to collect and respond to feedback, rumours, and complaints. Trusted leaders and groups can explain prevention measures in a way that is understood and accepted, as well as reduce fear, stigma and misinformation and build solidarity. Encourage them to lead by example by following measures themselves and especially in public.

- Train and enlist the support of essential workers such as pharmacists, market vendors, gas station attendants and frontline health workers, who have regular contact with people and can help share important COVID-19 information, including how prevention measures are being adapted to work in the local context. These groups can help share information and provide feedback on community concerns when other forms of face to face interactions are limited.

- Provide these groups with the resources they need to carry out RCCE activities, for example funding, mobile phone credit, radio sets, information education communication (IEC) materials and personal protective equipment.

- Encourage community leaders and groups to share information through their existing networks, using trusted and well known approaches for their community. Also encourage them to share feedback they receive from their networks with humanitarian and government responders.

- Engage religious leaders of all denominations in the dialogue since many people in Africa view COVID-19 through a religious lens and will be more likely to receive and trust messages sent by their faith-based leaders. Contact the [African Council of Religious Leaders](#) for advice. Working with religious institutions is also key to ensure the information they are sharing is accurate and so they can share back feedback they receive from community members.

CASE STUDY: Religious leaders play a pivotal role in COVID-19 response

Religious leaders are key influencers in the COVID-19 response. These well-respected members of the community have been relaying information about the pandemic, how to prevent infection, and importantly, reasons to avoid stigmatization. For example, Islamic religious leaders in Sahel were involved before the start of Ramadan in discussions about the vision and guidance Islam can provide in times of disease, including the directions and commands it gives about health prevention measures. Culturally apt messages on the pandemic were developed using proverbs and religious references. The early engagement of religious leaders ensured they endorsed messages of healthy living and adhering to medical norms. They play a pivotal role in ensuring that their followers understand public health measures and adhere to social distancing measures to control the spread of COVID19.

Secondly, religious leaders were key in finding alternatives to mass religious gathering. Many spiritual leaders are broadcasting sermons and preaching sessions via social and mass media. They have also aired public health messages, promoting the values of collective humanitarian action and community solidarity at this time of unrest.

- Tailor information and use different channels to reach different groups, as one approach or channel will not reach everyone. Co-create messages, approaches and materials with members of the target audience, as this will increase the likelihood of uptake and ensure that your efforts create change. The mix of communication channels should also include two-way options to allow people to ask questions and provide feedback and consider how to reach difficult to access groups, such as irregular migrants and urban refugees in countries with encampment polices.

- Avoid RCCE activities that would bring large groups together and increase the risk of COVID-19, for example large community meetings, community dramas, etc. Instead use one-to-one, digital, or remote RCCE approaches, such as social media, radio, telephone, or WhatsApp etc. See the annex of resources for guidance notes on remote RCCE options for COVID-19.

- Consider how to overcome the barriers some people may face in accessing information or using certain channels. For example, setting up free mobile phone charging stations, distributing wind-up/solar powered radios, using visual information, and sharing information through platforms that do not charge for data use, such as UNICEF's Internet of Good Things (IOGT).

- Collect testimonials from people who have recovered from COVID-19 to act as community champions and address rumours and misinformation, such as COVID-19 not being real.

- Ensure information and communication materials do not reinforce gender or other stereotypes. For example, do not only depict women in childcare or domestic work contexts.

What do we need to communicate about COVID-19?

- **About COVID-19:** Information should be shared explaining what COVID-19 is, how it spreads, what the symptoms are and what you should do if you suspect you might have the virus. Including what happens if you test positive, to reduce fears. People living in informal settlements already live alongside many infectious diseases and will need to understand why COVID-19 is different and requires such exceptional measures. When people perceive undue attention being given to some diseases, especially for the apparent benefit of other people, it can hinder trust and collective action. As evidenced by persistent community feedback that COVID-19 is not real or a tool to make money.

- **Prevention measures:** Explain why specific prevention measures help stop the spread of infection, with clear instructions on how they have been adapted and will be implemented in each specific context. People will only follow prevention measures if they understand why these are necessary and how they can practically follow them in their daily lives, especially if these measures cause disruption to their social and economic life.

