SocialNet2019

Community engagement training

Integrating social science-based interventions
in health emergencies response
Belgrade, Serbia, 8-13 December

White Paper and SocialNet Experience

World Health Organization

REGIONAL OFFICE FOR **Europe**

SocialNet2019

Community engagement training

Integrating social science-based interventions
in health emergencies response
Belgrade, Serbia, 8-13 December

Abbreviations

AAP	Accountability to affected populations
AAR	After-action review
BSS	Behavioural and social sciences
CDC	Centers for Disease Control and Prevention
CE	Community engagement
ECDC	European Centre for Disease Prevention and Control
ERC	Emergency risk communication
ERF	Emergency Response Framework
HRBA	Human rights-based approach
IHR	International Health Regulations (2005)
IM	Incident manager
IMS	Incident Management System
IMT	Incident Management Team
JEE	Joint external evaluation
KAP	Knowledge, attitudes and practices
NGO	Nongovernmental organization
PHEIC	Public health emergency of international concern
PIP	Pandemic Influenza Preparedness
SOCO	Single overarching communication outcome
SSI	Social science-based interventions
WHE	WHO Health Emergency Programme
WHO	World Health Organization
UNICEF	United Nations Children's Fund

Acknowledgements

Foreword

"The training was a life changing experience."

SocialNet Participant

Over 50 participants from countries and territories in the WHO European Region participated in a training course on risk communication, community engagement and social science that many of these participants felt was a life changing experience. The overwhelming feedback of many of the participants was a feeling that they would wake up on the day after the training looking differently at the way they work. When, previously, they had gone to work in their institutions or responded to emergencies, their attention to the "other", the receiver, the beneficiary and lastly the community had not been so acute in their minds and hearts as it would be in the future. In particular, the 2-day field simulation in the Serbian Red Cross camp was an eye-opener with regard to peer support, empathy and emotional intelligence.

Twenty people from the three levels of WHO, together with people from four partner organizations (CDC, ECDC, UNICEF and the Red Cross), were facilitators, mentors and role-players. Together, this team created the conditions for each participant to benefit from an exceptional learning experience. Classroom days with lectures, working groups, simulations, games and discussions established an intense interactive environment where members of six teams worked with each other. The field simulation included 72 role-plays in 15 hours, tent work, bonding and dancing together for an even deeper experience.

A thorough learning path was developed to allow participants to assess themselves and be assessed by their mentors against three WHO competencies: teamwork, communication and leadership. Their profiles will contribute to identifying suitable deployees in emergencies, to building better risk communication, community engagement and social science capacities in European countries and to advocating for this field of expertise to be embedded into emergency preparedness and response.

One participant wrote: "I still have so many emotions about training and being a team. It was the best training that I have ever had and probably one of the best things what happened to me in my whole life. It is so sorry to know that this is over and it will never be the same as it was in camp when we were all together. All for one and one for all."

Welcome to SocialNet 2019.

Cristiana Salvi

Programme Manager, External Relations, Health Emergencies and Communicable Diseases, World Health Organization Regional Office for Europe

Melinda Frost

Lead for Risk Communication and Community Engagement Capacity-building for WHO under the Pandemic Influenza Preparedness Framework, WHO Headquarters

Introduction

Every continent is vulnerable to emergencies and Europe is no exception. In a typical year, Europe suffers economic losses of approximately €10 billion from disasters and emergencies. Disasters and emergencies threaten people's health, disrupt communities and impose high economic costs.

Under the International Health Regulations (IHR (2005)) and the Pandemic Influenza Preparedness (PIP) framework, the WHO Health Emergencies Programme (WHE) provides support to countries to improve their national capacities to prevent, prepare for, respond to and recover from health emergencies of any type. This is one the main priorities of WHO's global vision up until 2023, and it is set up in the European Action Plan for Emergency Preparedness and Response that all countries endorsed in 2018 at the WHO Regional Committee for Europe. Improving the way we work towards emergency preparedness and response is at the core of the WHO European Health Emergencies Programme.

If there is one thing that emergencies have in common, it is that the community plays a central role in mitigating the consequences through emergency preparedness and speeding up the management of risks and response. Community engagement and risk communication are some of the weakest capacities in countries under IHR (2005). We can better engage communities and improve outcomes of emergency response through enhanced use of social science-based interventions before, during and after health emergencies.

Member States and ministries of health have increasingly recognized emergency risk communication (ERC) as a critical part of preparing for and responding to health emergencies. In 2017, the WHO Regional Office for Europe developed the ERC five-step capacity-building package to support the countries of the Region to establish plans and systems for effective communication in emergencies tailored to their specific contexts[1]. Despite progress in recent years, countries and territories still need to develop stronger capacities to engage and communicate with communities before, during and after health emergencies.

Social science interventions, community engagement and risk communication are effective, relevant and appropriate public health interventions. Engaging communities involves developing relationships with communities to include them as equal partners in finding solutions, using risk communication and community exchange for informed decision-making, and the further use of the social sciences to integrate community assets in the process of identifying and eliminating the barriers to health protection. Implementing these disciplines as part of emergency preparedness and response ensures that affected populations are involved and enabled to take informed decisions to protect themselves and their loved ones during crises and help to control the emergency sooner.

---

1   WHO. Emergency risk communication (ERC) 5-step capacity-building package. In WHO Euro/Health topics/Health Emergencies [website]. (http://www.euro.who.int/en/health-topics/health-emergencies/pages/whos-work-in-emergencies/risk-communication-in-emergencies/emergency-risk-communications/ emergency-risk-communications-tools/national-health-emergency-risk-communication-training-package; accessed 16 April 2020).

The WHO European Region is at the forefront of developing risk communication, community engagement and social science capacity and inextricably embedding them into emergency preparedness and response. People's knowledge, attitudes and practices (KAP) play a critical role in successfully managing an emergency and the engagement of affected populations is crucial to this.

What is SocialNet?

In 2017, WHE developed the SocialNet training course, designed to prepare social scientists, communicators and emergency response experts to engage communities effectively in emergency response. Through SocialNet, WHE and Member States work together to put these combined sciences high up on the emergency preparedness and response agenda, to enhance skills and have a stronger impact through deeper engagement with the communities that we serve.

Engaging communities involves:

- **Risk communication:** an exchange with the community for informed decision-making.

- **Community engagement**: developing relationships with the community to include it as equal partner in finding solutions.

- **Social science:** the use of reliable research methodologies to identify and eliminate barriers to health protection.

SocialNet provides an interactive learning experience, the sharing of best practices through multiple methodologies including lectures and working groups, and engaging participants in a simulated health emergency in the field requiring them to function in the community engagement capacity that would be expected of them in a real emergency.

SocialNet works to:

- Establish a roster of national and regional experts in community engagement.

- Build skills to communicate risks and engage communities affected in health emergencies.

- Scale-up risk communication and community engagement capacities under IHR (2005) and PIP.

"As technical experts, we are inclined to think about the risk assessments for affected and at-risk people in terms of hazards and vulnerabilities. [SocialNet] week is our special time to switch our thinking to the perception of the risk, how people think, feel and worry, and how communities need to be part of the solution"

Marijan Ivanuša, WHO Representative in Serbia

Boost coordination and peer support

Through presentations, lectures, discussions, group work, panels, mentoring and a field simulation, SocialNet engages attendees to interact and share, to network and exchange information, perspectives and experiences, but most importantly to learn how to engage people for their benefit and protection.

This style of training takes place with the support and participation of partner organizations and the three levels of WHO: country, regional and global. The programme is at once intensive and extensive, to replicate and experience the intense and dynamic pace of an emergency.

SocialNet builds capacity in the following key areas:

- Social science in public health emergency response.

- Community engagement.

- Mapping a national social science data ecosystem.

- Data collection and analysis.

- Communicating social science-informed recommendations to different audiences.

- Negotiation skills.

- Social science intervention design.

- Risk communication.

- Becoming a community engagement trainer.

- Strategic thinking for long-term impact.

- Security in the field.

- Implications of gender dynamics.

The first WHE SocialNet training session in the WHO European Region was conducted in Bishkek, Kyrgyzstan, from 10–14 December 2018 and included participants from 11 countries in the Region. The second SocialNet training in the WHO European Region, and third globally, took place from 8–13 December 2019 in Belgrade, Serbia.

Report structure

This training report consists of two main sections which both cover the core content, themes and concepts of SocialNet – but considered through distinctive lenses. The first section, the SocialNet White Paper, contains a series of white papers based on the main sessions during the first 3 days of the programme. Each white paper lays out the core concepts that were discussed and practiced during the classroom sessions and adds theoretical depth to the SocialNet content.

The second section covers the SocialNet experience, providing more detailed descriptions of training methodologies as well as participant pre- and post-test assessments, key feedback and lessons learned.

Together, the two parts represent the "thinking" and "feeling" modes of SocialNet, which are the two crucial sides of the same coin in emergency response work.

Section 1
SocialNet White Paper

This section of the report explores key theoretical frameworks, concepts and ideas underpinning the SocialNet fields of risk communication, community engagement and social science.

During the training programme, each key topic was covered by an interactive lecture combined with workshop-style sets of exercises, teamwork and short presentations (see Section 2).

1.1
WHO/WHE in outbreak and emergency response: two frameworks

Aphaluck Bhatiasevi
Acting team lead for Social Science Interventions and Risk Communication in the WHO Health Emergencies Programme (WHE) in WHO Headquarters, Geneva

WHO Member States face increasing numbers of emergencies with health consequences from all hazards, including infectious disease outbreaks, conflicts, natural disasters, chemical or radionuclear spills and food contamination. Many emergencies can be complex, with more than one cause, and can have significant public health, social, economic and political impacts. Within the context of outbreak and emergency response, WHO/WHE plays a key role and has specific responsibilities and accountabilities for emergency operations under two main frameworks:

- The **International Health Regulations (2005)** outlines an agreement between 196 countries, including all WHO Member States regarding cooperation for global health security. Through IHR (2005) countries have agreed to build their capacities to detect, assess and report public health events. WHO plays the coordinating role in IHR (2005), keeps countries informed about public health risks, and works with partners to help countries build capacity to detect, report and respond to public health events.[2]

- The **Emergency Response Framework (ERF)**[3] is an internal document developed to support WHO and its partners to respond more predictably and effectively in emergencies. In alignment with the requirements of the IHR (2005), the ERF clarifies WHO's roles and responsibilities and defines a common approach for its work in emergencies. The Framework provides WHO, at its three levels, with essential guidance on how the Organization manages the assessment, grading and response to public health events and emergencies with health consequences, in support of Member States and affected communities.

---

2   WHO. Strengthening health security by implementing the International Health Regulations (2005). In: WHO/IHR [website]. Geneva: World Health Organization. (https://www.who.int/IHR (2005)/about/en/, accessed 16 April 2020).

3   WHO. Emergency Response Framework, 2nd edn. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. (https://apps.who.int/iris/bitstream/handle/10665/258604/9789241512299-eng.pdf?sequence=1, accessed 16 April 2020).

International Health Regulations (2005)

The International Health Regulations (2005) is a legally binding document, which Member States have endorsed and that WHO coordinates the implementation of, and is the central guiding document for WHO's work in supporting Member States in public health emergencies. The purpose and scope of the IHR (2005) are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". WHO acts as facilitator for the IHR (2005), with a main goal to help countries and territories implement the treaty's requirements.

In a health emergency, various sections of the IHR (2005) are crucial to determining what steps WHO takes in preparedness and response, from the precautions countries have to take to stop potential international spread of diseases, to declaring a public health emergency of international concern (PHEIC).
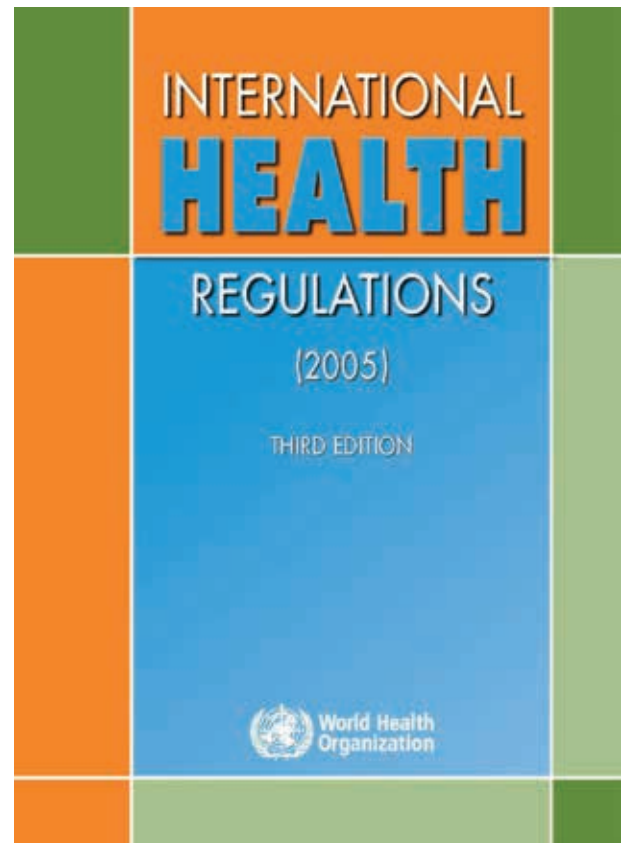
The IHR (2005) contain a range of specifications for Member States including:

- a scope not limited to any specific disease or manner of transmission, but covering "illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans";

- State Party obligations to develop certain minimum core public health capacities;

- obligations on States Parties to notify WHO of events that may constitute a public health emergency of international concern according to defined criteria;

- provisions authorizing WHO to take into consideration unofficial reports of public health events and to obtain verification from States Parties concerning such events;

- procedures for the determination by the Director-General of a "public health emergency of international concern" and issuance of corresponding temporary recommendations, after taking into account the views of an Emergency Committee;

- protection of the human rights of persons and travellers; and

- the establishment of National IHR (2005) Focal Points and WHO IHR (2005) Contact Points for urgent communications between States Parties and WHO.

IHR (2005) in the context of SocialNet

Risk communication is one of eight core capacities under IHR (2005). The goal for risk communication under IHR (2005) is that States Parties use "multilevel, multisectoral and multifaceted risk communication capacity for public health emergencies".

The real-time exchange of information, advice and opinions during unusual and unexpected events and emergencies must inform decisions to mitigate the effects of threats and allow for protective and preventive action. This includes a mix of communication and engagement strategies, such as media and social media communications, mass awareness campaigns, health promotion, social mobilization, stakeholder engagement and community engagement.[4]

Evaluating risk communication capacity under IHR (2005): five indicators

The main tool for measuring progress towards IHR (2005) goals and core capacities is the Joint external evaluation (JEE). The JEE is a way to voluntarily assess country capacity to prevent, detect and rapidly respond to public health threats independently of whether they are naturally occurring, deliberate or accidental.

States Parties' risk communication capacity under IHR (2005) is qualified and quantified by five main indicators:

- Risk communication systems for unusual/ unexpected events and emergencies, including a recently reviewed and tested national multihazard, multisectoral emergency risk communication plan and sufficient allocation of resources.

- Internal and partner coordination for emergency risk communication, including effective, regular and inclusive communication coordination with partners and stakeholders and clear definition of roles, sharing of resources and joint action plans.

4   WHO. Joint external evaluation tool: International Health Regulations (2005), 2nd edn. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. (https://extranet. who.int/sph/sites/default/files/document-library/document/9789241550222-eng.pdf, accessed 16 April 2020).

- Public communication for emergencies, including robust planned communication with continuous engagement and proactive media outreach, guided by risk communication best practices, and achieving comprehensive geographical coverage, evidenced by regular coverage of health issues and risks in relevant languages, as well as by media and social media activity during an emergency.

- Communication engagement with affected communities, with the end goal of an equal partnership with communities in the risk communication process as evidenced by review of a simulation exercise or tested during a real health emergency. This indicator includes regular briefing, training and engagement of social mobilization and community engagement teams including volunteers, and effective mechanisms to harness scale-up capacity.

- Addressing perceptions, risky behaviours and misinformation, including effective mechanisms for systematic gathering of information on perceptions, risky behaviours and misinformation and the systematic use of such analysis for shaping the response.

To increase risk communication capacity in these five core areas, in 2018 WHO Regional Office for Europe formalized the flagship Emergency Risk Communication Five-Step Capacity-Building Package (Five-Step Package – see Section 1.6), which is an iterative process to develop, test and adopt national health ERC plans and to integrate them into new or existing national action plans for emergency preparedness and response under the IHR. The steps in this comprehensive package include multisectoral training, capacity mapping and development, testing and the adoption of an ERC plan – with dedicated tools for each step.[5]

The five-step package builds on and dovetails with the JEE indicators by centring on four core capacities, each of which contributes to trust as the core driving principle of effective risk communication. The four capacities are:

1. **Transparency and early announcement:** including providing timely, complete information about a real or potential risk and its management, communicating what is known and what is not yet known – and what is being done to find out.

2. **Coordinating public communication:** including proactive external public and internal communication and coordination with partners before, during and after an emergency.

3. **Listening through two-way communication:** including centring communities in a health emergency response by understanding who to target, how key audiences and communities understand and perceive a given risk, their beliefs and practices.

4. **Effective channels and key influencers:** including the ability to select and prioritize those channels used by target audiences, and engaging influencers as trusted opinion-makers who are often part of the community.

The IHR (2005), the JEE indicators and WHO Regional Office for Europe's five-step package provide the legal and theoretical underpinning of the clear and manifest need for robust risk communication, community engagement and social science capacities as crucial components of a successful emergency response.

---

5   WHO. Emergency risk communication (ERC) 5-step capacity-building package. In WHO Euro/Health topics/Health Emergencies [website]. (http://www.euro.who.int/en/health-topics/health-emergencies/pages/whos-work-in-emergencies/risk-communication-in-emergencies/emergency-risk-communications/ emergency-risk-communications-tools/national-health-emergency-risk-communication-training-package; accessed 16 April 2020).

The Emergency Response Framework (ERF)

While IHR (2005) provides the legal framework for WHO's work in emergencies, the practical and operational details involved in mounting such a response at the local, national, regional and global levels are governed by a second document: the Emergency Response Framework (ERF).

In response to public health events and emergencies, WHO works to fulfil core commitments to Member States. The ERF requires WHO to act with urgency and predictability to best serve and be accountable to populations affected by emergencies, supporting vulnerable communities with country-centred responses.

An emergency is a situation impacting the lives and well-being of a large number of people, or a significant percentage of a population, and which requires substantial multisectoral assistance. An emergency with clear health consequences may justify a WHO response at one of three levels, depending on scale, urgency, complexity, capacity and reputational risk of the emergency:

ungraded

- **Grade 1 (limited response):** a single country emergency requiring a limited response by WHO, but which still exceeds the usual country-level cooperation.

1 grade

- **Grade 2 (moderate response):** a single country or multiple country emergency, requiring a moderate response by WHO, always exceeding Country Office capacity.

2 grade

- **Grade 3 (major/maximal response):** A single country or multiple country emergency, requiring a major/maximal WHO response, requiring major organizational and/or external support.

3 grade

When an emergency strikes, WHO commits to:

- Undertake a timely, independent and rigorous risk assessment and situation analysis, which may lead to grading of an emergency.

- Deploy any necessary experts and material resources early in the event/emergency.

- Establish a clear management and coordination structure for the response in-country based on the Incident Management System (IMS).

ERF | EMERGENCY RESPONSE FRAMEWORK
Second edition

World Health Organization

WHE Incident Management System (IMS) structure
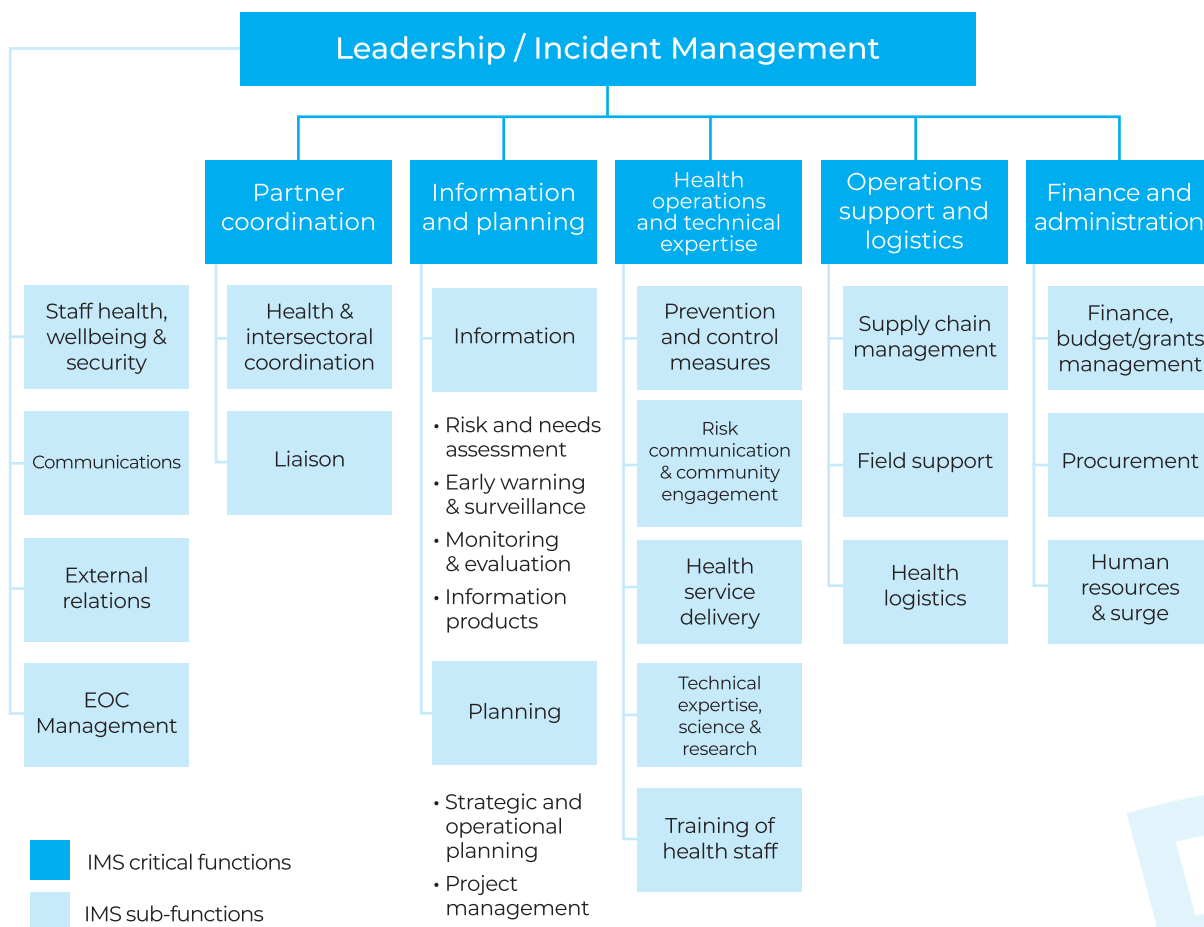
Figure 1 WHE Incident Management System (IMS) structure

The Incident Management System (IMS)

The grading of an emergency triggers the activation of WHO's Incident Management System, which provides a standardized yet flexible approach to managing WHO's operational response to the emergency.

WHO's critical functions for emergency response under the IMS are:

- Leadership (including communication)
- Partner coordination
- Information and planning
- Health operations and technical expertise (including risk communication and community engagement)
- Operations support and logistics
- Finance and administration.

An Incident Management Team (IMT) is activated alongside the IMS at the three levels of WHO depending on the emergency grading: country office, regional office, headquarters. It is structured around the six critical IMS functions and their associated sub-functions. The IMT is led by an incident manager (IM), responsible for strategic leadership and day-to-day management and oversight of WHO's response to the emergency.

ERF in the context of SocialNet

Examples from the field: WHO Incident Management System and emergency response

Within 12 hours of the earthquake that hit Albania on 26 November 2019, Abebayehu Mengistu, Coordinator for the Health Emergencies Hub in the Balkan region and Coordinator for WHE activities in Serbia, was deployed to the affected area as incident manager (IM). He worked with the WHO Country Representative to implement the ERF, conducting a rapid risk assessment and grading the emergency to move forward with planning the response, with support provided by both the WHO Country Office and the Regional Office. According to Dr Mengistu's experience, the IMS is key for a rapid, coordinated response. As part of his deployment, Dr Mengistu mapped all responding organizations, partners and government bodies noting who was doing what, where and when. His Incident Management Team identified beneficiaries and target groups as a base for a response plan which served to mobilize resources from WHO's Contingency Fund for Emergencies. With funding mobilized, Dr Mengistu and his team were able to provide and coordinate rapid support to health facilities that were damaged or completely destroyed in the earthquake and aftershocks.

In addition, the IMT communication pillar rapidly collected data on community behaviours to develop messaging and activities to manage concern. The many aftershocks in the Albanian quake provoked strong fears in the affected population, causing many people to refuse to go home. At the same time, members of the community were the first to support people who were displaced by the earthquakes with food, blankets and heaters. Often during an emergency, governments and ministries may find it hard to do any sort of reflection or evaluation in the moment. For this reason, the After-Action Review (AAR), a tool from the IHR Monitoring and Evaluation Framework, allows for a post-response assessment to inform future development and make improvements to coordination and communication.

1.2
Community engagement

Naureen Naqvi
Global lead of Social and Behavior Change and Community Engagement in humanitarian actions within the C4D section, UNICEF HQ

Community engagement is a process of developing relationships with the community that enables stakeholders to work together to address health-related issues and promote well-being to achieve positive health impacts and outcomes, including in public health events such as emergencies.[6]

Engaging communities is an important component of an emergency response as information on health and well-being is a basic right and the implementation of policies that affect communities requires the engagement and involvement of all key stakeholders. Evidence from recent health emergencies, from the 2009 influenza pandemic to Zika and multiple Ebola outbreaks, clearly indicates the need to go beyond "communication" to "engagement".

> Responders must be consciously and actively engaging during each step of the process as our behaviours play a critical role in how our work is perceived in various different communities and contexts.

Introduction to community engagement
The context and culture of an emergency are hugely important to the development of effective programmes and interventions. There is an interdependent and reciprocal relationship between health service providers and responders and health service users, their families and communities that needs to be addressed and utilized in the design of health interventions in communities, globally.

The general key principles of community engagement are:

1. Be clear about the purposes or goals and the populations and/or communities you want to engage – **risk assessments (rapid qualitative behavioural assessment).**

2. Know the community's perceptions, culture, economic conditions, social networks, political and power structures, norms and values, languages, beliefs, history – **social data**.

3. Learn about the community's perceptions of those initiating the engagement activities. **Feedback** is key.

4. Establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders – **influencers**.

---

6 WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017 (WHO/HIS/SDS/2017.15). Licence: CC BY-NC-SA 3.0 IGO.

5. Recognize and respect the diversity of the community – **rights-based**.

6. Consider community feedback and cultures of a community in planning, designing, and implementing approaches – **participation/ engagement**.

7. Commit long-term to community collaboration by the engaging organization and its partners – building capacity.

Defining and understanding the community

To effectively communicate and engage with a community, the population needs to be explicitly defined, as do the goals of the intervention. This includes understanding who participates, why they participate, how they participate and how they are connected individually and collectively. A community can be defined by physical boundaries, such as villages, towns or groups, by religion, educational background, profession or skills, differences or similarities in language, and traditional systems. Various environmental, social, economic, political settings define our communities and how, and at what levels, engagement takes place.

Generally speaking, community engagement is the involvement and inclusion of a community affected by a certain hazard or emergency in the health interventions designed to alleviate that hazard and strengthen community health. It is important to note that the principles of community engagement can be applied to other communities that are not affected by the hazard but are involved in the response.

In order to begin engaging and working with the community, it is essential to use social data to gather information about the community. It is important to understand how to know who to speak to, who serves as the entry points and what the local power dynamics are. Different systems exist in different countries and may range from traditional leadership systems and bureaucracies to individual and direct communication. Addressing the different layers of these systems requires considering culture, economic conditions, social networks, political and power structures, norms and values, languages, beliefs and history.

Collecting information

Data is a crucial component of engagement and different types and levels of epidemiological and social data are critical to understanding informing plans for community engagement. This data is prerequisite to addressing barriers and drivers for change at each level of influence. Communication and social science can help to overcome barriers at each level, beginning with the identification of behaviours, barriers, acceptance and the data required to overcome barriers.

Important considerations to make when identifying data need includes:

- What type of information do you already have?

- What are the strengths of this current information?

- What information are you missing? What are the gaps in what you know?

- What information do you need to collect? How will you collect it?

- What challenges do you anticipate throughout this process?

For more detail on data collection, see the Data collection and analysis section.

Community influence and empowerment

For each community, it is important to understand the layers of influencers at multiple levels and how they affect human behaviour, and in particular, how they can result in or remove barriers. The socio-ecological model of social and behavioural theory demonstrates the various layers of influence and describes the various relationships between each level (Figure 2).

Socio-ecological models

Socio-ecological models are developed to further the understanding of the dynamic interrelations among various personal and environmental factors. The model states that the entire ecological system in which human behaviour occurs needs to be taken into account to understand that behaviour.

Commonly included levels of analysis in socio-ecological models include:

- **Individual**: knowledge, characteristics, attitudes and skills including an individual's age, race, gender or other demographics.

- **Interpersonal**: the social network surrounding an individual, including friends, family and co-workers.

- **Community**: the relationship among organizations with rules and regulations that can affect an individual or group, such as schools, workplaces, and neighbourhoods or other areas in which social relationships occur.

- **Public policy**: laws and regulations the government puts in place at various levels (city, state, municipality, national).

Complex issues such as those pertaining to health often need to be addressed at and between the multiple levels of the model, with necessary steps at each level to address barriers. Communication and community engagement can help to overcome barriers by involving the community to gain insights into specific barriers and complexities to allow for tailored planning.

For example, for a child who requires vaccination an important influencer is the parent and they are in turn influenced by other layers such as media, peers and health workers. Addressing barriers and drivers to change at multiple levels is necessary and it is unrealistic to expect individuals to change their behaviour if barriers at higher levels are not removed.

Figure 2 Adapted from the Ecological Framework for Human Development developed by Urie Bronfenbrenner[7]

Two-way communication and community empowerment

The diverse and varying needs of a community and culture need to be considered through the application of rights-based approaches[8] and community feedback. Engaging the community is paramount in planning, designing and implementing approaches. Feedback is an important mechanism for ensuring that the perceptions of the community are integrated in planning the interventions and activities and to improve them.

Community engagement goes beyond telling people what to do and involves two-way communication and participation to ensure needs are met. This also lends to capacity-building, as successful engagement and increased knowledge help communities develop their own skills and capacities to both understand and act.

Methods and approaches for including the community in the response

Provision of information:

- Notification of key life-saving information and decisions.
- Community involvement in design of messages, interventions and communication process.

Consultation and data collection

- Collecting qualitative data.
- Collecting and responding to feedback.
- Gathering data to inform response and the community.
- Validating pre-formed plans.
- Build community capacity: train community (influencers) to collect data.

Facilitation of decision-making and empowerment to action

- Communities are actively involved in design, planning, leading, implementing and evaluating programmes and initiatives.

Human rights-based approaches

The Human rights-based approach (HRBA) aims to support better and more sustainable development outcomes by analysing and addressing inequalities, discriminatory practices and unjust power balances at the heart of development problems.

A human rights-based approach to health aims specifically at realizing the right to health and other health-related human rights. Health policy-making and programming are to be guided by human rights' standards and principles and aim at developing capacity of those responsible to the community to meet their obligations and empower the community to claim their health rights.

7   CDC. The Social-Ecological Model: A Framework for Prevention. In: CDC/Violence prevention [website]. Atlanta: Centers for Disease Control and Prevention; 2020. (https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html, accessed 16 April 2020).

8   WHO/OHCHR. A human-rights based approach to health. Geneva: World Health Organization; 2009. (https://www.who.int/gender-equity-rights/knowledge/hrba-to-health-en.pdf?ua=1, accessed 16 April 2020).

This involves participation and inclusion, meaning people are entitled to active, free and meaningful participation in decisions that freely affect them, such as the design, intervention and monitoring of health interventions. Participation increases ownership and helps ensure that policies and programmes are responsive to the needs of the people they are intended to benefit.

Regional/national case studies – the Red Cross of Serbia
Branimir Knežević,
Organisational Development Coordinator,
Red Cross of Serbia

Strengthening and expanding access to diagnosis and treatment of tuberculosis (TB) and multidrug resistant TB cases with special emphasis on most vulnerable population: The Red Cross and the Roma community

The Red Cross of Serbia (RCS) initiated the Strengthening and Expanding the Access to Diagnosis and Treatment of TB/MDR-TB Cases with Special Emphasis on Most Vulnerable Population project in 2015, funded by Global Fund to fight AIDS, Tuberculosis and Malaria. The Red Cross (RC) is a trusted community-based organization with volunteers in almost every community globally and which works to bring people together and provide treatment, advocacy and support. This is a critical feature of the RC and important in the scope of this project. The project was done in alliance with the Ministry of Health and seven other NGOs and civil society organizations, working to find and support active cases of TB/MDR-TB.

The Roma community in Serbia is stigmatized, as is the highly contagious disease TB. Although many people hold negative attitudes towards both the Roma population and TB patients, RC volunteers and staff on the ground achieved the overall goal of the project by listening to, learning about and forming a part of the communities in need.

Red Cross and civil society organizations played the role of interlocutor with the communities, establishing links and trust in areas where TB rates were high, based on data from multiple sources. Once cases were found, patients were referred to health institutions, while verification and tracking of patients was organized when possible and TB treatment was followed and supervised.

The project specifically targeted people on the margins of society, including unregistered non-permanent residents, with Roma qualifying as most vulnerable. The Serbian Roma population experiences high rates of social exclusion and risk and usually faces difficult circumstances. Their vulnerability is complex and includes multiple factors such as lack of shelter, food security and health problems caused or complicated by poverty. In addition, this community often remains unregistered without national ID numbers so they are on the fringes of society and are excluded from health or school systems.

By applying effective community engagement, the RCS was able to build a trusting relationship and gather detailed information on the community's religion, elements of the subculture, habits and tradition. As a result, the RCS's TB programming was able to adopt a tailored approach, including accommodating for various language and belief system differences.

1.3
Data collection and analysis

Christine Prue
Associate Director for Behavioral Science, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention (CDC)

John Kinsman
Expert in Social and Behavioural Change Communication, European Centre for Disease Prevention and Control (ECDC)

In the social sciences there are methods for engaging communities, identifying problems and finding solutions to those problems. Data collection is an essential part of this process. In an emergency response, we lean on laboratory results and epidemiology, which are crucial and tell an important part of story but not the whole story – we need social scientists in the community to gather other data and insights to ensure that what we offer communities as solutions fits the community needs and is well received. To achieve this, it is important to understand data collection methods and their applications, as well as the data itself.

Social science data, especially in an emergency, needs to be good enough, defensible, transparent and comprehensive enough that public health professionals can explain what is being done, why is it being done and how the information gathered will be used. The challenge is balancing the speed with quality: determining how to rapidly gather needed information in a way that allows us to defend our findings.

Data collection in emergency and outbreak responses: What do we need to know and how do we get those answers?
Emergencies offer a very narrow window of time to put research into practice. In this context, data collection is about asking the right questions and getting good answers quickly, so we can apply the information to our response and solutions. It is important to ask:

- Why do we collect data or "who needs to know what and why?"

- What are the types of data we will collect and what can each type tell us?

- What are the key actions/skills required for data collection – how do we ask our questions?

Traditional public health experts often consider and try to answer the common and essential questions during an outbreak: Who? What? Why? Where? When? and How?

WHO is affected by the event, is everyone at risk?

This information comes from epidemiologists and comes in at various levels of quality and from various sources.

WHAT is the nature of the disease?

What is the disease phenomenon we are dealing with? Is it a new strain; is it an easily transmissible strain?

WHY did the disease emerge?

Epidemiologists must often study how and in what groups the disease emerged and possible causal factors.

WHERE is the disease showing up and how is it moving?

Person, place and time: what are the vectors and modes of transmission?

WHEN does it happen?

Some diseases are seasonal; some are irregular; some are more enduring.

HOW can we stop the spread of disease?

What public health (pharmaceutical and non-pharmaceutical) interventions are available to prevent and treat the disease?

The added value of integrating behavioural and social sciences

These traditional questions are of great importance, but only offer a partial picture. To understand things such as how a community functions and what types of circumstances and limitations they experience, social and behavioural sciences are crucial. Understanding community dynamics, circumstances and behaviours allows health professionals to collect better data and implement more precise health interventions.

"As public health professionals, it is easy to wonder why people don't just act on our recommendations ... and it is difficult to understand how other people can have the opposite perception. Our task as researchers and human beings is not to judge them, but to try to understand why these people think what they think, to try to understand their reasons."

Data collection through the behavioural and social sciences lens: Five important questions

1. Are there social or structural factors and/or behaviours that may be contributing to the spread of a disease, or that may be part of a solution?

- This can include a number of factors, such as social, political, economic, demographic, cultural, geographical, spiritual, environmental influences and more.

2. What behaviours do we recommend to help people protect themselves, their families and their community?

- What behaviours offer protection or prevent spread? Be specific about the target behaviour: **who** needs to do **what**, **where**, **when**, **how often**, for **how long** and **with whom**?

3. How can we help people to successfully perform these protective behaviours?

- What are behavioural motivators? What are the drivers or inhibitors of target behaviour? How can we act on these to motivate a change in habits, routines or skills – using evidenced-based approaches and behaviour change techniques and adapting to context and limitations?

4. How do we engage communities (stakeholders) in identifying problems and implementing solutions in a way that builds trust? How do we optimize "fit" between interventions and community contexts?

- Are we dictating a plan or offering a range of solutions and engaging the community to find the ones that suit?

5. How do we know interventions are being delivered as planned and are having the intended effects?

- How do we know our work is effective? Does the community receive interventions as planned or are their obstacles?

Qualitative and quantitative data collection and analysis

To answer key social science questions, experts use qualitative, quantitative and mixed method data collection methods. Which method and tool will be most effective depends on the purpose and design of the research questions. In general, quantitative research answers questions such as "How much?", "How many?" or "How frequent" whereas qualitative research focuses on questions like "How?" and "Why?"

Basis for comparison	Qualitative Data	vs	Quantitative Data
Definition	Qualitative data is information that can't be expressed as a number		Quantitive data is data can be expressed as number or can be quantified
Can data be counted	NO		YES
Data type	Word, objects, pictures oberservations and symbols		Numbers and statistics

Figure 3 Simplified comparison of qualitative and quantitative data characteristics

"The value of social science in
an outbreak situation really cannot
be overstated"

John Kinsman, SocialNet facilitator

Qualitative data collection

Qualitative research can reveal how a group of people feels about a certain phenomenon, what they think and why. The collected data is generally text-based and conversational with a focus on emotions and thoughts.

Qualitative data collection methods include various kinds of interviews and unstructured discussions with small groups that share key characteristics. Common formats are key informant interviews, focus group discussions, participant observations and gatekeeper reviews.

This type of data collection has a number of advantages. First, it allows for in-depth explanation and exploration of topics. Second, because it allows participants a lot of freedom in formulating their responses, it is normally rich, detailed and contextual, offering many ideas and concepts to inform programming. Finally, qualitative research is flexible regarding locations and timing since there is no need to interview a large number of people at once – which means qualitative data collection often requires a smaller budget.

Disadvantages of qualitative research include the inability to quantify and extrapolate conclusions to a larger demographic – for that, we need quantitative research instead.

Qualitative data collection methods

Focus group discussions

In focus group discussions (FGDs), a trained and skilled moderator facilitates discussion on a selected topic among 6 to 10 respondents, allowing them to respond spontaneously to the issues raised.

In outbreak response this method is often used to identify barriers to and motivators for protective behaviours, collect data on cultural factors affecting interventions, as well as collect feedback on ongoing projects. FGDs are also useful to test communication messages for clarity, appropriateness and effectiveness.

> Focus group discussions can provide an opportunity for a better understanding of feelings, motivations and past experiences related to the health issue.

An effective FGD requires an environment where all participants feel free to share their point of view. The moderator guides participants through the research topics or questions, records responses and asks follow-up questions on unexpected or valuable topics that are raised. Group interaction can bring to light new ideas and reflections, provides the opportunity to probe respondents' answers and explore the complexities of the audience's thinking and behaviour.

Focus group discussions can be hosted in person, by telephone or via the Internet and normally last between 45–90 minutes, depending on the medium used. As always, the decision for the right method depends on purpose, objectives and design of the research.

In-depth interviews

In-depth interviews allow for exploration of long, complex and sensitive topics and for intensive investigation of an individual's thoughts, opinions and attitudes. An in-depth interview is normally guided by a list of high-level topics and questions per topic that you plan on covering, called the interview guide. The list is more flexible than a quantitative survey in that it allows for follow-up questions and minor diversions.

In-depth interviews offer more detailed and rich findings on such issues as attitudes, beliefs and comprehension.

This approach relies significantly on interviewer skill, especially regarding in active listening, probing, note taking and intercultural and contextual sensitivity. In-depth interviews take up a relatively large amount of time and require a level of trust between interviewer and respondent, especially when dealing with sensitive or threatening material.

Participant observation

Participant observation allows researchers to learn what life is like for a community insider while remaining an outsider themselves. It documents people's behaviours and activities, what they do, how frequently, and with whom and helps to discover community perspectives. Observation data can also serve as a useful contrast to focus group and interview data: sometimes, behaviours and beliefs stated in interviews does not match behaviour in reality (see page 34 – The KAP gap). As with the other methods, the research objectives and questions drive the selection of the relevant observation location.

Participant observation is valuable to validate participants' subjective reporting of what they believe and for gaining insights about physical, social, cultural, and economic contexts where people live, relationships among and between people, contexts, ideas, norms and events.