- **Where to go for more information:** Give details of where people can go to get more information or if they have questions or need further support. For example, are there local leaders and groups who can act as COVID-19 focal points, who can provide help and support.

- **Update information regularly:** Based on feedback received from communities and changes in context and epidemic phase and to address rumours and misinformation.

- **Support services available:** Ensure people know about support services available to help them manage the wider impact of COVID-19, such as loss of livelihoods, food insecurity, access to healthcare for other needs.

CASE STUDY: Using local radio to encourage safe practices and reduce fears

An average 1700 customers visit Nakasero Market in Kampala, Uganda, daily. The market has a community radio station called Vendors' Voice Radio, where experienced presenters run daily shows broadcast from a small studio via speakers mounted at strategic points around the market. To help customers and vendors protect themselves from COVID-19, an expert from the Ministry of Health and Uganda Red Cross Society (URCS) are participating in one hour daily interactive shows on Vendors' Voice Radio. A range of topics are discussed, including COVID-19 transmission, signs & symptoms, prevention methods and correcting the myths surrounding the virus. Listeners, including vendors and customers, can call or SMS with questions, comments and suggestions which are answered live on air by the health experts, with the aim of providing clear, factual information. All the talk shows are conducted in the local language, Luganda, including the recorded music, spots, and jingles on COVID-19. Presenters also broadcast frequent reminders to the traders and their customers, to utilize the hand washing facilities at designated spots within the market.

During Uganda's lock down period, the Government asked all food vendors to sleep at their stalls to reduce the risk of COVID-19 transmission. Up to 900 vendors were allowed to operate on a rotational basis during the lockdown. The radio shows are equipping vendors with important knowledge they are passing on to their customers and having a visible impact on the adoption of recommended health practices such as frequent hand washing with soap and chlorinated water, maintaining physical distancing at the stalls and cooperating with the temperature checks at the entrances to the market, as well as use of masks by the vendors and their customers. Namukasa Jane, a vendor in the market, says the radio shows have helped her to understand COVID-19 and eased the anxiety as well as boredom in the market during the difficult lockdown period. "I was able to call the presenters and have my questions answered in real time which was fulfilling."

CASE STUDY: Moto taxi drivers help reduce rumours and misinformation in DRC

Thousands of motorbike taxis transport people every day in North Kivu and Ituri, in the Eastern Democratic Republic of Congo (DRC). They are not only a critical entry point in the community, but they also carry a lot of influence. When Ebola first spread to Komanda and response efforts began to ramp up, many motorcycle drivers became a key source of spreading rumours and misinformation, that led to a lot of resistance in the community. "We thought we were being lied to by Ebola responders. That the disease was not real. There was resistance," said Chance Evariste, Motorcycle Association Vice President in Komanda. "We also thought the water to wash hands had some disease. We refused to wash our hands or to transport people to the hospital because there was a belief that things would be put in our bodies." The DRC Red Cross collectively began to work with the motorcycle drivers in communities like Komanda to help change their ideas about Ebola. Slowly by slowly, motorcycle taxi drivers understood more about Ebola and how responders were there to help and not harm. "Red Cross came to us and sensitized us about Ebola, our important role to carry people who are sick to the hospital and how we can protect ourselves." Now the motorcycle drivers spread information instead of rumours, and leaders like Chance are members of the RCCE coordination meetings and a key partners in the response.

Step 4: Listen, analyse, and act on community feedback

- Rumours and misinformation travel fast and can quickly undermine risk communication efforts and lead individuals to adopt ineffective prevention measures, increasing the risk of infection. Therefore, it is essential to establish a system for listening, analysing, and responding to perceptions, rumours, misinformation, stigma, questions, and suggestions from communities.

- Use trusted channels and people within the community to collect community feedback and review these approaches regularly to check they are working. This is especially important in settings such as refugee and IDP camps and informal urban settlements where mistrust is high and people may be less willing to share feedback with you, either because they fear it may be used against them or have little faith their feedback will be listened to and acted upon.

- Discuss community feedback and how to act on it with key stakeholders such as community leaders, groups, service providers and local authorities. Enlist their support in implementing actions that respond to feedback, both in terms of RCCE and broader changes to the response.

- You must update community members on how their feedback has been used and acted upon, in order to build trust and ensure they keep sharing their feedback with you.