This method can be time-consuming, and researcher memory, discipline and objective observation skills all play a limiting role.

Quantitative data collection

Where qualitative research asks "how" and "why", quantitative research focuses on questions like "how much" or "how often". If designed and executed properly, quantitative research findings can be extrapolated to the entire population.

Quantitative research usually involves surveying a large group of people using a structured questionnaire with closed-ended questions. Its main tools are surveys of different kinds, with pre-set answers, administered through face-to-face interviews, (computer-assisted) telephone interviews, and self-administered surveys via handout, mail, or Internet. Contrary to qualitative research, quantitative research findings can be generalized beyond individual groups of participants – and even an entire population if the survey involves a large enough, statistically valid random sample. The most common limitations of quantitative studies are potential cost and the inability for researchers to ask follow-up or targeted questions.

Quantitative data collection methods
Surveys: knowledge, attitudes and practices

The knowledge, attitudes and practices (KAP) survey assesses the proportion of your target audience within a community that:

- has knowledge relevant to performing protective behaviours or practices a behaviour;

- has positive, negative or neutral attitudes about relevant aspects of the behaviour or the response more generally;

- receives/recalls a message or information, and through which communication channel it was received.

KAP surveys are useful in peacetime but have special advantages during outbreaks and in emergencies as a tool to track changes in knowledge, attitudes and practices. KAP surveys are often repeated at regular intervals to assess trends over time and can be a source of feedback on interventions.

The KAP gap: differences in reported versus actual behaviour

A KAP survey aims to accurately represent a population's knowledge, attitudes and practices at a given point in time – or over time, if the same survey is repeated. One challenge with a KAP, and any kind of self-reported data, is the gap between the stated values, attitudes and practices of an individual, and the observable behaviour.

This "KAP gap", also called the value-action gap, attitude-behaviour gap, or intention–behaviour gap, can be large or small depending on economic, political, cultural and cognitive factors.

Gatekeeper review

Gatekeepers are individuals who facilitate, complicate, or deny access to target populations, including those who control distribution channels. Although gatekeepers are in many cases not the target audience of an intervention, their commitment may be necessary to ensure programme implementation.

Gatekeeper review is inexpensive and often crucial to programme success. Thus, it is wise to include a gatekeeper review in early stages of programme design to ensure sufficient buy-in.

> Gatekeeper review is best used to ensure that messages will be disseminated and programme plans carried out by obtaining gatekeeper approval prior to programme dissemination. In outbreak/emergency responses, engaging community leaders about interventions, especially medical interventions that may be unfamiliar, is essential.

Mixed method data collection

Most study designs are neither purely qualitative nor completely quantitative, instead employing a mix of both types of methods. This is referred to as mixed method research. Additionally, some research methods can either be used in a qualitative or quantitative manner depending on whether they focus on the "how/why" or the "how many" question.

Doer/non-doer analysis

Doer/non-doer analysis is a general research analysis used to explore the differences between target audiences or audience segments on targeted behaviours. By comparing members of an audience who successfully perform a certain behaviour to those who do not, it is possible to identify motivating and inhibiting factors relevant to behaviour change.

Doer/non-doer interview guides commonly include three pairs of open-ended questions about:

- The perceived consequences of performing the desired behaviour:
  - What do you see as the advantages or good things of performing the behaviour?
  - What do you see as the disadvantages or bad things of performing the behaviour?
- Self-efficacy:
  - What makes it easier to perform the behaviour?
  - What makes it difficult to perform the behaviour?
- Norms:
  - Who approves or supports you doing the behaviour?
  - Who disapproves or objects to you doing the behaviour?

This analysis is simple to conduct and analyse as it focuses on a single clearly defined behaviour and thus does not require a large sample size.

Review of existing data

A review of existing data (also called desk review, literature review or secondary research) is the structured evaluation of existing research, including information previously collected by local, state or national agencies. Analysis of existing data is useful for subsequent planned primary research, because it provides a better understanding of the bigger picture and helps avoid researchers collect data that already exists.

Organizations may collect data that is not originally intended as health data, but is useful nonetheless; examples include grocery store receipts and even school attendance records.

Data analysis

Data analysis is a process of inspecting, cleaning, transforming and modelling data with the goal of discovering useful information, informing conclusions and supporting decision-making. Data analysis follows data collection, although often rapid analysis of preliminary data collection results can redirect data collection, especially during qualitative research – for example, when an interviewer decides to ask follow-up questions because they detect (analysis) an unusual or interesting element in the interviewee's answer.

Data analysis, especially of quantitative datasets, can be very complex and requires knowledge of sophisticated statistical software. For the purpose of SocialNet, the instruction focused on the principle of coding.

Coding

Coding is an analytical process in which data, in both quantitative forms (such as questionnaire results) or qualitative forms (such as interview transcripts) are categorized to facilitate analysis. One purpose of coding is to transform the data into a form suitable for computer-aided analysis. This categorization of information is an important step, for example, in preparing data for computer processing with statistical software. Coding can also be used to discover patterns in qualitative data.

When coding a series of interview transcripts, researchers familiarize themselves with the material by actively reading and re-reading the transcripts while taking notes. Two different types of themes – or codes – will generally be found in the material:

- **deductively derived codes**: those that are already known about or expected in the materials;
- **inductively derived codes**: themes not previously anticipated and that emerge from the text.

One of the major advantages of qualitative data is that the open-ended discussion style format allows for the identification of new, inductively derived themes about which the researcher was not previously aware.

As a final step, codes are assigned to the relevant pieces of text. To minimize bias, two or more researchers generally code the material independently, and then combine their findings into a single coded dataset. The systematic process of coding and identifying themes in qualitative data allows the researcher to analyse the extent of disagreement or agreement about the various issues identified within the community, as well as why this may be it can also help to identify potential solutions to issues arising during an outbreak, as voiced by the community.

Once all material has been reviewed, it is important to see how responses from the data relate to public health responses, those which are necessary and those which would be "nice to have". Differentiating those allows for ranking of responses, codes and themes and the next step in the development of an intervention.
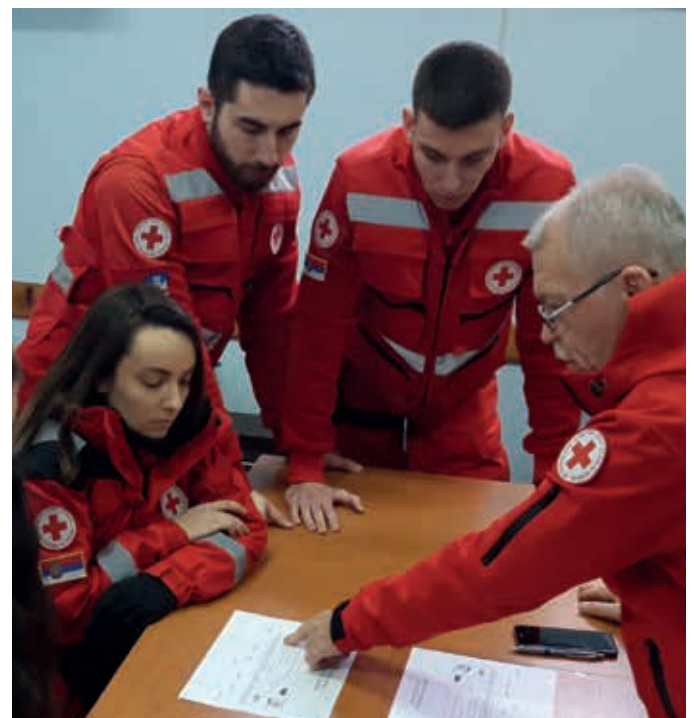
1.4
Intervention design considerations

A number of important considerations from social and behavioural sciences feature in the design and development of public health interventions:

- behaviour change communication;
- social media for social science;
- vulnerable populations;
- monitoring and evaluation;
- community preparedness and community engagement;
- accountability to affected populations.

Behaviour change communication
John Kinsman
To increase frequency of protective behaviours in a public health emergency, responders must first have an understanding of all issues that influence that behaviour and how they interact. Two widely used models for understanding behaviour change are the health belief model and the Capability, Opportunity, Motivation and Behaviour (COM-B) model.

> "Statistical data only tells you so much – the topics covered by SocialNet really help participants understand what makes people behave in a certain way"
>
> Sergiu Tomsa, SocialNet Facilitator

Health belief model
The health belief model is a social psychological health behaviour change model developed to explain and predict health-related behaviours, particularly with regard to the uptake of health services. It lists six main factors that influence an individual's behaviour related to a health hazard:

- **Perceived susceptibility**: "Is this hazard going to affect me? Will I catch this disease?"
- **Perceived severity**: "If it affects me, will the hazard's impact be severe?"
- **Perceived benefits**: "How will I benefit from performing protective behaviour, and, if I do benefit, how much?"
- **Perceived barriers**: "What stands in the way of me performing the behaviour?"
- **Cues to action**: "What is the prompt for my engagement in the behaviour?"
- **Self-efficacy**: "Do I feel able to perform this behaviour and overcome any challenges?"

Some components are easier to address than others. Self-efficacy, for example, is often the result of something that an individual has or does not have in their life; it is not something that can easily be given as the result of a programme or message.
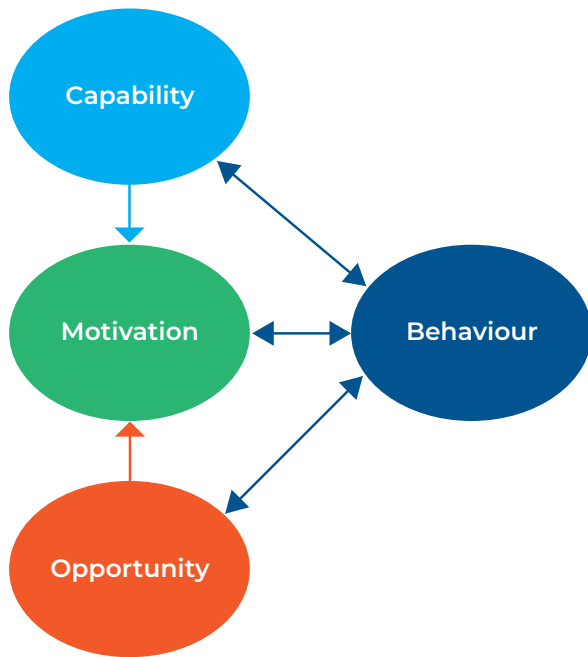
Figure 4 The COM-B model by Michie et al.[9]

The COM-B model of behaviour change

This model focuses on how the concepts of capability, opportunity and motivation drive behaviour:

- **Capability**: an individual's physical and psychological capacity to engage in the activity concerned, including the necessary knowledge and skills.

- **Opportunity**: all the factors, both physical and social, that lie outside the individual that make the behaviour possible or that prompt it.

- **Motivation**: all those brain processes that energize and direct behaviour, including those that are automatic (habitual processes, emotional responding), and reflective (conscious, analytical decision-making).

- **Behaviour**: the outcome of all these different influences.

Perceived barriers in Latvia to vaccination

In previous years, Latvia's health system had a circuitous way of dispensing influenza vaccines to citizens. Acquiring the flu vaccine required an individual to see a physician to receive a prescription for a vaccine, followed by a trip to the pharmacy to pick up the prescribed vaccine and then a follow-up appointment with the doctor to administer the vaccine. This complicated system often served as a barrier to those interested in vaccination. Within the last year, changes in policies and procedures now allow individuals to make a single visit to the physician who can administer the vaccine there and then. The increased access and convenience of this new process translates into a reduced perception of barriers to vaccination and an increase in vaccine uptake.

9   Michie et al.: The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science 2011 6:42.

Social media for social science
Maria Fernanda Falero Cusano

WHO Lead for Social Sciences, Community Engagement and Risk Communications for the Ebola response in the Democratic Republic of the Congo (DRC).

Social media plays a central role in today's information and communication ecosystem, including in the context of community engagement in public health emergencies. Health care workers and public health professionals can engage communities in the response by sharing important information via SMS networks, institute two-way listening and analytics via social media platforms, and establish hotlines and other digital feedback mechanisms for case reporting, rumour monitoring, as well as general feedback on the response.

Although government actors generally dedicate little capacity to using social media for risk communication and community engagement, this appears to be slowly changing with more interactive and rich dialogue and feedback taking place beyond a simple government website comment form.

A concept related to social media that is of particular value in low-resource settings is crowdsourcing, or the outsourcing of tasks to a large network of people. By opening channels of collaboration with an engaged public, emergency responders can multiply the reach and effectiveness of their communications. Crowdsourcing can sometimes solve unexpected challenges. When flooding hit Serbia in 2014 (see page 48), cell phone networks went down as well. Radio amateurs filled the gap, sharing information on the location and condition of trapped residents to emergency responders, enabling search and rescue operations to move forward quickly and effectively.

CASE STUDY

USHAHIDI

Crowdsourcing platforms can be a way to collect information directly from communities. Ushahidi, which means "testimony" or "witness" in Swahili, is one of the first and most well-known of such platforms. The Ushahidi platform allows for the collection and mapping of eyewitness reports in crisis response, human rights reporting and election monitoring.

Ushahidi was developed in 2008 to map reports of violence in post-election Kenya, and an analysis by Harvard's Kennedy School of Government concluded that the data collected by Ushahidi during the elections in 2008 was superior to that reported by mainstream media outlets in Kenya during the time.

The Ushahidi platform has been used by the United Nations Department of Field Services and Peacekeeping in response to the Haiti Earthquake in 2010 and to monitor the Nigerian elections in 2011, by the Nepalese army to respond to the earthquake of 2015, by local activists groups such as Humanitarian Tracker to monitor violence in the Syrian civil war and by HarassMap to help women report on sexual harassment in Egypt.

Vulnerable groups
Branimir Knežević

In any emergency or non-emergency setting, resources must be allocated where they are needed most. To do this, responders need an understanding of which groups are most vulnerable and why, as well as how to respond to these vulnerabilities.

Whereas some vulnerabilities related to medical reasons (e.g. children and elderly people are more susceptible to certain diseases), some stem from socioeconomic, cultural or political factors (e.g. migrant populations in many countries who are marginalized in one or more ways).

Before, during and after an emergency it is crucial to ensure all vulnerable groups are included in your own and partners' activities. Important steps to working with and integrating these groups into community engagement and tailoring support are:

- identifying vulnerable groups;
- determining access points, e.g. via leaders or influencers;
- identify specific barriers these groups face;
- identify actions to address special needs.

Including vulnerable populations
Vulnerable populations often require different or additional support to their needs. They often include people without access to the health system or health insurance, people marginalized within a social system generally, people living in remote areas, and people living in poverty. These existing gaps in equity are often exacerbated during emergencies. A lack of trust between these groups and authorities or majority populations may also cause self-isolation, where marginalized people refuse to receive support or otherwise engage with an emergency response or system.

> It is important to identify groups of special concern and their barriers, then analyze and determine who is best placed to engage these groups. Once barriers are identified, public health professionals must identify actions to address the special needs of the population.

Vulnerable populations and community engagement
Emergency responders must be mindful of the special requirements of community engagement with vulnerable populations, particularly with regards to tailor-fitting response measures to the particular needs of the community.

Whenever possible, community stakeholders and affected people should be included in the process of designing the services meant to address the most urgent needs of the affected population. Mobilizing community resources, especially knowledge of culture and subculture, positively affects the success of an intervention. Involving members of the community, such as community health professionals, can have another benefit: the engagement builds the capacity of those involved as well as strengthens the relationship between the affected community and the emergency responders.

Finally, responders must be accountable to the affected population at all times, by ensuring the availability of appropriate communication channels for improvement of an intervention – such as the beneficiary satisfaction survey (see section on page 46).

Evaluation of behavioural and social sciences interventions
### Christine Prue

Evaluation is a measurement of performance that makes space for recommendations on how to improve further performance. At its core, evaluation is gathering data and information to make decisions but it differs from research data collection as it is focused on decision-making. Programme evaluation is "a systematic collection of information about the activities, characteristics, and outcomes of programmes to make judgements about programme effectiveness, and/or inform decisions about future programming".[10] Thinking about evaluation from the beginning of any programme or response is very important as the goal is to ensure that what is being done and what is expected to be done are aligned.

In the context of social and behavioural sciences, evaluation is an opportunity to engage with audiences and make collective decisions about changes and interventions that will adapt and protect people in need. Implementing interventions, monitoring delivery and effects, refining as needed and reporting results to stakeholders. The challenge of evaluation is ensuring accountability for resources, activities and programme effects and outcomes and this can be integrated through systematic planning of an intervention.

Effective evaluations need to be:

- **Useful**: serve the information needs of intended users;
- **Feasible**: are realistic, prudent, diplomatic and frugal;
- **Properly done**: behave legally, ethically and with due regard for the welfare of those involved and those affected;
- **Accurate**: reveal and convey technically accurate information.

10   Patton MQ. Utilization Focused Evaluation. Thousand Oaks: SAGE; 1997.
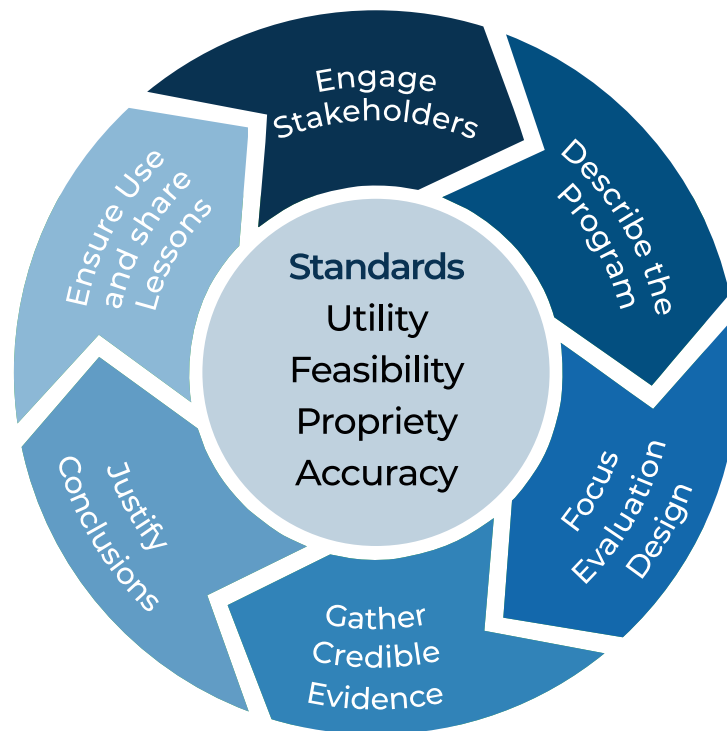
Figure 5 Framework for Program Evaluation in Public Health

Evaluation frameworks

Evaluation frameworks also provide structure to the programme planning and evaluation process. The Framework for Program Evaluation in Public Health (Figure 7), used by CDC,[11] shares features with many widely accepted evaluation frameworks and consists of six main steps:

1. Engage stakeholders
2. Describe the programme
3. Focus the evaluation design
4. Gather credible evidence
5. Justify conclusions
6. Ensure use and sharing of lessons learned.

The second step, describing the programme, is the planning phase and is important because each stakeholder involved has a different perspective on the programme and different priorities and the project should be clearly defined so there is a common understanding across stakeholders.

In this step, a public health professional need to summarize the programme being evaluated, establish common definitions and terms, delineate programme objectives and established the programme's ability to make changes and describe how the programme fits into the larger picture. When describing a programme, it is crucial to include **Goals** outlining what the programme is ultimately trying to achieve, the targets or **Objectives and** the specific activities **or Actions.**

11　CDC. A Framework for Program Evaluation. CDC/PPEO [website]. Atlanta: Centers for Disease Control and Prevention; 2017. (https://www.cdc.gov/eval/framework/index.htm, accessed 16 April 2020).

Through the programme description phase of the evaluation process, health actors develop one common summary of what will be included in the evaluation – and what will NOT be included; establish a common vocabulary; explain what the programme is trying to accomplish and establish the programme's ability to make changes; clarify roles and responsibilities; and how the programme fits into the larger picture, such as community, political and other programmes operating alongside. This process can be supported and structured through the use of logic models.

Logic models

These challenges can be supported by integrating evaluation into programme planning, and this can be done through the use of logic models. **Logic models** are graphic representations of the *intended* relationships of a programme's activities and their *intended* effects and form a disciplined "road map" identifying the substance of a programme and what it expects to achieve. Figure 8 outlines the considerations and steps of a logic model.

Figure 6 Constructing a logic model[12]
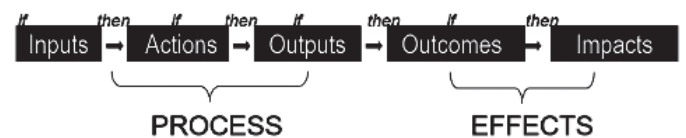
For starting a new program: start with impacts and outcomes (move right to left), and ask "HOW can I achieve the outcome and what is needed?"

For existing programs: start with actions/activities (move to left to right), and ask, "if I do this actoin, what do I expect to accomplish?"

Inputs	Resources used by the activity
Activities	Actions
Outputs	Product(s) of an activity
Outcomes (or Effects)	Results and benefits to programme participants
Impact (or Distal Effects)	Long-term effects and changes in organizations, communities, or systems

12   UN. Sendai Framework for Disaster Risk Reduction 2015–2030, Geneva, United Nations Office for Disaster Risk Reduction; 2015. WHO. A strategic framework for emergency preparedness. Geneva: World Health Organization; 2016.

There are specific categories of evaluation questions to consider when planning a programme. **Process** addresses what is taking place and how is the programme operating. It includes **inputs, actions** and **output**. Inputs include the people, time, budget and supplies required to implement the programme. Actions are the actions taken with resources available, and can include the team developing campaigns and how are they spending time. Outputs are the resulting products of the combined process and activity.

The **Effects** phase includes **outcomes**, which applies along the project continuum and looks at how well intended programme objectives are being met. **Impact** looks at the immediate and long-term progress of the programme in contributing towards ultimate objectives. Together, these factors help identify if interventions are being delivered as planned and are having the indended effects..

Community preparedness and community engagement
Jetri Regmi
Technical Officer for Preparedness at the WHO Regional Office for Europe in the Country Preparedness and International Health Regulations (2005) division

There are strong linkages between community preparedness and community engagement in the development of a resilient community. The concepts of preparedness and community engagement both view and treat the community as the solution and a crucial component of planning and implementation of programmes and interventions, as do the two main documents that guide WHO activity in community preparedness: the Sendai Framework and the WHO Strategic Framework for Emergency Preparedness.[13]

Community preparedness
The Sendai Framework focuses on key priority actions for the reduction of disaster risk, as well as losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of people, communities and societies. This risk reduction is done through the prevention of new risks and reduction of existing risks through integrated and inclusive measures across all sectors (economic, structural, legal, social, health and more) that reduce and prevent exposure to hazards and vulnerability to disaster, while increasing preparedness for response and recovery and resulting in more resilient countries.

The WHO Strategic Framework for Emergency Preparedness builds on the concepts set forth by the Sendai Framework and defines emergency preparedness as the knowledge and capacities and organizational systems developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent, emerging or current emergencies. Using this definition, the framework identifies the principles and elements of effective country health emergency preparedness, built on the major lessons of previous initiatives, and lays out the planning and implementation process by which countries can determine their priorities and develop or strengthen their operational capacities.

Linking preparedness and engagement
Both frameworks are led by the concepts that risk reduction and preparedness lead to resilient communities and that there is overall strengthening and recovery of a community where governments engage with relevant stakeholders, including women, children and youth, persons with disabilities, poor people, migrants, indigenous peoples, volunteers, the community of practitioners and older persons in the design and implementation of policies, plans and standards. Community engagement facilitates and develops an understanding of risks and perspectives, attitudes and behaviours with involved communities that are more accepting to response time frame and measures.

13   UN. Sendai Framework for Disaster Risk Reduction 2015–2030, Geneva, United Nations Office for Disaster Risk Reduction; 2015. WHO. A strategic framework for emergency preparedness. Geneva: World Health Organization; 2016.

Figure 7 Causes and consequences of community resilience (J. Regmi, 2019).
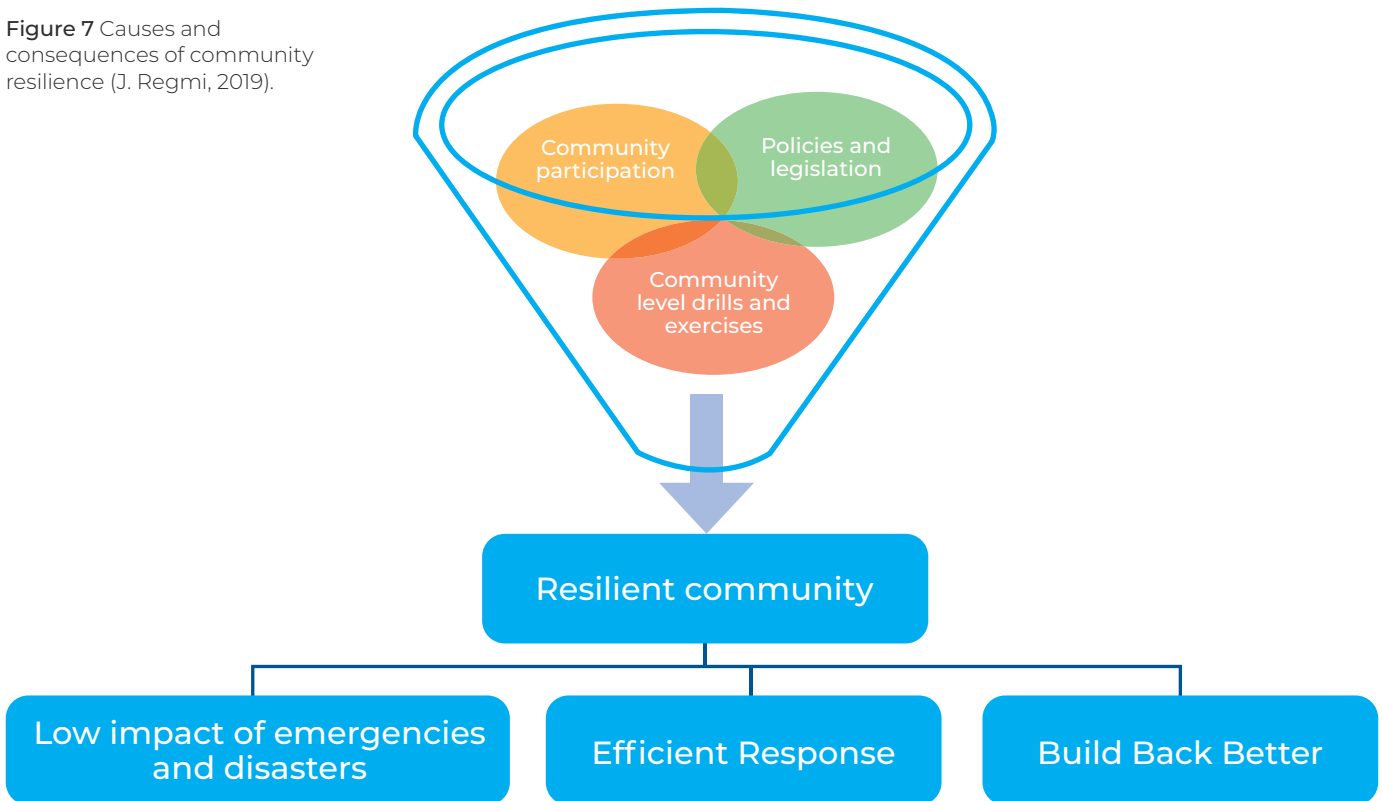
Within the Sendai Framework, it is explicitly noted that there needs to be a broader and a more people-centred preventive approach to disaster risk and the framework introduces the concept of community resilience by discussing a need for focused action within and across sectors by States at local, national, regional and global levels in the four priority areas:

1. Understanding disaster risk.

2. Strengthening disaster risk governance to manage disaster risk.

3. Investing in disaster risk reduction for resilience.

4. Enhancing disaster preparedness for effecting response; "building back better" in recovery; rehabilitation and reconstruction.

The WHO preparedness framework pushes for integrated action to support preparedness efforts. The framework focuses on community and individual preparedness and comprises the basic principles guiding WHO work and outlines three core elements that can be used to design effective plans and that can be applied at policy, strategy and implementation levels. These elements are:

- **governance**, the national policies and legislation that integrate emergency preparedness, response, recovery, and coordination;

- **capacities** and assessments of risks and capacities to determine priorities for emergency preparedness, from surveillance and early warning to development and evaluations to inform and accelerate emergency preparedness; and

- **resources,** including financial resources for emergency preparedness and contingency funding for response, logistics mechanisms and essential supplies for health, and dedicated, trained and equipped human resources for emergencies.

With an engaged and receptive community that is involved in preparedness, response periods and time frames are shorter because the community responds faster. With community engagement, responders can discuss specific hands-on skills and expertise that can be given to the community to create resilient communities and minimize the impact of an emergency or disaster.

Accountability to affected populations and community engagement
Naureen Naqvi

When we discuss accountability to an at-risk or affected population (AAP), whether affected by disease outbreaks or disasters of another source, there need to be in place feedback mechanisms from the affected population on the services provided in order to ensure their needs and rights are being met. From outset of the preparedness process, health professionals need to ensure the engagement and participation of affected communities. It is very important to note that community engagement is a broad area that has many outcomes, one of which is the AAP. From outset of the preparedness process, health professionals need to ensure the engagement and participation of affected communities.

> The needs, capacities, and constraints of a community or group need to be well reflected through the humanitarian programme cycle and the emergency cycle. Being accountable for this, involves engaging affected people in the processes and decisions that have an impact on their lives.

Engagement for accountability requires talking to people and asking relevant questions, learning to read between the lines (a big advantage of using qualitative data), involving affected people throughout the project cycle and letting them know what is going on in ways they can understand, and allowing them to contribute.

Accountability and engagement should happen in a number of forms and levels of programming:

- Leadership and governance
- Transparency
- Feedback and complaints
- Participation
- Design monitoring and evaluation

For every individual context, capacities need to be evaluated and people need to know where they can get information and provide feedback on programmes. Each programme needs to work with the reality of the country it is based in, and these feedback processes should reflect that situation. All activities and decisions should support understanding of the context, culture, customs and beliefs and account for vulnerable populations.

In emergencies and outbreak scenarios, many communities are in need of help and it is difficult to determine which groups have the most immediate need. Depending on the emergency and the focus of the organization or programme, it is not possible to cater to every need of the entire population, and deliberate efforts will need to be made for certain populations. Established and transparent coordination with other organizations and government bodies is important to make sure no one is left behind.

To proceed with accountable programme development, the following play an important role:

- Coordination mechanisms to support transparent leadership and governance of the emergency response must be established to ensure programmes are fit for the community.

- It is essential to break down all processes and make a strong, evidence-based case for programme decisions and direction through transparent analysis and assessment.

- Sound accountability mechanisms and two-way communication channels are crucial, even in the data collection and analysis phase. Professionals should consult the population and ensure disaggregated data is collected and analysed, and that programming appropriately reflects specific needs in objectives in the data and indicators.

- Information should be made available to the community, donors, partners and relevant stakeholders. Based on context, there can be dashboard available to share data collected for accountability and transparency and social media can be leveraged to encourage participation and communication with the population. There are many methods available to encourage accountability and transparency and local resources must always be considered.

- Accountability is further strengthened through monitoring and evaluation processes that involve community input and feedback.

Regional and national case studies – the Red Cross of Serbia
Branimir Knežević

Flooding in Serbia – national coordination and community empowerment

In 2014, Serbia experienced severe flooding that resulted in a very complex emergency across the nation. The flooding caused widespread physical and infrastructural damage. As the disaster was on a national level, there were many actors and stakeholders involved in the response and one of the main challenges that the Red Cross of Serbia (RCS) and other partners faced was coordination within the country with all agencies, the government and other institutions involved. It was equally challenging to manage and coordinate the interests of international partners from abroad including Serbian diaspora who wanted to assist.

Fortunately, the RCS of was well prepared, structured and positioned for such a disaster and the coordination required. The RCS has a strong national presence with a network all over the country and in every community – a key strength that applies in many national branches of the International Federation of the Red Cross. Each branch of the organization is well-integrated into the community and has a good relationship with many community stakeholders.

These relationships and having widespread teams and other resources ready for disaster response and support contributed significantly to successful operations. This is even more the case with national organizations because they will remain in place after the end of an emergency operation. Localization of humanitarian aid is one of the priorities highlighted in the World Humanitarian Summit in 2016 in Istanbul, and the Red Cross is one of the core organizations with the capacity to do this.

Activities within each phase of an emergency require different approaches to working with the community based on the context. In the response phase, when stakeholders and responders are undertaking life-saving activities and providing basic assistance, it is important to talk about and show accountability to the community. Moreover, international donors and international agencies are increasingly trying to engage affected population in the response. When the right of affected people to participate in making decision about their own future is honoured, building resilient communities starts within those communities and they become owners and central actors in solutions to their own problems.

1.5
Training social science and community engagement teams

Melinda Frost
Lead for Risk Communication and Community Engagement Capacity-building for WHO under the Pandemic Influenza Preparedness Framework, WHO Headquarters

Training in behavioural and social science response can address many issues in a community and build skills and understanding about how to address a response. To better integrate responders (especially those from the affected community such as police, health workers and students) it is important not just to undergo training but to also understand training methods, how to conduct a training needs assessment, how to plan, conduct and evaluate training.

Challenges in training and retaining information

As a first step, responders must understand the learning process and how people absorb, process and retain knowledge during learning. An audience may completely miss a message or an important piece of information because humans are wired with selective attention: without continuous review or regular application of new knowledge, we forget half of the information we learn in just a matter of days.

Studies and models, such as the Ebbinghaus forgetting curve, demonstrate the decline of memory retention. The stronger the memory, the longer period of time that a person is able to recall it. A typical graph of the forgetting curve shows that humans tend to halve their memory of newly learned knowledge in a matter of days or weeks unless they consciously review the learned material.
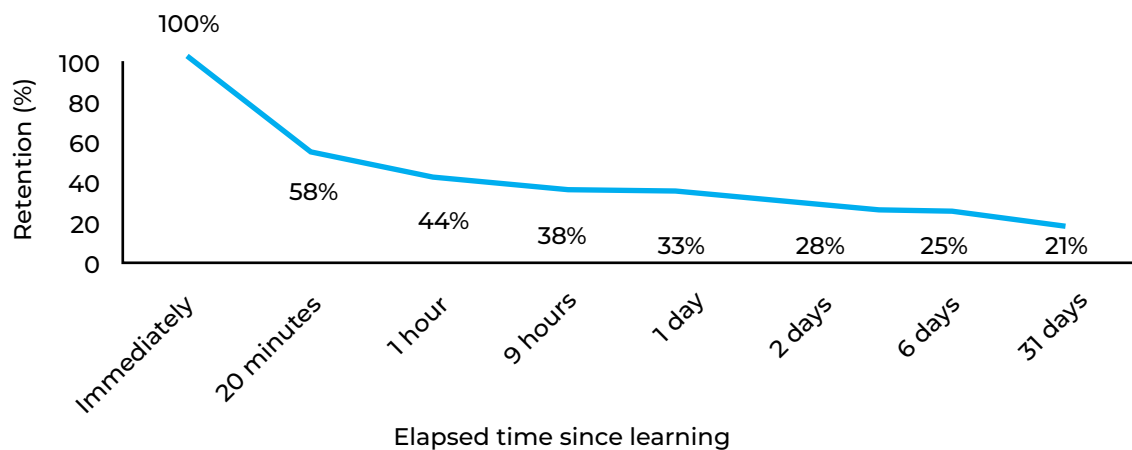
100%
100
80
60
58%
40
44%
20   38%   33%   28%   25%   21%
0

Retention (%)

Immediately   20 minutes   1 hour   9 hours   1 day   2 days   6 days   31 days

Elapsed time since learning

Figure 8 Ebbinghaus forgetting curve[14]

The brain can multitask and process a great deal of information but it does not always capture everything. So, to get the key points of a message across, it is important to make messages memorable, use different channels and spark attention. The brain processes words much faster on the thinking level than on the speaking, listening and reading levels and people are often thinking about something else instead of, or in addition to, specific messages. This is called marginal listening, passive listening or fake listening and is a major challenge in audience attention and message retention.

There is also a connection between sleep and memory: the more you sleep, the more you remember. According to the CDC, 1 in 3 adults do not get enough sleep, which can significantly affect information retention, and naps or rest in general can increase memory performance.[15]

Solutions to training in the community
To facilitate information retention in our audience, it is helpful to use various approaches:

• Multisensory learning increases memory retention so consider new approaches to communication outreach efforts. When people have something to do, even if it is to call a number, visit a website, be vigilant, etc., they tend to remember messages better.

• People tend to remember the first thing and the last thing they hear, and often forget what is said in the middle.

• Compelling, new or surprising information aid memory; this can take the form of a surprising statistic, a story or an analogy. People also understand and retain information if there are regular "breaks". Present one idea at a time and take physical breaks if possible. This could mean presenting an idea and inviting questions or reflections before going on to the next.

• Memories are stronger when associated with an event or "episode". In communications, "episodes" can be created by making connections between our messages and relating/associating them to personal experiences or to existing/known information (of our own, or our audiences). We can do this by using stories, analogies or facts that our audience can associate our messages with.

14   Wikipedia contributors. Forgetting curve [website]. Date of last revision 16 April 2020 11:30 UTC. Wikipedia, The Free Encyclopedia. (https://en.wikipedia.org/w/index.php?title=Forgetting_curve&oldid=951280818, accessed 17 April 2020).

15   CDC. 1 in 3 adults don't get enough sleep. In: CDC Newsroom [website]. Atlanta: Centers for Disease Control and Prevention; 2016. (https://www.cdc.gov/media/releases/2016/p0215-enough-sleep.html, accessed 17 April 2020).

Going out into the community
Quick tips on designing effective training:

Define the gap between actual behaviour and desirable protective behaviour: your training should address that gap in a way that is acceptable and appropriate for the trainees.

Figure out the best way your participants learn, and a convenient way to deliver the training.

Structure the content: test and try, provide content in steps.

Observe and adapt.

1.6
Risk communication

Cristiana Salvi
Programme Manager, External Relations, Health Emergencies and Communicable Diseases, World Health Organization Regional Office for Europe

Simon van Woerden
Risk Communication Officer, Health Emergencies Department, World Health Organization Regional Office for Europe

Emergency risk communication (ERC) is the real-time exchange of information, advice and opinions between experts or officials and people in an emergency who face a threat to their survival, health or economic or social well-being.[16] By doing so, risk communication lets people take informed decisions to prevent or minimize the negative impact of the threat. ERC is an interdisciplinary effort, relying to an important extent on risk and behaviour change communication, community engagement and accountability to affected populations, and social science research methodologies and interventions.

Emergency risk communication (ERC) is a public health intervention during outbreaks and health emergencies and is a core capacity under the IHR (2005). Recent global health emergencies have proven that effective ERC shortens the time required for emergency control and ensures that affected communities receive the information they need as they need it.

Communication: four core capacities for trust in the emergency lifecycle

Effective risk communication requires trust: between all key stakeholders, communities at risk and the public health responders. If trust is high, communities are far more likely to follow responders' recommendations. They are equally more likely to share their concerns and needs, and responders in turn are more likely to take these seriously. All of these dynamics accelerate and improve the response.

In the model developed by WHO's Regional Office for Europe, trust is a function of four core capacities, each of which plays a different but equally important role in building trust:

1. **Transparency and early announcement of a real or potential risk**

   Providing timely information about a real or potential risk, its management, any gaps in knowledge and what is being done to address these unknowns allows at-risk communities to make informed decisions and hold responders

16   WHO. Risk communication: Frequently asked questions. In: WHO/Risk communication [website]. Geneva: World Health Organization; no date. (https://www.who.int/risk-communication/faq/en/, accessed 17 April 2020).

to account, which bolsters trust. As the emergency unfolds, authorities and responders must continue to transparently update available information to maintain trust.

2. **Coordination of public communication**

   Contradicting messages from authorities and responders creates confusion which damages trust. Coordinating public communication with response partners can prevent this; for example by establishing and using standard operating procedures and information release protocols, as well as multisectoral working groups and ERC teams before, during and after an emergency. As an added benefit, strong coordination of public communication also improves efficient use of resources by eliminating duplication of efforts, further improving the response.

3. **Listening through two-way communication**

   Trust increases when communities at risk can be sure that authorities and emergency responders consider their concerns and needs and that they understand how community (risk) perceptions, beliefs and practices play a role in how the community responds to the risk. To achieve this, authorities may collect social science data by employing listening and two-

way communication techniques such as mass and social media monitoring, hotlines, focus groups, surveys (including knowledge, attitudes and practices surveys), and feeding analysis of this data back into the response.

4. **Selecting effective channels and trusted key influencers**

   The fourth and final factor in trust relates to information coming from the right channel or key influencer. Because the target audiences have different relationships and more or less trusting attitudes towards different channels and key influencers, selecting and engaging the ones with the highest measures of trust is crucial. Examples of channels are mass and social media, and hotlines, whereas influencers are normally trusted opinion-makers, often part of the community, such as religious or community leaders or trusted professionals such as community health care workers.

   "Best training I ever participated in. It's more than enough to say. Excellent job!"