- Address fear, misinformation, stigma, and rumours quickly, by enlisting the support of trusted community leaders and groups to correct rumours and misinformation circulating in the community. Information provision alone might not be enough to address stigma and fear and you may need to discuss with communities the underlying causes of these issues.

CASE STUDY: Importance of listening to community feedback to build trust in an epidemic response

Misinformation, mistrust of outsiders and conspiracy theories spread quickly across areas of the Eastern DRC affected by the 2018-2020 Ebola epidemic: "We don't trust the response team because they started their operations badly and the team was made up of foreigners" (community feedback quote, DRC 2019). Decades of violence and displacement, along with unfamiliarity with the disease and response activities, contributed to a lack of trust that hampered the response. In order to respond to communities' objections to the response and to improve it based on people's concerns, an innovative community feedback system was launched in August 2018 by the IFRC in close partnership with the US Centres for Disease Control and Prevention (CDC). Over 800 volunteers gather regular community perception data through open conversations during social mobilization activities, including key beliefs, misinformation, questions, suggestions, and concerns across all affected areas. The information is analysed and provided to all first response actors. The information enables the response to understand barriers and drivers related to the uptake of medical interventions, to adapt interventions in line with community suggestions, and to better address community concerns and expectations. Nearly 400,000 data points were collected in the first year of the system. The impact of this has included a reduction in resistance towards safe and dignified burials, thanks to the introduction of semi-transparent body bags as a result of widespread feedback which showed many people believed the body bags used by responders were actually filled with rocks or dirt to hide the fact that body parts had been removed and sold.

4. Adapting standard prevention messages for these settings

Given the challenges faced by people living in urban informal settlements and refugee and IDP camps, standard public health messages must be adapted to reflect these challenges or risk causing frustration and being ignored. Actual health messages should be designed with the community and provide clear information on the specific solutions identified through the steps above. Studies in the region have shown that people are willing to adapt their customary behaviours (e.g., related to funerals, greetings etc.) to reduce risk of disease transmission, if the reasons are clearly explained and accurate information is provided through trusted channels.

Tips on developing messages for COVID-19 prevention and response:

- First and foremost, messages developed need to be evidence-based, using the findings from the assessment and/or community feedback data. They should build on existing knowledge and perceptions of COVID-19.

- Messages need to acknowledge the challenges people face in complying with public health measures. Telling people to physically distance when it's impossible will only lead to frustration.

- Messages should be developed with the community, or at the least be adapted for each context.

- Messages should be clear, simple, practical, specific, and locally contextualised. Messages should be provided in local languages and include pictorial representations for illiterate populations.

- Messages should explain why measures are required and focus on building people's understanding of how the virus transmits so that prevention measures make sense. For example, messages about not shaking hands should explain the reasons why and suggest culturally acceptable alternatives.

- Messages need to clearly explain the measures put in place in each community, why, how long they will be in place (where possible) and include practical information about what people need to do and how they can ask questions or access more information. For example, messages about physical distancing should explain the specific steps the community has agreed on to reduce this, such as having one-way pedestrian flows or staggered access to markets.

- In places with high population density, where physical distancing is challenging, it is important to raise awareness about other preventive measures, such as wearing masks and handwashing, while also ensuring people have the means to implement these (access to masks, water, soap).

- Link messages to available services and resources (ensuring that hotline numbers and websites are accessible). For example, details of social safety nets to counter the impact of lock downs.

- Messages should not contribute to stigma against any particular group and instead should emphasise the importance of social responsibility, and solidarity, considering ways this can be achieved in different contexts, with the ethos that "*we are all in this together*".

- Messages should instil confidence with a positive tone that reinforces the specific behaviour(s).

- Repeat the message across multiple channels frequently to increase reach and recall.

- Specific messages should be developed to target key population groups, such as adolescents, who have more social contacts, or the elderly, who are more at risk of serious outcomes, or those who have influence over peoples' health behaviours, like men, older women, and traditional and religious leaders and healers.

Avoid:

- Blaming individuals, organizations, or institutions for the emergency.

- Fuelling fear and anxiety, they are likely already elevated.

- Using language that can be interpreted as judgmental or discriminatory.

- Using technical jargon and complex, technical words.