   SocialNet Participant

Figure 9 WHO Regional Office for Europe's model of trust as a function of four coref capacities[17]
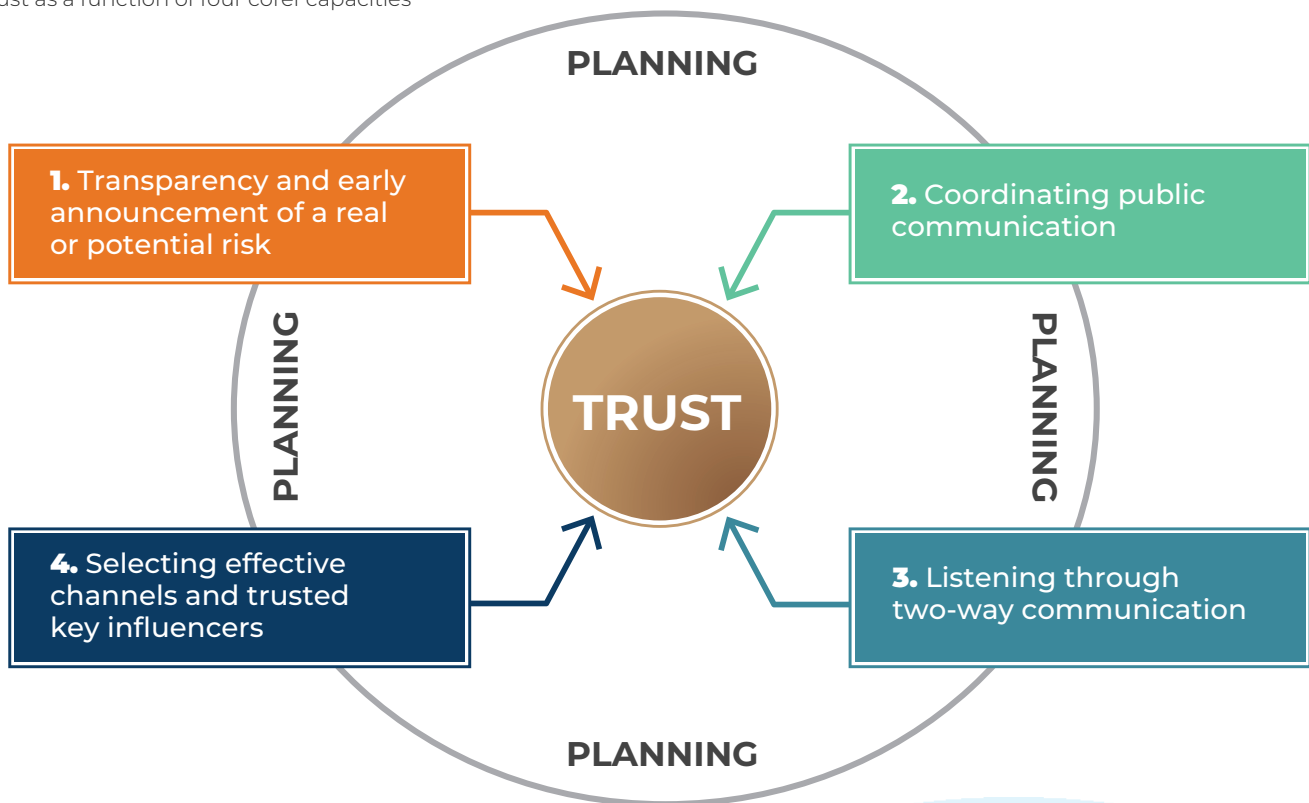
The four core capacities apply before, during and after an emergency in different ways and require different actions from public health authorities, responders and other stakeholders. For example, before an emergency authorities need to invest in preparedness measures such as establishing a trained roster of spokespeople (transparency and early announcement) and setting up systems for mass and social media monitoring (listening through two-way communication); once a crisis develops, the focus will be on activating and using these systems to maintain and bolster trust.

By combining the four core capacities for trust model with the emergency lifecycle model, responders and authorities gain a more detailed understanding of this interplay.
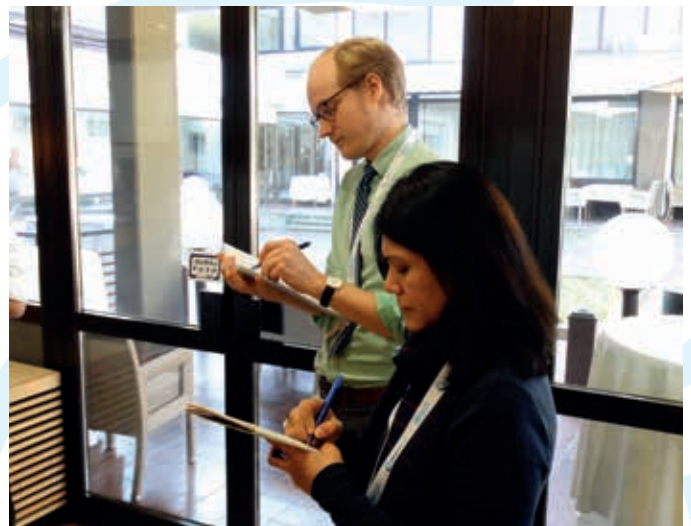
17   WHO. Capacity-mapping package: Four-core capacity method. Copenhagen: WHO Regional Office for Europe; 2018, p. 21.
      (http://www.euro.who.int/__data/assets/pdf_file/0004/380254/02a-erc-eng.pdf?ua=1, accessed 17 April 2020).
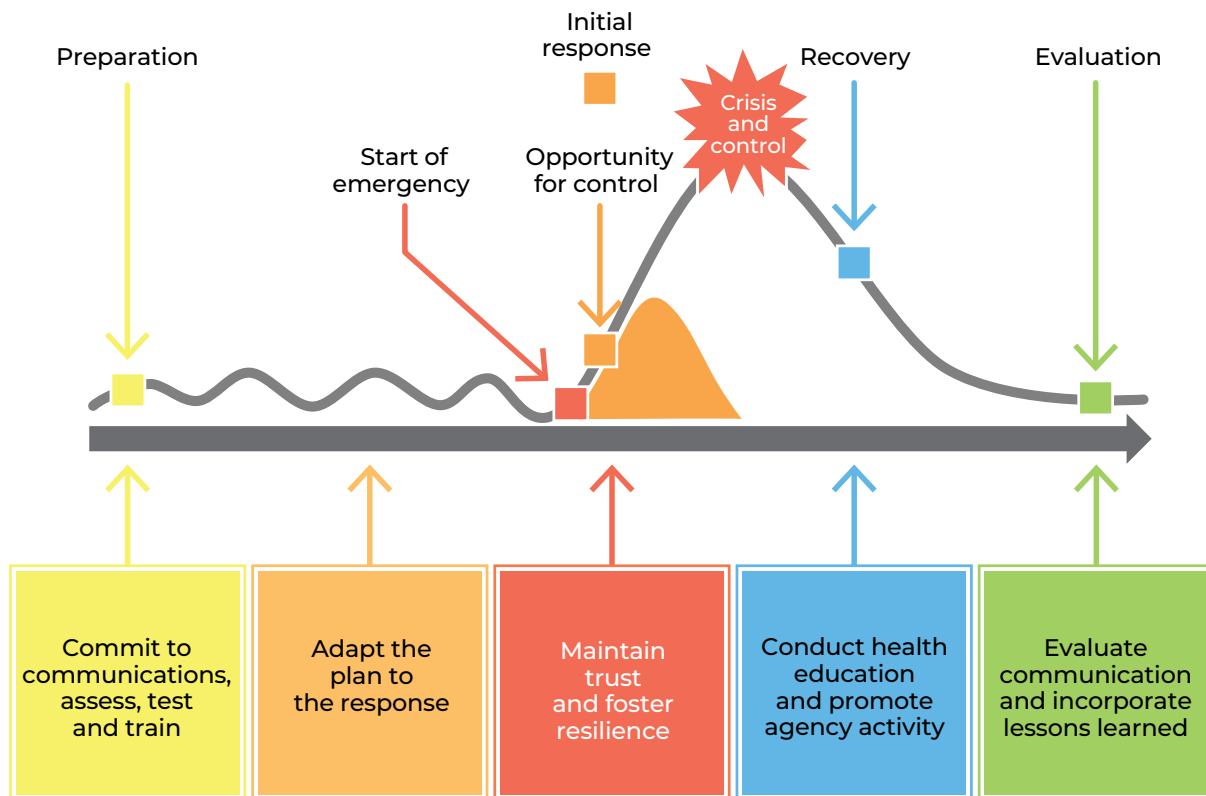
Figure 10 The five phases of the emergency lifecycle and necessary ERC functions[18]

Effective communication: framing your communication and developing messages and materials

To further operationalize the above models, it is important to master a number of key practical concepts or steps that allow for effective communication. These include:

- Communicating for action.
- Conducting a stakeholder analysis.
- Selecting the right risk communication strategy.
- Developing actionable messages.

Communicating for action emphasizes the "why" of risk communication before getting to the "what" and "how". Central to communicating for action is the Single overarching communication outcome (SOCO), which aims to effect a behavioural change in a specific target audience. For example, when addressing an epidemic driven by a respiratory pathogen, a SOCO may be: "People should practice hand and respiratory hygiene and physical distancing". To develop a strong SOCO, communicators need clarity on their issue, on why and how the issue is relevant right now, and on who their audience or stakeholders are.

With a strong SOCO in hand, communicators must conduct a **stakeholder analysis.** Although specifics will vary based on national context, there are four main categories of stakeholders, following two criteria:

- the support for the SOCO among various stakeholders;
- the level of energy invested.

---

18   WHO. Capacity-mapping package: Four-core capacity method. Copenhagen: WHO Regional Office for Europe; 2018, p. 24.
(http://www.euro.who.int/__data/assets/pdf_file/0004/380254/02a-erc-eng.pdf?ua=1, accessed 17 April 2020).

This yields the following overview and graph:

Category	Attitude towards SOCO	Level of energy invested	Behaviour	Communication response
Champions	Positive/agree	High	Visibly, actively support SOCO	Acknowledge, inform, empower
Silent boosters	Positive/agree	Low	Passively support SOCO	Educate, enable, inform, motivate and energize
Avoiders	Negative/disagree	Low	Passively resist SOCO	Inform or ignore depending on their influence on your SOCO
Blockers	Negative/disagree	High	Visibly, actively resist SOCO	Monitor, ignore if not influential; if influential, confront by providing facts and enlisting champions

y = level of activity

x = attitude towards SOCO
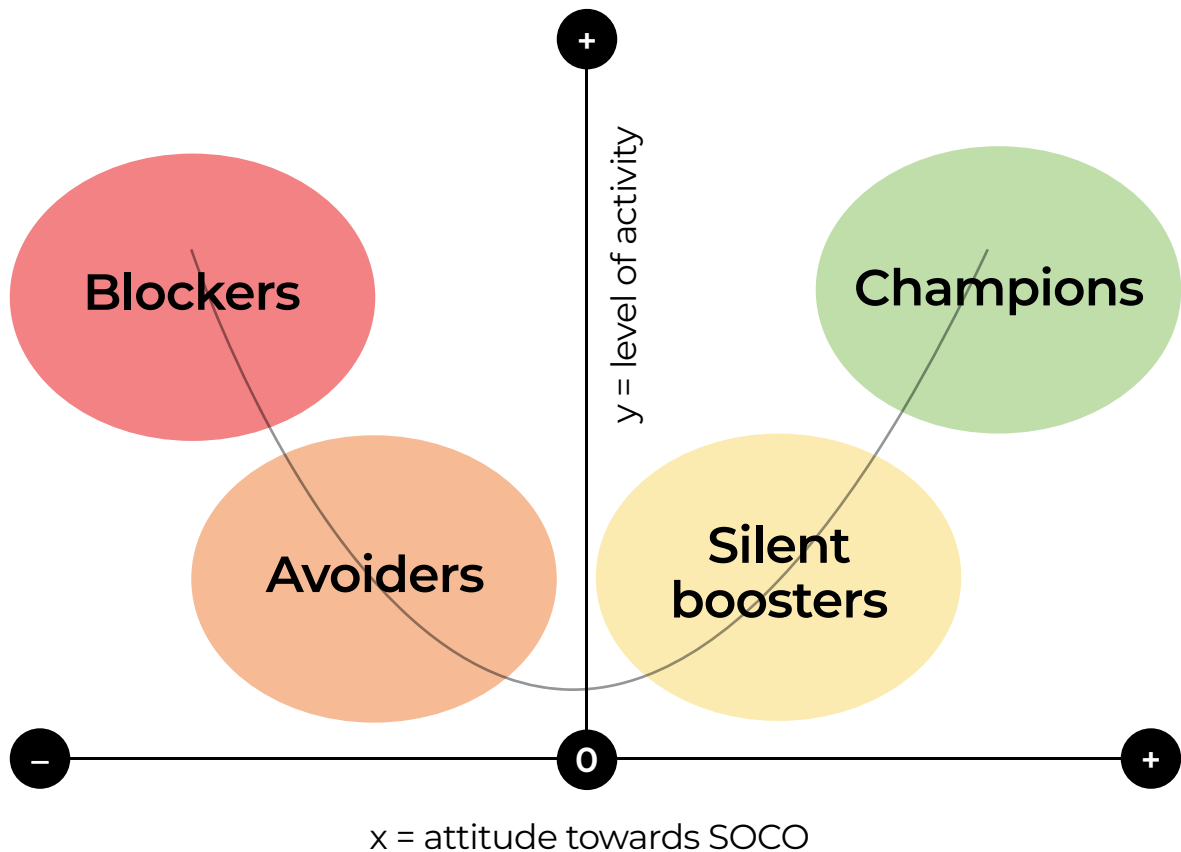
Figure 10 Two-dimensional stakeholder analysis based on (dis)agreement with SOCO and level of energy invested (high/low)

It is important to note that the stakeholder analysis must be periodically updated since groups may change their attitudes to the SOCO and the level of energy they invest over time. Once stakeholder analysis is complete, it is time to **choose the appropriate risk communication strategy**. Based on work by risk communication scholar Peter Sandman, there are four kinds of risk communication following two organizing principles:

- the size of the hazard, which can be understood as an expert risk assessment and is based on magnitude and probability of undesirable outcomes;

- the level of outrage, which can be understood as the public's risk perception. This perception is based on subjective assessments of whether a certain hazard is, for example, voluntary or coerced; familiar or exotic; dreaded or not dreaded.[19]

---

19   The full list of twelve dichotomies (with the lower outrage-provoking qualification on the left and higher on the right) includes: 1) voluntary/coerced, 2) natural/industrial, 3) familiar/exotic, 4) not memorable/memorable, 5) not dreaded/dreaded, 6) chronic/catastrophic, 7) knowable/unknowable, 8) individually controlled/controlled by others, 9) fair/unfair, 10) morally irrelevant/morally relevant, 11) trustworthy sources/untrustworthy sources, 12) responsive process/unresponsive process. Source: Sandman PM. Twelve principal outrage components. In: The Peter M. Sandman Risk Communication Website/Handouts; 1991. (http://www.psandman.com/handouts/sand58.pdf, accessed 17 April 2020).

Risk communication strategies
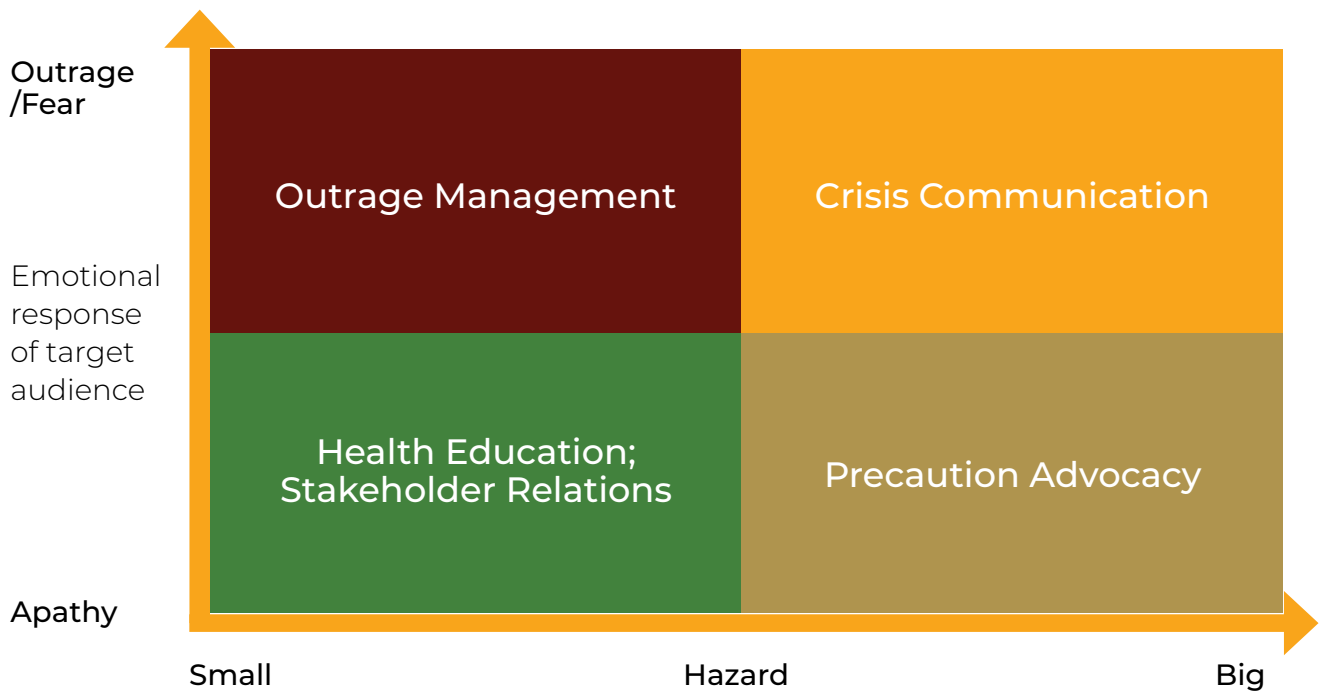
Figure 11 Four main Risk Communication strategies[21]

This yields the following matrix and descriptive table:[20]

Risk communication strategy	Hazard	Outrage	Strategy	Catchphrase
Crisis communication	Big	High	Explain what is happening, deal with emotions	"We'll get through this together"
Outrage management	Small	High	Listen and acknowledge truth, provide facts about lack of danger	"Calm down"
Precaution advocacy	Big	Low	Increase outrage to motivate action, arouse emotions to prevent secondary crisis	"Watch out"
Stakeholder relations	Medium	Medium	Conduct communication surveillance, identify and address	"And what do you think?"

20   Sandman PM. Introduction to risk communication and orientation to this website. In: The Peter M. Sandman Risk Communication Website; 2020. (https://www.psandman.com/index-intro.htm, accessed 17 April 2020).

21   Sandman PM. Introduction to risk communication and orientation to this website. In: The Peter M. Sandman Risk Communication Website; 2020. (https://www.psandman.com/index-intro.htm, accessed 17 April 2020).

CASE STUDY

EBOLA IN GUINEA

At the very start of the Ebola outbreak in Guinea, not many people were familiar with the disease or cared very much – other day-to-day concerns were much more pressing. With a large hazard but low outrage, precaution advocacy was needed to help Guineans understand the seriousness of the situation.

Upon return to Europe, the response team found a completely opposite scenario with an extremely outraged public facing a fairly small hazard – given the low number of cases and strong health systems in the Region. In response to this, outrage management was the strategy of choice. Experts and representatives needed to understand and acknowledge concerns, to help lower the risk perception in line with the risk assessment.

When the response teams travelled back to Guinea, they found alarm in the public coupled with the hazard which was still very high. In addition, the message of "Ebola kills" did not have the intended effect of raising outrage to the appropriate level, but instead fostered an attitude of hopelessness. Guineans were not seeking out health care because they preferred to die at home. In addition, the fact that some Ebola patients recovered caused people to distrust all messaging about the disease, further complicating risk communication efforts. At this point, communications teams utilized crises communications and spoke with transparency, increased coordination and addressed the high outrage and high-risk situation. Within the many phases of an emergency and given various contexts, it will be necessary to adapt the communications strategy to meet the specific combination of community outrage and hazard risk. Despite the differences in the above situations, it is key in all scenarios to both build and rebuild trust and it is important to always state what is known, what is not known, set up an expectation for change in the situation, and to speak with uncertainty and transparency.

Before drafting messages, one more step must be completed: clearly identifying **the point**, which is the main conclusion or core part of the message. The concept of the point is relevant since public health experts normally communicate in a logical, complete, and accurate way to avoid being misunderstood. They provide all the context and arguments before reaching a conclusion. The average audience, on the other hand, listens in exactly the opposite way: they need communicators to get to the point quickly and providing more explanation, statistics, or evidence as necessary.
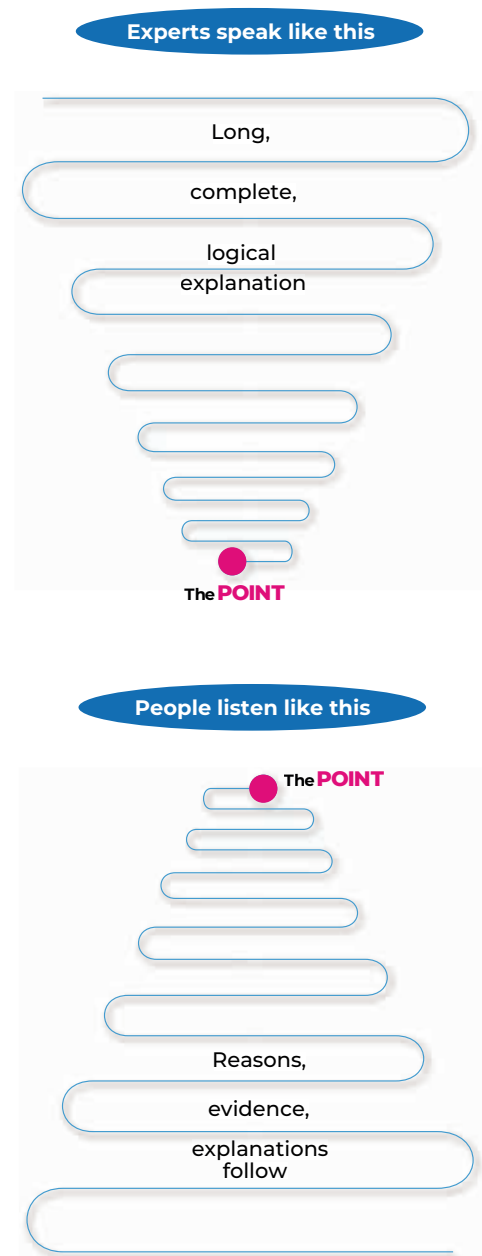

Figure 12 How experts tend to communicate versus how people tend to listen[22]

Get to the point: start with your conclusion or the most important piece of information then back it up with supporting information in decreasing order of importance.

All of these steps are necessary to lay the foundation for **developing actionable key messages.** Good messages follow the acronym of SUCCES(S), meaning that they are:

- **Simple:** give a single message and action, breakdown numbers and avoid jargon.

- **Unexpected:** tap into surprise, interest, shock, revelation or curiosity.

- **Concrete:** be specific instead of abstract, use analogies and examples.

- **Credible:** depending on context this may mean using evidence, using credible spokespeople as influencers, or using a personal angle.

- **Emotional:** emotion, both positive and negative, is a strong motivator to action – following the adage "they may forget what you said, but they will never forget how you made them feel". Emotion can also demonstrate "what is in it" for the audience.

- **Stories:** paint a visual picture to give people something to connect the messages to.

Once drafted, communicators should **test the messages** for appeal, clarity, relevance, appropriateness and effect, using social science research methodologies. Finally, they should **select the right channels and influencers** for their audiences, by making an appropriate and evidence-based selection from all the available options.

CASE STUDY

TRUSTED INFLUENCERS IN GUINEA

Mariana is a 60-year-old woman who takes a 3-hour motor bike ride every morning to various communities in Guinea. She reaches Ebola-affected villages that responses team cannot access because of the high levels of mistrust of outsiders. At 07:00 every morning, she attends the response coordination meetings for the most updated information and them does her 3-hour drive to the villages to talk to them. She not only speaks the common verbal language but also speaks the language of cultural understanding and gestures. She is a trusted influence and is the only way that people in these rural areas can develop a trust of the messages. In order to reach out to stakeholders, you must understand who influencers are and mobilize them.

22   WHO. Effective communications participant handbook. Geneva: World Health Organization; 2015, p.14.
(https://apps.who.int/iris/bitstream/handle/10665/249241/9789241509466-eng.pdf?sequence=3&isAllowed=y, accessed 17 April 2020).

The Emergency Risk Communication Five-Step Capacity-Building Package[23]

A key tool for building risk communication and community engagement capacity in WHO's European Region is the Emergency Risk Communication Five-Step Capacity-Building Package (Five-Step Package): a unique, sustained and country-tailored capacity-building project developed by the WHO Regional Office for Europe.

The Five-Step Package engages Member States in an iterative process to develop, test, adopt and implement national health ERC plans and integrate them into new or existing national action plans for emergency preparedness and response under the IHR (2005). Eighteen countries of the European Region and Kosovo[24] have begun implementation, and a further 10 countries will join over the coming biennium.

The five steps guide workshop participants through the process of:

1. Bringing response partners together to establish understanding of effective ERC.
2. Identifying shared capacities.
3. Developing a plan for an interdependent response by national, regional and local partners.
4. Practising the plan in simulation exercises.
5. Adopting an ERC plan.

The package builds on previous training in ERC in the Region since 2014. The approach consists of combining sustained technical guidance with the ingenuity of the host country, taking into account the country's assets and ERC structure. The comprehensive package results in an ERC plan that is written by and for national communication responders and is adapted to the country's emergency response system. The five-step package is designed to support development or strengthening of ERC response under the IHR (2005) in line with national approaches and commitment.

The Five-Step Package: challenges and opportunities

Implementing the five-step package has brought to light six common challenges:

1. No, or scarce, dedicated ERC resources in ministries of health.
2. Limited health sector role in hazards other than infectious diseases.
3. Transparency protocols lacking or in need of strengthening.
4. Intersectoral coordination in need of strengthening.
5. Community engagement, listening, message testing and rumour management are weak.
6. Key influencers (e.g. health care workers) unprepared and underequipped on ERC.

In addition, six common opportunities for improvement exist:

1. Updating or developing laws for ERC national action plan adoption.
2. Training and repurposing health promotion staff for ERC.
3. Linking the emergency and health sectors for coordination purposes.
4. Ensuring the ERC plan connects to existing emergency structures.
5. Using existing community engagement expertise from civil society and international partners.
6. Engaging with trusted opinion leaders and influencers.

---

23   WHO. Emergency risk communication (ERC) 5-step capacity-building package. In WHO Euro/Health topics/Health Emergencies [website]. (http://www.euro.who.int/en/health-topics/health-emergencies/pages/whos-work-in-emergencies/risk-communication-in-emergencies/emergency-risk-communications/emergency-risk-communications-tools/national-health-emergency-risk-communication-training-package; accessed 16 April 2020).

24   All references to "Kosovo" should be understood as "Kosovo" (in accordance with Security Council resolution 1244 (1999)).

1.7
Rumour management and misinformation

Maria Fernanda Falero Cusano

A rumour can be defined as circulating information whose truth is still unverified at the time of circulation. Rumours occur for a number of reasons, generally because of lack of sufficient factual information or lack of access to factual information, misunderstanding or misrepresentation, mistrust or fear, too much information, or reasons related to past experiences or cultural beliefs. Most often rumour activity is due to uncertainty and anxiety, and rumours are a way of regaining control and a sense of meaning or certainty in events such as emergencies.

> Ultimately, the rumour mill is primarily an attempt to restore a sense of preparedness and understanding to one's experience by processing and evaluating information through a group.

Rumours and public health risks

Rumours can have catastrophic effects for communities and organizations. They can threaten lives in emergencies, create suffering or anger and provoke detrimental behaviour or violent reactions and may prevent people from making informed decisions. Because of the potentially severe consequences, rumours need to be monitored and managed instead of ignored, and can often provide a form of feedback on actions taken during the emergency. Ultimately, rumours distract from and compete with intended health messages. When it comes to health topics, there can be serious costs to acting on false beliefs and figuring out what is true and acting accordingly is of the greatest importance.

How rumours develop

Communities have their own communication networks and rumours can spread fast and exert a large influence. With the exception of disinformation (false information that is spread deliberately), people generally share rumours for a variety of reasons. These include:

- belief in the rumour's (partial) truthfulness;

- entertaining or novel aspects of the rumour;

- to define oneself by being "in the know" or making others look bad;

- to develop relationships by using information as a currency;

- to feel connected to issues affecting them;

- to explain a situation or an event.

In the context of an outbreak of an infectious disease, there are two important kinds of rumours: those about possible cases (alerts) and those about community explanations of causes.

The strength of a rumour and its persistence is a complex function of anxiety and uncertainty that can occur from internal states of individuals (trait anxiety) or from the outside, as state anxiety or from interactions. The two main factors that influence a rumour are:

- importance of the subject to the individual (how likely do I perceive this rumour to affect my well-being, health, life etc.);

- ambiguity.

Rumour monitoring

Learning about rumours early is crucial to managing them, and rumour monitoring is the best way to identify rumours as they emerge. Monitoring mass and social media information from trusted sources and hotlines and surveys are all key to identifying rumours.

Some issues to consider during rumour monitoring:

- Traditional media monitoring uses keywords to identify reports and stories that do not correspond to evidence. The number of reports or stories published gives an indication of the strength of the rumour, as does the validity of the source.

- Social media can distribute news faster and to a wider audience than traditional news sources. Information can be shared by anyone, is not monitored or moderated and can lead to major questions in quality and validity of the information. It is important to react quickly with widespread use of social media contributing to the spread of misinformation and rumours. For social media, it is important to monitor all sources, identify the outlier stories and information being posted, and analyse the information, commentary and range of the information to develop an appropriate response.

- With information from trusted sources, the community can be engaged through collection of feedback through surveys and focus groups, which can then be analysed to identify unusual stories/rumours and assess the strength of the belief to see how strong the rumour is within the community.

Practically, responders may use a rumour log to track, categorize and prioritize rumours. A rumour log is a sheet with several columns, such as, for example:

- date and time where the rumour was first encountered;

- source (including URL if the rumour was from an online source);

- platform or outlet;

- credibility of the source;

- reach: how large is the actual or potential audience for this rumour, as measured by subscriptions or viewership for mass media, and retweets, views and other metrics for social media;

- short description of the rumour;

- verification: is the information verifiably true or false?

- public health implications: can the rumour discourage people from seeking health care, encourage false cures or contradict authoritative public health advice?

- actions: is a response required and if so, what kind?

Rumour management

Managing rumours involves five steps: monitoring, verifying, analysing, engaging and feedback. This process starts with being more attuned to listening for rumours, holding conversations and listening to identify rumours, verifying the facts behind them and engaging communities with new narratives to counter rumours.

Listen!

Noise

1

Is it a rumour?

- A current circulating story or report of **uncertain or doubtful** truth
- A statementor report **current without known authority** for its truth

YES   **NO**

2

Is is harmful? Risk? Potential bad consequence?

- Be happy
- Keep in your radar

YES   **NO**

- **Meet with your team**
- **Answer and analyse**

- Be happy
- Put out facts quickly
- Continue monitoring

4

3

Is the rumour...
- spreading fast?
- spreading intensively?
- strongly believed?
- percieved as a risk to the people?
- harmful for the affected population?

YES

- **Draft and carry out action plan**
- **Involve all stakeholders, coordination**
- **Engage influencers and communities**

Is rumour calming down?

5

NO   **YES**

- **Continue to engage with communities, collect feedback and review your action plan**
- **Engage sources in cooperative manner**
- **Enhance your action plan with stakeholders**

- Be happy
- Continue tracking
- Review with your team
- Document: case study, article

Listen!
Keep records of rumours

Figure 13 Rumor management (WHO/2019)

Approaching these steps in coordination with other actors and drawing on the expertise of partners and community, including monitoring and collecting feedback from communities, increases the likelihood of successful rumour management. These specific steps can be viewed in detail in Figure 13.

Rumour strategy and preparedness

It is important for public health professionals to be proactive with preparedness when it comes to communication and rumours and to focus on developing strategies to manage rumours. ERC planning must occur well in advance and be a continuous process with a focus on preparedness as well as response. Planning should be sensitive to stakeholders' needs, participatory, responsive to the context and incorporate feedback from affected groups. Preparedness is key – it is impossible to prevent rumours, but it is possible to mitigate the power of a rumour by:

- learning about and understanding the community;
- sharing information and working the solution with the community;
- explaining reasons for decisions taken by organizations;
- providing the opportunity to raise questions and issues, feedback;
- training everyone involved about importance of working with rumours;
- putting a rumour strategy in place, with roles and responsibilities.

Understanding how rumours spread within a community is central to containing them, and often requires defining the target audience and then developing and testing a new compelling narrative to replace the rumour. Once developed, it is important to deliver the new narrative with adapted language and using trusted channels and influencers. Finding the right channels involves:

- identifying the audience;
- reviewing audience access, preferred and trusted sources and influencers;
- considering different levels (national, regional, local) and crisis context;
- working in coordination with partners;
- using various channels to collect feedback;
- looking at what is working:;
  - existing surveys and field research;
  - experience from partners and networks;
  - best practices from projects and associations;
- monitoring to see if the new narrative is heard, understood, believed and applied;
- conducting a listening and dialogue process if having little success with the previous steps.

Risk perception

Once a strategy has been developed and the new narrative has been released, it is important to continue monitoring and managing rumours and the information that has been shared. Ultimately, it is perception, rather than fact, which drives public action and a continued focus on risk perception of the community is crucial to the success of ERC activities. The public or community at risk will view the risk very differently than the experts communicating and developing messages from an informed and unaffected standpoint, and it is extremely important to approach messaging and communications from the community perspective, involving them and engaging them in the management of rumours and misinformation (see also Sandman's 12 dichotomies, Section 1.6[25]).

---

25   Sandman PM. Twelve principal outrage components. In: The Peter M. Sandman Risk Communication Website/Handouts; 1991.
      (http://www.psandman.com/handouts/sand58.pdf, accessed 17 April 2020).

Section 2
SocialNet Experience

The theoretical and practical concepts set out in the White Paper section were introduced and practiced during the SocialNet classroom sessions, and further built upon and tested in a high-pressure field simulation exercise spanning two days.

This report section details the SocialNet Experience: all the practical exercises that brought the theoretical lessons to life. It also shows results from pre- and post-tests that show a clear growth in participants' self-assessed knowledge, skills and confidence, as well as feedback on the training content, setup and recommendations for future SocialNet trainings.

2.1
Workshops

The SocialNet workshops took place over the first 3 days of the 5-day training session and were specifically developed to build and reinforce important skills for public health professionals and emergency responders or potential deployees. Each major session and technical topic has been summarized as a white paper for review in the first section of this report, and the following section outlines the complementary activities that took place within these plenaries and sessions to help attendees apply their knowledge and skills within the context of the simulation exercise and their own experiences. Depending on the topic and content, various styles of activities were conducted, from guided group discussions to more immersive role-plays based on ongoing development of the simulation exercise scenario.

Each session was designed around specific learning outcomes, and dynamic group activities were used to guide and support teams in their delivery of specific outcomes. Throughout the course, there were multiple forms of assessment, evaluation and opportunities to provide feedback to participants, course mentors and facilitators. A key component of training was the facilitator evaluation of participants and for each session, facilitators focused on pre-selected WHO core competencies adapted to the SocialNet context; each session's learning objectives were also connected to a number of specific relevant competencies. The complete table of competencies can be viewed in Annex 3.

SESSION 2:
COMMUNITY ENGAGEMENT

NAUREEN NAQVI

SocialNet application of concepts

Following the plenary presentations and case studies, attendees received a situation update and emergency briefing related to the training and simulation exercise pandemic scenario, and participated in breakout group work.

This exercise guided participants through the application of various concepts learned throughout the sessions on community engagement. As a result, participants were able to develop and apply skills that enabled them to describe partnerships and collaboration for community engagement, identify the potential impacts on the response of gender, ethnicity, political affiliation, history, beliefs, health seeking behaviour, and identify next steps for meeting with the community, including potential information resources and needs of key communities.

> "I found this training very enriching. I liked the structure of the training as well as the way the presentations and activities were led by the presenters. As for me, I really appreciated getting to know the experts from different fields of work and getting to work with them and gaining some experience thanks to them."

Community briefings

This group work was structured as group rotations to conduct briefings with members and representatives of the response, donor and affected communities. Each group worked together to develop talking points and an action plan for initial engagement with the community that needed to include what information the affected community needs to know, who in the community the team wants to meet with, in what order and any other information they want to know from the community.

After the scenario, role-players and facilitators provided overall feedback on ways participants could better prepare for and approach briefings and initial engagement opportunities, as well as ways to take initiatives to help get necessary information back from the community. This included tips and insights on how to integrate diverse and sometimes opposing perspectives from many stakeholders to identify meaningful information, common goals and find compromise with members of the community. Finally, facilitators noted that it is always important to identify what we can provide to the community and what they can provide, as well as being mindful of our behaviours and how we present ourselves and interact. As humanitarian actors, it is our job to be prepared and be aware at all times.
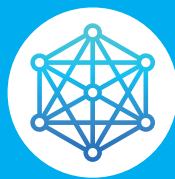
SESSION 3:
DATA COLLECTION

CHRISTINE PRUE

SocialNet application of concepts

The goals of the session were to enable participant to understand and describe the types of data collection methods, differences between quantitative and qualitative data and identify which types are best suited to various situations. Through activities, groups were asked to lead and practice various methodologies, including focus group discussions, conducting intercept interviews and key informant interviews, and, ultimately, to demonstrate the ability to create a record of the qualitative data collected.

Focus group discussion

The first activity was a focus group discussion following guides provided by the organizers and the information provided in the plenary session. These guides included content relating to the continuing emergency situation in the simulation exercise and integrated updates to the scenario and new information provided by the incident manager. Two groups alternated roles responding to and moderating to practise both the facilitation of this data collection method and understand the respondent perspective with more objectivity.

Interviews

The following exercise tested understanding and application of KAP surveys and interview skills. One set of groups of participants conducted in-depth interviews focusing on influenza prevention behaviours, working to identify barriers and supportive or obstructive behaviours and influences. The other groups conducted interviews on knowledge, attitudes and practices.

Prior to attending training, participants had been asked to conduct an observational review and take note of their observations in travelling to Belgrade related to existing measures and behaviours aims at preventing or controlling pandemic flu. Various participants shared their observations with the plenary group and had an open discussion. As a final activity, all attendees participated in an interactive poll and question session, "Prue's Clues", to examine and review their understanding of the lessons and information disseminated on social and behavioural science functions within outbreak response.

SESSION 4:
DATA ANALYSIS

JOHN KINSMAN

SocialNet application of concepts

The goal of this session was ultimately to introduce SocialNet participants to qualitative analysis data principles to enable participants to learn to analyse qualitative data, list key findings of qualitative data collection, and identify next steps to create an action plan for sharing the data. As a result, facilitators aimed to teach or reinforce groups to use social science data to identify gaps and concerns in the response; use community engagement and risk communication principles to recommend and advocate for social science-informed interventions to address identified gaps.

Analysis of focus group discussions

Following the plenary presentation and discussion examples, attendees conducted an analysis of focus group discussion data using actual transcripts about the influenza vaccine from the Eurobarometer report of the 2009 H1N1 influenza pandemic. Individuals from each team applied the principles of data analysis in their work, carefully reviewing and reading the materials, identifying core themes and codes individually before discussing and combining their findings and developing codes. Teams then created talking points for how to communicate data to different audiences and discussed how to make sense of the data collected and analysed to design interventions for the next stage of the training and simulation exercise. Following the group discussions, participants shared feedback and their thoughts on the process. Many observed that as health professionals, it was challenging to separate their own opinions, knowledge and perspectives from those in the transcripts, and they frequently needed to bring themselves back to a place of objectivity. The consensus was that it takes a lot of discipline to maintain that objectivity, especially when you are an "outsider" or do not have the full context of a situation and a culture.

Participants discussed that when it comes to analysis, different people have different perspectives on deductive and inductive codes and in emergency situations, what a researcher identifies depends if they are dealing with a situation inside their own country or outside and how well others understand the context. The intervention development process was also reported as challenging as nearly all groups had difficulty narrowing down codes and combining themes, which sometimes complicated the design of the intervention.

It was noted that the group dynamic was crucial to avoiding bias and that when you are an outsider looking at data for a group of people for whom you do not have a context, it is necessary to bring someone from that community into the analysis of that data. What might be remarkable to a researcher identifying codes, with their own prejudices and knowledge, may be unremarkable to someone who has a complete understanding of the context, and vice versa – they will have a different perspective on what is relevant and important. It is also important to remember this in the final stages of data analysis and to validate conclusions by presenting them to local people.

As a final step, each group briefly presented the interventions they had planned in terms of the public health response and how they were developed. Attendees agreed that small amount of qualitative data can give you so much information to work with. In a survey, you predefine what you are looking for, but in this qualitative data, important themes emerge and appear though the open-ended process.

SESSION 5: INTERVENTION DESIGN CONSIDERATIONS

LED BY VARIOUS FACILITATORS

For the subsessions on intervention design, facilitators presented talks to attendees on the topics of behaviour change, evaluation, community preparedness, vulnerable groups, social media and accountability to affected populations. Groups rotated throughout the six stations, taking the opportunity to discuss the concepts with facilitators and to learn to apply these concepts to their own intervention planning for engaging the at-risk community in the ongoing simulation exercise.

Behaviour change
John Kinsman

The subsession on behaviour change aimed to help participants describe two main theories of behaviour change and identify elements of those theories as found in health education materials on SimEx-relevant issues. Following a brief presentation, Introduction to behaviour change principles and concepts, the groups focused on two primary model – the Health Belief model and the COM-B model of change.

After the presentations, participants reviewed and discussed health education materials developed during an outbreak of H1N1 influenza to identify links to the theories. As a part of group work, each flyer or information poster was discussed to determine how the materials reflected the various theories and how might this be improved.