- Providing information that is dishonest, unproven, or factually incorrect.

CASE STUDY: Refugees lead communication efforts on COVID-19

Tahaini Adaw Nabil has lived in the Alrdis 2 refugee camp that is host to South Sudanese refugees, in White Nile State, Sudan, since 2016. Tahaini is also a volunteer with the Sudan Red Crescent Society (SRCS) and a member of the camp Emergency Committee for COVID-19. She says: "I heard about the confirmed COVID 19 cases in Khartoum and decided to look for information on social media and translate it into the local languages. I asked a highly respected priest within the refugee community to record the messages, in his own voice, for mass dissemination. He would sign off at the end of each message with his name and designation to inspire trust in the information shared within the community. These messages talked about prevention methods to keep COVID-19 away from the camp. I shared these audio recordings with youth groups who spread then on social media as well shops in the market. I also walked around with a megaphone in public places where people gathered and focused a lot on explaining physical distancing because of the congestion in the camp which posed a high risk of transmission." As a result of Tahaini efforts, the camp population has responded positively to the lock down of the markets and social clubs. SRCS volunteers have drawn 1.5 meters squares to help ensure physical distancing in the areas of food distribution, water points and markets. "I now see people keeping distance when they meet and this has helped to maintain no cases of coronavirus in my community," adds Tahaini.

In Ethiopia, UNHCR faced initial challenges engaging refugee youth in prevention of COVID-19. There was frustration among youth as a result of the cancellation of group activities in an effort to reduce overcrowding and adhere to physical distancing. There were also rumours spreading among youth networks that COVID-19 was not real. To address these challenges refugee youth groups worked with UNHCR in a pilot initiative to engage young people in development of child-friendly posters on COVID-19. Similarly, in Kakuma camp in Kenya, UNHCR is engaging youth-based structures and CBOs (including Kakuma Shapers Hub supported by World Economic Forum) in designing and sharing fliers, posters, pictures, animation, and short movies in line with official ministry of health messages.

Documents used to develop this guide

The guidance note draws heavily on a number of existing guidance notes and research briefs, including:

- "Key considerations: COVID-19 in informal urban settlements (March 2020)", Social Science in Humanitarian Action Platform
- "Compliance with physical distancing measures for COVID-19 and implications for RCCE in Eastern and Southern Africa (April 2020)", Social Science in Humanitarian Action Platform
- "Key considerations: quarantine in the context of COVID-19 (February 2020)", Social Science in Humanitarian Action Platform
- "Public health and social measures for covid-19 preparedness and response in low capacity and humanitarian settings", "IASC Interim Guidance, May 2020
- RCCE in special settings: Refugee camps and migrants, urban settings, informal urban settings, rural settings and gender considerations – Key considerations in the context of COVID-19", UNICEF ESARO C4D Section, April 2020
- "Communities' challenges to comply with public health measures for COVID-19 – Community feedback brief", Community feedback sub-working group – East and Southern Africa, June 2020
- "Tips for Engaging Communities during COVID-19 in Low-Resource Settings, Remotely and In-Person", GOARN, April 2020
- "Practical guidance for risk communication and community engagement (RCCE) for Refugees, Internally Displaced Persons (IDPs), Migrants, and Host Communities Particularly Vulnerable to COVID-19 Pandemic", RCCE global subgroup for migrants and refugees.

Useful resources

- The East and Southern Africa RCCE online hub on the Ready platform is where all agencies share resources, guides and materials. Key resources include:
  - A wide range of guidance notes on work in fragile settings
  - Materials to respond to community feedback and rumours
  - IFRC Ask Dr Ben and Demandez au Dr Aissa factsheets with key messages
- The Red Cross Red Crescent Community Engagement Hub is an online site with a wide range of COVID-19 and broader community engagement materials, including training packs, templates, feedback toolkits and more. Key resources include:
  - RCCE one-day training pack
  - CEA toolkit, including feedback toolkit
  - COVID-19 resources
- Guidance for National Societies on safe and remote risk communication and community engagement during COVID-19, IFRC, April 2020
- http://www.mixedmigration.org/
- Rumour has it: A practical guide to working with rumours, CDAC, June 2017
- Faith Community Guides on COVID19 response
- WHO COVID-19 site

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