Participants were asked to identify the main message presented and consider how this is related to the two behaviour change models, and which aspects of the models were utilized, as well as analysing the various strengths and weaknesses and the ability of the image/message to bring about behavioural changes. Team members for all teams reviewed and analysed the efficacy of the various materials, looking at how the materials reflected one of both of the theories of health behaviours discussed and offered perspectives and possible improvements to messaging and content based on their learning.

Vulnerable groups
Branimir Knežević
The goals of the subsession on groups of special concern were to guide SocialNet participants through the identification of potential vulnerable groups needing special consideration during outbreak and the identification of potential actions to ensure groups are included, partner organizations working with these groups and other entry points.

Over the course of this facilitated group, participants discussed special populations that would require additional attention in various settings and events. Facilitators asked group members to consider how different groups are impacted by different outbreaks and emergencies, and to identify actions to address special needs. Groups proceeded to discuss the types of special concerns in each country and how to engage with organizations or individuals working with them in advance of an outbreak, as well as other considerations for reaching special populations. As a result of this session, SocialNet participants were able to identify potential vulnerable groups of special concern and describe how best to engage these groups and respond to needs appropriately.

Social media
Maria Fernanda Falero Cusano
In the breakout session on social media, the facilitator initiated a group discussion on current types of media and the current challenges of social media use at the national level in a number of Member States. Based on these discussions, various alternative methods of using social media were shared, including crowdsourced data and information. Members of the groups shared their own in-country experiences and examples, often speaking of low resources and staffing and a need for alternative channels of information. Many agreed that crowdsourcing could serve as a great alternative in resource-constrained countries, and further help to collect transparent data and involve communities in response.

Following the engaging discussion and brainstorming groups, participants left informed on the current profile of today's social media, and could identify novel and emerging ways social media could be used to gather and analyse data to have a meaningful impact on outbreak response, in particular to the context of the simulation exercise.

Evaluation
Christine Prue
The goals of this session were to guide SocialNet participants through the process of identifying and visualizing the intended outcomes of a specific intervention and list steps in creating a logic model for their intervention, and start on a logic model or intervention in preparation for their simulation exercise.

A presentation was provided to give an overview of the evaluation process and planning requirements, including the key principles of evaluating behavioural and social science interventions; ensuring evaluation is built in to interventions from the beginning, and the introduction of logic model. Groups worked together with the facilitator to develop and apply the concept of the logic model to the simulation exercise, in order to ensure they considered evaluation needs such as process, outcome and impact, in the design and development of community-based interventions.

Community preparedness
Jetri Regmi

This subsession on intervention design considerations focused on community preparedness and the relationship between community engagement and community preparedness; identify existing resources and gaps in participant countries. Participants focused on the role of community engagement in preparedness and resilience, and the importance of building trust and a strong foundation with a community prior to an outbreak or emergency.

After receiving background about essential documents that guide the emergency preparedness process, the Sendai framework and WHO Strategic Framework for Emergency Preparedness, the facilitator and groups went through the scenario for the simulation exercise with its ongoing developments, and worked to identify existing resources and opportunities at policy, strategy and implementation levels, considering the governance structures, national capacities and resources.

Participants identified their role, other roles to be filled and opportunities where connections can be made to strengthen community preparedness. At the end of the session, attendees were able to list opportunities for developing relationships, gathering information and connecting community preparedness with response at multiple levels of community and society.

Accountability to affected populations

In this session, participants viewed and discussed a video on providing accountability to affected populations and how to ensure that community engagement facilitates programme and intervention accountability. This involved defining the necessary roles and responsibilities of affected community, agencies and organizations, and what steps and considerations are needed in the planning and implementation of programmes that involve the community. As a result, participants acquired clarity on their questions regarding accountability to the communities they serve and how to combine accountability and community engagement.

Training exercise

In order to practice and develop training skills, groups were asked to practice training health promoters, who were role-played by other team members; these roles were then switched so all team members had the chance to experience both sides. Following the role-play, participants provided constructive feedback on the experience, including the challenges identified or faced in both roles. This exercise guided participants through the identification of relevant training needs, different training methods for quick impact, and helped guide them in creating a training plan for specific target audience and topic and conducting training for social science and community engagement.

SESSION 6:
TRAINING

MELINDA FROST

SESSION 7:
RISK COMMUNICATION

CRISTIANA SALVI, SIMON VAN WOERDEN AND MARIA FERNANDA FALERO CUSANO

SocialNet application of concepts

Training is an important aspect of behavioural and social science response and this session provided an overview of issues that can be addressed with training versus those that cannot, how to conduct a training needs assessment, planning for training situations and provided tips for conducting training and training evaluation. Following a plenary presentation on how the brain works and the requirements of designing training sessions and training in the field, groups were provided with an inject and asked to create a plan to train health promoters on how to communicate with the affected community about the current situation.

SocialNet application of concepts

A number of exercises were conducted during the session in an effort to review and practice the skills taught. Groups began by working together to identify SOCO relevant to the SimEx response situation. In this situation, the groups discussed the change the team would like to see in the target population, which included identifying the key target audience, the action that they would like to see undertaken in that audience and then develop the SOCO.

Following the development of the SOCO, groups conducted stakeholder analysis to analyse their audience, important key considerations, and to translate statistics and other data of interest to the receiver, meaningful to the audience and helpful in advancing public policy. This exercise preceded an exercise in using the data collected and provided throughout the injects, and in selecting appropriate channels and influencers to reach the target audience. This data includes information collected from focus groups, KAP interviews and requires the understanding not just of the proper channels to use, but identifying who the people trust to deliver messages.

These exercises guided participants through the application of various concepts learned throughout the sessions on risk communications. As a result, participants were able to develop and apply skills that enabled them to describe how to build trust with affected communities, explain the rationale for early, transparent communication and coordination among multiple response agencies, identify steps in determining risk perceptions of affected community, create the SOCO and the appropriate action points for risk communication strategy, and demonstrate ability to manage rumours.

SESSION 8:
SECURITY BRIEFING

APHALUCK BHATIASEVI

Participants received a presentation on numerous topics relevant to field security, including personal and team security, harassment and exploitation, evacuation procedures and tools and resources available for further learning. Additionally, groups were briefed on their core responsibilities when deploying as part of the UN.

SESSION 9:
FIELD ACTION PLANNING

MARIA FERNANDA FALERO CUSANO

A presentation was given on the requirements for a field action plan, including models for coordinated planning for the overall response and how social science deployees contribute to plans, as well as a review of steps involved once deployment begins; teams were asked to prepare plans. This activity required participants to apply all social science work carried out so far to the target population of the simulation exercise. This activity served to connect the whole response with all the learned and developed skills in mind, and groups were able to identify step by step actions to be taken during deployment and collaborate to begin creating an overall plan of action.

"When it comes to design of training and the dynamic during the training, I can only say that the different methodologies used contributed significantly to success of the event. I hope that most of the other participants also valued this approach. In addition to the theoretical knowledge provided to participants, the most valuable part was an effort to put people in a realistic situation on the ground that might happen when deployed as a health professional. The combination of different approaches used during the training was nicely facilitated in a smooth way."

SocialNet participant

Following instructions and time allocated for group work, each team was assigned a specific community and worked to prepare a final community engagement plan prior to their deployment to the field; teams built on their cumulative knowledge from the week. Each team provided a background with relevant information on the country, as well as identifying the primary problem to be addressed, developed objectives and suggested interventions for their community, completed a stakeholder analysis, identified the necessary activities and data collection and analysis procedures, provided a timeline and estimates for human resources and budget, and specified an evaluation process for their activities. The plans closely followed the simulation exercise timeline and were informed by the most recent updates to the scenario.

In a session titled "Dragan's Den" (a playful reference to both the popular game-show Dragon's Den and the first name of the tough Incident Manager character, Dragan Odren), where participants pitch business plans to a critical panel of judges), each group presented their plan to the rest of the SocialNet attendees in a series of four slides and answered rapid-fire questions from a panel of judges on content and further development of their plan. Groups were evaluated based on overall impact for target audience, budget and cost effectiveness, involvement of the target audience in process, the team plan for evaluation of their intervention, and overall presentation/communication skills. Over the course of these presentations, teams had the opportunity to practice and demonstrate their ability to use social science data to identify gaps and concerns in the responses, use the principles of community engagement and risk communication principles to recommend and advocate for social science-informed interventions to address identified gaps, and to communicate their social science data and findings in a concise, clear and timely manner.

Additionally, teams demonstrated an ability to utilize clear internal and external communications and demonstrate their capacity to capture and summarize relevant emergency information to inform evidence-based decision-making.

After all the presentations and question and answer sessions had taken place, presentations were submitted and evaluated by the highly critical judges. A number of criteria guided deliberations, including:

- thorough and appropriate application of principles of risk communication, community engagement and social science;

- demonstration of key SocialNet competencies of communication, teamwork and leadership;

- effective use of resources as demonstrated by a detailed budget;

- compelling speaking skills (including responding to questions) and design of presentation materials.

Based on the above criteria, Team Delta was selected as the overall winner.

SESSION 10: EMOTIONAL INTELLIGENCE AND THE IDEAL DEPLOYEE

**DJORDJE NOVAKOVIC
SIMON VAN WOERDEN**

Emotional intelligence

This session emphasized the centrality of emotional intelligence in emergency response and the importance of developing the ability to recognize and understand one's own emotions and those of others. This ability is crucial for both individual performance as a deployee, is to the overall benefit of the response, and is a key component of leadership.

This activity was structured as a guided mediation and reflection where participants practiced understanding and naming their emotions, and identifying mechanisms and patterns. After defining and discussing emotional intelligence and other related concepts, such as the relationship between awareness and emotion, participants were led through a series of visualizations. The facilitator took attendees through scenarios of happiness to discomfort to grief in matter of minutes to illustrate how easy is to shift emotional state based on our focus, and that focus can be driven and dictated by others unless we manage our awareness. The session closed with a brief reflection and tips on mindfulness, focused awareness and concentration and self-management of emotions.

The overall message was that the trigger to an emotion can be a pattern that we need to explore, identify and manage. Once we understand our triggers, we can address them and learn to relieve stress, communicate effectively, empathize with others and overcome challenges. This capacity is critical when working with communities who are affected or at risk: there might be multiple emotional burdens to cope with, so it is important for deployees to know to which extent they can manage themselves to help others.

The ideal deployee

This session was a group activity, where each group was asked to come up with a visual representation of their ideal social science and community engagement deployee, and present their product to the rest of the SocialNet participants. After 3 days of workshops, discussions, activities and reflection, teams were able to highlight the qualities that they believed to be most important to the success of a health intervention and in general deployment scenarios.
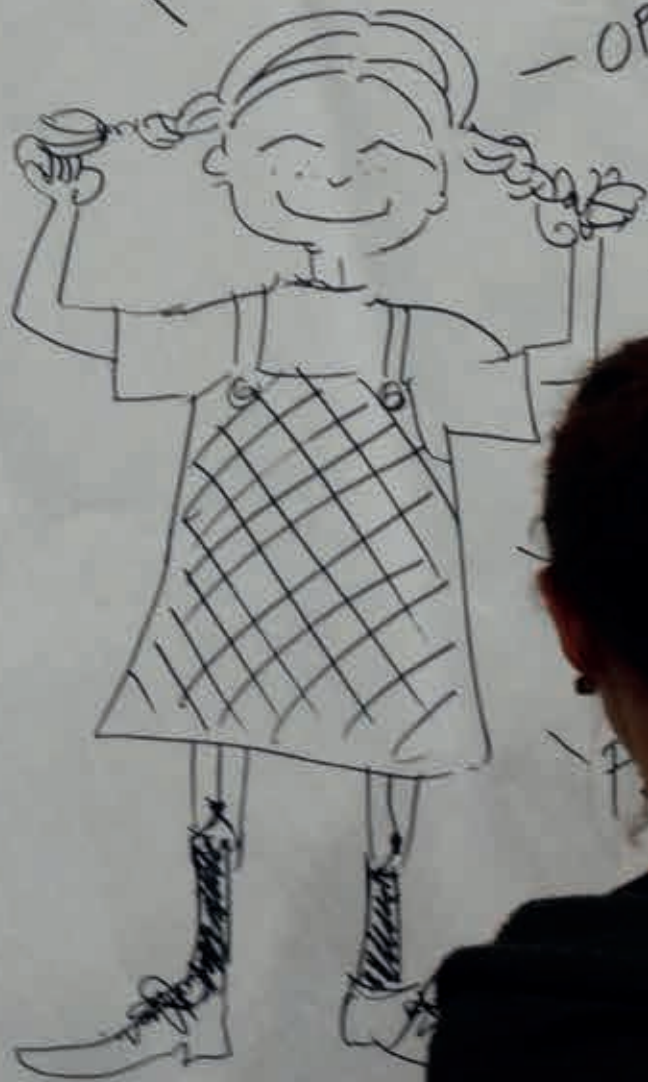
Using flipcharts and various materials, each group listed qualities or drew a picture that showed a combination of the qualities they felt were most important in a deployee. Teams modelled their creativity and communications skills by using detailed metaphors and analogies to make their point – including an orange tree, a smartphone with lots of applications, Pippi Langstrumpf (Pippi Longstocking) and one of the facilitators.

Across all presentations, the qualities mentioned most often for the ideal deployee were: knowledgeable, adaptable, reasonable, flexible, realistic, technically and emotionally intelligent and resilient, professional, driven by a love for what they do, a team player who is willing to learn and teach, compassionate and of course, communicative.
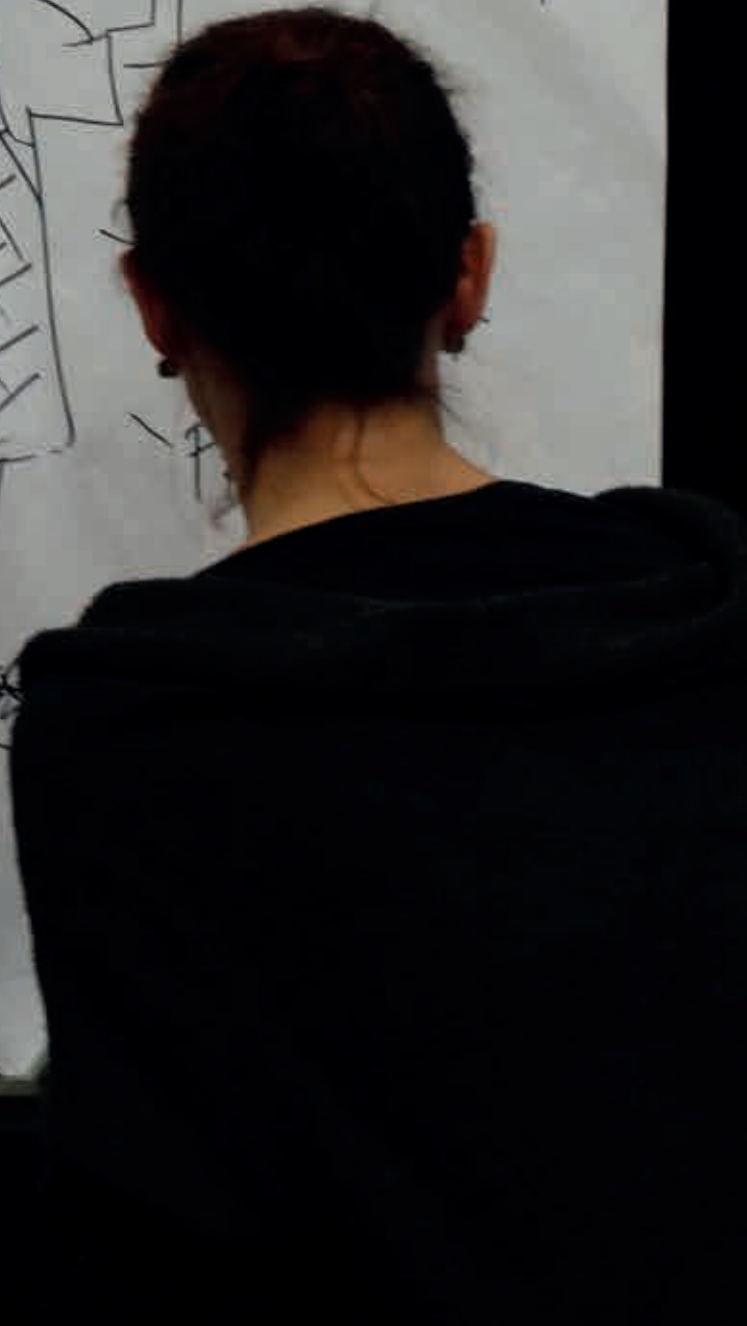
CREATIVE FLEXIBLE
FRIENDLY
&
KIND

—OPTIMISTIC
—LISTENS

—STRONG

2.2
Predeployment

Technical public health/medical (epidemiology, sociologist)

Leadership public health/medical/other (team, unit, department)

Communications or Public Relations

Other

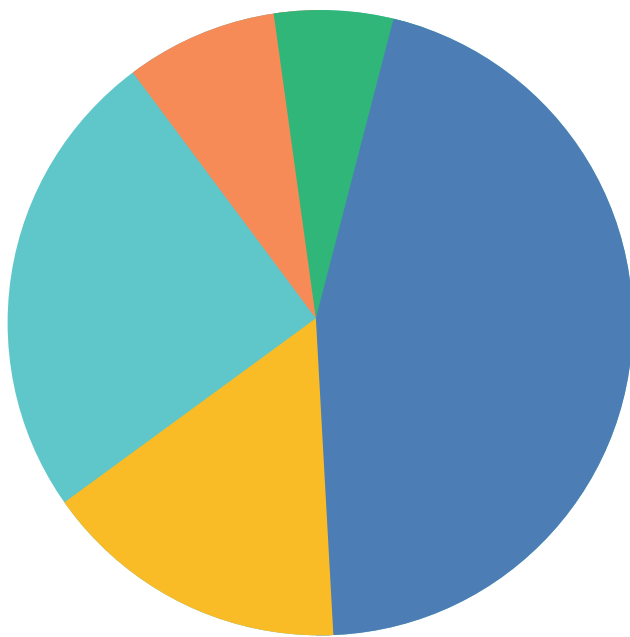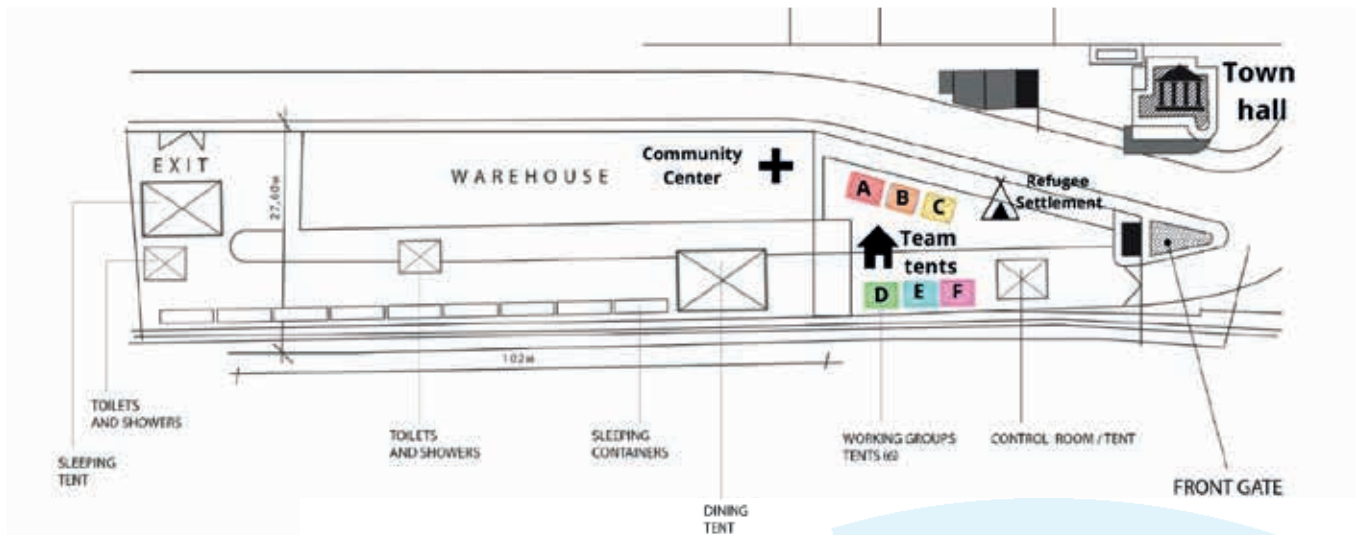Social science specialist (anthropologist, sociologist etc.)

Figure 14 Profile of SocialNet 2019 participants

Prior to the simulation exercise, SocialNet participants were emailed a package of materials for background and review, as well as to set the scenario for the forthcoming 5 days of immersive training, group work and role-play. The package was curated with country and regional profiles for the area where they would be responding, traditional and social media coverage of the emergency as it developed, and WHO recommendations. Participants were requested to complete preparatory online training modules available through OpenWHO[26] and presentations providing an introduction to seasonal, avian and pandemic influenza were distributed to further refresh participants' knowledge and contextualize the emergency.

All participants also received a detailed terms of reference to introduce them to the expectations of their deployment position as risk communication and community engagement experts. Additional materials included a deployment email, introducing participants to the various roles with whom they would be communicating and interacting, and a participant workbook with overviews of training, important WHO and SocialNet competencies and behaviours, and guidelines for the training, to help guide and set ground rules for interpersonal collaboration and allow them to reflect on their own progress and competencies.

26   WHO. Open WHO [website]. Geneva: World Health Organization. (https://openwho.org/, accessed 17 April 2020).

2.3
Simulation exercise

Figure 15 Map of the Serbian Red Cross camp where SimEx activities took place including major role-play rotation stations

"Having deployed to emergencies, I can tell you this training is as close as it gets to the real thing."

WHO Representative in Romania and SocialNet participant

Following the 3 days of intensive plenaries and workshops, SocialNet participants were deployed to the field: a realistic but safe simulated emergency experience developed with the help of the Serbian Red Cross.

This "Hard SimEx" lasted approximately 1.5 days and tested and applied individual technical knowledge gained from the first part of the week, as well as group dynamics and leadership capacities. The pace and length of the days and activities was developed to replicate the intensity and pace of work in a real emergency, with teams engaged and active in intervention strategy development for over 13 hours on the first day.

17.15 - 21.00	Rotation 3					
	✚	🏠	♥	🏠	⚡	🏠
17.15 - 17.45	Project H3.1					
17.45 - 18.15	Team Alpha	Team Bravo	Team Charlie	Team Delta	Team Echo	Team Foxtrot
18.15 - 18.45	Team Foxtrot	Team Alpha	Team Bravo	Team Charlie	Team Delta	Team Echo
18.45 - 19.15	Team Echo	Team Foxtrot	Team Alpha	Team Bravo	Team Charlie	Team Delta
19.15 - 20.00	Dinner					
20.00 - 20.30	Team Delta	Team Echo	Team Foxtrot	Team Alpha	Team Bravo	Team Charlie
20.30 - 21.00	Team Charlie	Team Delta	Team Echo	Team Foxtrot	Team Alpha	Team Bravo
21.00 - 21.30	Team Bravo	Team Charlie	Team Delta	Team Echo	Team Foxtrot	Team Alpha
21.30 - 21.45	Daily Debrief					
21.00 - 21.30	**Evening meeting and evaluation**					

Figure 16 Sample rotation agenda showing how each team moves through three sections of role-play with time for teamwork in between

Injects and scripted and/or guided role-plays were developed and routinely inserted throughout the day to mimic the dynamic, evolving nature of an emergency. These injects dealt with government and high-level stakeholder discussions, as well as engagement and feedback from the community and vulnerable populations. Facilitators, members of the Serbian Red Cross and Red Cross volunteers and community members participated in role-playing, adding an even more realistic element to the scenarios and discussions that took place.

Participants followed regular, structured rotations, punctuating the role-play experiences with group work activities and the live adaptation and updating of their community engagement plans, based on outcomes of recent scenarios. Each of the 12 role-plays had a defined deliverable and outcome, and conversations and plan development were specific to each groups' experiences and direct engagement, as were the timings of additional scenario injects. Different rotation stations represented community religious centres, health facilities, governmental centres or town halls, local migrant communities and team tents for meetings and developing action plans. With each rotation, injects were delivered in various formats and channels to move the scenario along and give team new information to process and integrate into their plans.

“The training was a life changing experience. The facilitators were fantastic. And if there are persons who would like to complain about the pace or sleeping in a tent, then they are maybe not fit for emergency settings. There was not a boring moment and the training was simply fantastic.”

SocialNet participant

Each scenario was developed to give participants insights into real issues they would face and potential conversations, questions and barriers they could encounter in the field, encouraging them to find solutions and think critically how to address these barriers in their community outreach and interventions.

Over the course of the hard SimEx and the group rotations, team mentors remained active and present throughout to help provide immediate feedback after each exercise to help guide teams. Each rotation was structured as a community engagement opportunity for the initial 20 minutes under the oversight of mentors, with the final 10 minutes reserved for questions, assessments and open discussion about challenges and alternatives for real life situations, as well as reinforcement of positive engagement with various communities. Two-way communication was emphasized throughout and mentors were able to provide real-time, tailored guidance to each team prior to their teamwork sessions and further plan development.

Inject H.1.1

Scenario	• Facing increasing media and public pressure, Lamarus reinforces its border by errecting fences with barbed wire, adding visa requirements for an non-Tustrian migrants, and rigorous health checks. • The measures lead to a large build-up of migrants of Tustria's border region, increasing tensions, and cramped living conditions		
Role-players	IM	**Script**	• IM distributes updated SitRep
Scenario	• Absorb the information • Divide tasks ahead of time • Ask clarifying questions if needed		

Figure 17 Sample inject, delivered to participants on the bus to the simulation exercise location

Overview of simulation exercise rotations

Rotation 1: Arriving in the field and non-pharmaceutical interventions

The first of four SimEx rotations focused on immersing participants in the scenario, and focusing their attention on non-pharmaceutical interventions (e.g. social distancing, health promotion, hygiene) as neither a vaccine nor effective treatment was available.

As the bus pulled into the camp, role-players were waiting for the participants and immediately accosted them with outraged questions and rumours ("Are you doctors?" "No?" "Why are you here then?" "Useless!" "Why don't we have the medicines we need already?") forcing participants to apply their newly learned skills. When teams did not substantially engage the communities, they immediately received a scolding email from the incident manager – who of course had heard about this.

Other role-plays in the first rotation included:

- an impromptu interview with a journalist, where teams practiced key techniques in speaking to the media such as bridging, showing emotion, getting to the point quickly, and using clear top-line messages;

- a focus group discussion (FGD) on non-pharmaceutical interventions with community members, where the task included both practising carrying out a proper FGD and analysing notes for themes and patterns;

- a key informant interview with the Mayor to identify additional leaders and entry points for community engagement, which pushed participants to negotiate and find common ground between the response objectives and the Mayor's agenda;

- a meeting with migrant community members to collect inputs for a simple draft KAP survey.

After each role-play, teams retreated to their designated tents to absorb and discuss the new evidence, share experiences and adjust their response plans to the changing situation.

Rotation 2: Pandemic vaccine shipment inbound

After the morning rotation, the scenario made a time jump to where research and development had yielded a successful vaccine. News was shared that a shipment was inbound, and preparatory work had to be done to ensure the medicine could be deployed without delay.

Role-plays in the second rotation included:

- training a group of health care workers to conduct an FGD, which required participants to combine their knowledge of FGDs with pedagogical skills in successfully training a group of people;

- a meeting with the Mayor to discuss and agree on priority target groups for the vaccine, again testing negotiation and presenting a compelling medical and social science argument;

- meeting with a religious leader, the Father Superior of the Uskayrite Brotherhood, to map the specific religious concerns that might spoil efforts to deploy a vaccine in this community.

Rotation 3: Vaccine delay

After two intense rotations, the teams were feeling the pressure but excited that a vaccine was on its way. However, the start of rotation 3 immediately dashed these hopes: the shipment had been delayed for several weeks, right at the time participants had raised expectations with the community. The role-plays in this rotation focused on managing the tension of an unkept promise, and included role-plays on:

- media briefings, to practice engaging journalists as partners in the response;

- meeting with angry community members, to practice emotional intelligence skills, managing outrage, and if successful applying health promotion to reinforce non-pharmaceutical protective measures;

- meeting with the Women's Health Volunteers, to develop a community engagement manual with them as key influencers in the community.

Ministry of Health Republic of Tustria

Overview of H20N20 Vaccination Clinics in Stana Province

Name of clinic	Target population	H20N20 vaccine delivered	Pregnant women	Children under 12	Migrants	Immuno-compromised	Healthcare workers	Other
Tango	20,000	3350	1435	245	684	537	254	195
Squirrel	45,000	7229	3353	750	1232	1014	635	245
Gecko	15,000	1489	630	120	254	267	123	95
Zulu	150,000	967	421	221	50	50	99	126

Figure 18 Sample inject: data sheet on vaccinations per clinic, provided to teams for analysis

Evening programme: Simulating social life in a boot camp

After the last rotation, after over 12 hours of simulations, participants were called to the Dining Tent for a final meeting, which was announced by the IM in grave tones. However, upon their arrival they found an unlikely surprise: the "community" had organized a live music event (a performance by a local folk music group). This provided a hands-on experience of the importance to unwind, bond socially and enjoy healthy coping mechanisms, such as music, with fellow responders in any emergency.

Rotation 4: Vaccine deployment impact and escalating tensions

After spending the night on field beds in a large communal tent or sleeping containers, the scenario jumped ahead another couple of weeks. Vaccine deployment had been ongoing for some time and analysis of vaccination data offered opportunities for adjusting the response.

Role-plays during the final rotation included:

- meeting with health care workers to discuss vaccination data and understanding some key differences in clinic vaccination data;

- meeting with senior experts on the Incident Management Team, to present a compelling argument for the value of social science in emergency public health response;

- meeting with refugee community members, to engage leaders and key influencers and discuss any residual vaccine hesitancy.

"Although it was challenging , after a few days, when my impressions settled, I realized how much I had learned and how much I had improved my skills regarding risk communication and community engagement."

SocialNet participant

EXERCISE   EXERCISE   EXERCISE

EXERCISE   EXERCISE   EXERCISE

Figure 19 Sample inject: security update delivered to teams before the EndEx

"EndEx"
Towards the end of the final role-play, reports began trickling in of angry protestors seen in and around the camp. Participants were told by UN security to remain confined to their team tents until further notice. Finally, a group of armed protestors entered the camp, forcing an evacuation and giving participants a taste of what an intense security situation in the field may look and feel like.

Once the evacuated participants were safely gathered in the central tent, facilitators announced the long-awaited "EndEx": end of exercise, and the signal that participants could pack their things and get back on the bus to Belgrade. The only things that remained were a team and individual debriefing with mentors (see below), a certificate and closing ceremony, and a well-deserved group dinner.

2.4
Evaluation

Materials and methodology

Throughout the course there were multiple forms of self-assessment and evaluation, as well as external mentor assessment and evaluation. This was coupled with opportunities to provide direct feedback to the course mentors and facilitators, as well as other participants and SocialNet organizers.

Table 1 outlines and describes the various techniques for assessment and evaluation used in the course. The methods that will be analysed in this section include the self-assessments and course assessments, as well as content from final mentor evaluations.

"Although the pace was insanely hectic, the overall experience was simply great. Plus: how can we learn emergency response if simulations are wishy-washy?"

SocialNet participant

Table 1

Assessment and evaluation	Description/purpose	Outputs	Impact
Self-assessment test – pre-course questionnaire	A multiple-choice questionnaire will be given out before the course to test the initial level of knowledge, skills and core competencies necessary for the training. The results of this test are confidential	Overview of participant knowledge and skills against the core competencies. This will provide insight for the mentors when following and evaluating the progress of each participant during the course	Better prepared participants with increased self-awareness of skills and competencies needed for emergency deployment
Feedback survey at the end of the training	At the end of the course, you will be asked to indicate your: Overall rating of the course Whether your expectations were met How useful you found each module for your purposes What new knowledge or skills you have developed during the training How you rated the facilitators Other comments	Consolidated results of the survey, presented in the final report in form of infographics	Improved sessions design and facilitation
Final mentor evaluations	Team and subsequent one-on-one conversations with team mentors, to discuss and finalize personal development plans	Personal development plans	Capacity development
Yellow feedback cards for "the box"	Yellow feedback cards will be provided in the plenary session and a box will be available in which participants can deposit any suggestions, requests, concerns or recommendations	Constructive feedback for the facilitators and mentors when planning next activities and tasks	Feedback submitted in an anonymous manner will facilitate more honesty and contribute to facilitator/mentor development
"Mailbox"	Envelopes with names of each participant, mentor and facilitator will be placed on the wall for others to leave comments, suggestions or a friendly note	An individual take-away from the course, intended to highlight strengths or weaknesses, skills and competencies, added value to the teams and strengthen overall relationships between participants	Boosts professional confidence and allows participants to reflect on and reinforce others strengths
Daily mentor debriefing	At the end of each day, mentors debrief their teams to: obtain feedback on sessions, flow, training content, personal experience of the training, etc. evaluate skills and core competencies in the form of an informal conversation/narrative	Narrative/testimonials that will be a part of the event report. Feedback will be incorporated into planning of the next session	Comprehensive input to contribute to the improvement of future SocialNet training sessions, including building interpersonal relationships and supporting participant growth

Daily organizers' debriefing	All mentors and core team share evaluations and debriefing notes from their teams and personal observations	Feedback to improve coming days of programming and training	Tailored training and sessions for specific audiences/participants
"First 3 – Top 3" Takeaways after the first 3 days of soft SimEx	During the third day, each team will be asked to summarize the knowledge and skills obtained and briefly present the Top 3 lessons or skills obtained from the first 3 days. Ideas will be presented on post-its for easy collection and discussion	Narrative/testimonials that will be a part of the event report	Participant recognition of lessons and techniques learned throughout the course/training
"Catch the bug" rapid-quiz	At the end of each session, mentors will throw ball-sized virus/bacteria to a random participant, and give them a quick recap question to answer. Once the participant is done with his answer, he/she will then randomly throw the virus to a next person	Quick summaries of main takeaways and lesson learned from specific parts of the training – rapid recap	Enhanced and reinforced knowledge of participants
Presentations (for the Dragan's Den session)	Informal and interactive presentations where participants have limited time and to present community engagement plans and interventions to a panel of ERC and BSS experts, as well as interact with the audience according to the SocialNet simulation	Introduce quick, clear and concise overviews of community engagement plans, based on cumulative learning from the training. Geared to help participants learn concepts regarding elevator pitches and streamlined messaging, as well as share group work and progress	Direct development of competencies and skills for clear and concise communication and effective and engaging methods for presenting information

Participant self-assessment (pre-course)
Before beginning the SocialNet training course, attendees were asked to complete a multiple-choice, self-evaluation form to answer questions about their existing skills and level of technical knowledge, and self-perceived knowledge and behaviours in keeping with WHO competencies. The assessments were intended to emphasis teamwork, leadership and communications and provide general insight for the mentors when following and evaluating the progress of each participant during the course

Of the 50 participants, 20 completed this initial assessment, providing a baseline of overall initial knowledge in the areas of community engagement, BSS in emergency response, data collection and analysis, ERC and emotional intelligence and interpersonal skills. Participants were also asked specific questions in regards to the understanding of the interrelationships between these areas of work and competencies, including their level of understanding on how community engagement contributes value in health emergency response and how BSS approaches can contribute to the uptake of desirable health behaviour change and health outcomes.

For individual skills related to the simulation exercise and training, the self-assessment also covered:
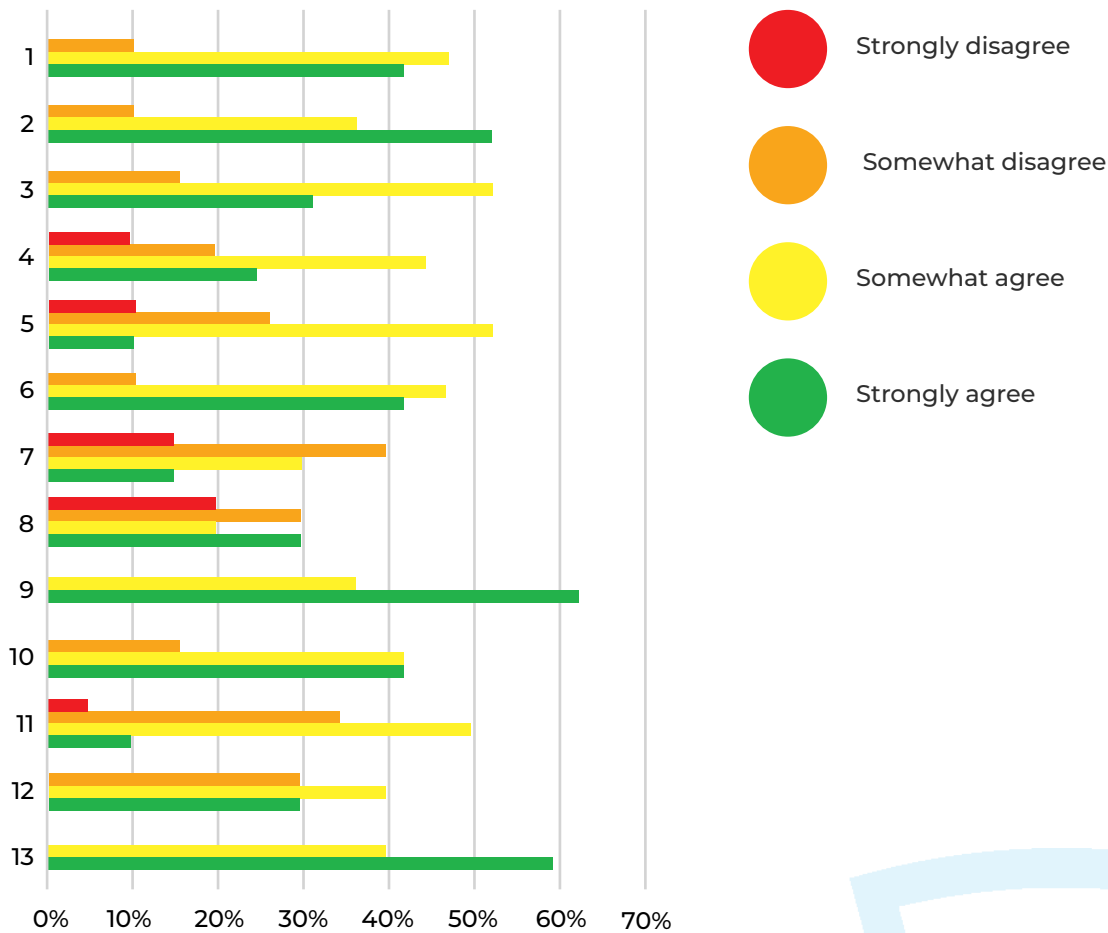
- individual level of ability to describe and consider how different gender, culture, religious or ethnic background or physical ability may result in different experiences of an outbreak;

- designing and implementing qualitative data collection methods;

- implementing risk communication principles and tools to establish the exchange of real-time information;

- advice and opinions between experts and people facing threats to their health, economic or social well-being.

With an emphasis on the status and further development of leadership skills, participants were asked to:

- rate their ability to effectively manage and resolve conflict in a diverse and dynamic environment;

- develop and strengthen relationships with different peers and ad hoc teams;

- recognize and mitigate potential threats to the mental and physical health of others and themselves;

- recognize and engage community leaders and mobilize supporters by building trust and listening to their needs.

Results were varied and participants reported a wide range of knowledge across the various disciplines and competencies. Selected results from this initial evaluation can be seen below, and a more in-depth, comparative analysis is available in the section on the post-course participant self-assessment.

Legend:
- 🔴 Strongly disagree
- 🟠 Somewhat disagree
- 🟡 Somewhat agree
- 🟢 Strongly agree

Pre-training self-assessment

1. I am able to recognize and mitigate potential threats to the mental and physical health of others and myself.

2. I am confident in my ability to develop and strengthen relationships with different peers and ad hoc teams.

3. I can effectively manage and resolve conflict in a diverse and dynamic environment.

4. I can describe and consider how different gender, culture, religious or ethnic background or physical ability may result in different experiences of an outbreak.

5. I know how to apply risk communication principles and tools to establish the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being.

6. I have a clear understanding of how risk communication principles apply in health emergency response.

7. I can design and implement qualitative data collection methods, such as focus group discussions, intercept interviews and key informant interviews.

8. I am familiar with different qualitative and quantitative data collection methods.

9. I understand how knowledge, attitudes and behavioural factors can impact disease transmission and other health outcomes.

10. I understand how behavioural and social science approaches can contribute to the uptake of desirable health behaviour change and health outcomes.

11. I am able to effectively communicate the perspective and needs of the affected community to the response community and other stakeholders.

12. I am able to recognize and engage community leaders and mobilize supporters by building trust and listening to their needs.

13. I understand how community engagement contributes value in health emergency response.

Participant self-assessment (post-course)
Following completion of the SocialNet training, participants were again asked to complete and assessment and re-evaluate their skills and knowledge as a result of the 5-day training. In both the pre- and post-course assessments, participants were asked to gauge their abilities and skills on a four-point scale relative to each statement, from "Strongly disagree" (1 point, minimum rating), "Somewhat disagree" (2 points), "Somewhat agree" (3 points) and "Strongly agree" (4 points, maximum rating). The initial and final answers were compared, resulting in a measure of absolute and relative development in skills and capacity.

Overall, respondents reported a significant increase in abilities, awareness and competencies across all areas evaluated. Weighted values measuring the self-assessed capacities in community engagement, BSS skills, ERC,emotional intelligence and interpersonal skills and showed consistently positive, quantitative results.

All respondents were given the opportunity to reply to questions or add additional information via free-text options and commentary, and the qualitative responses reinforced the data summarized in this section.

Pre   Post
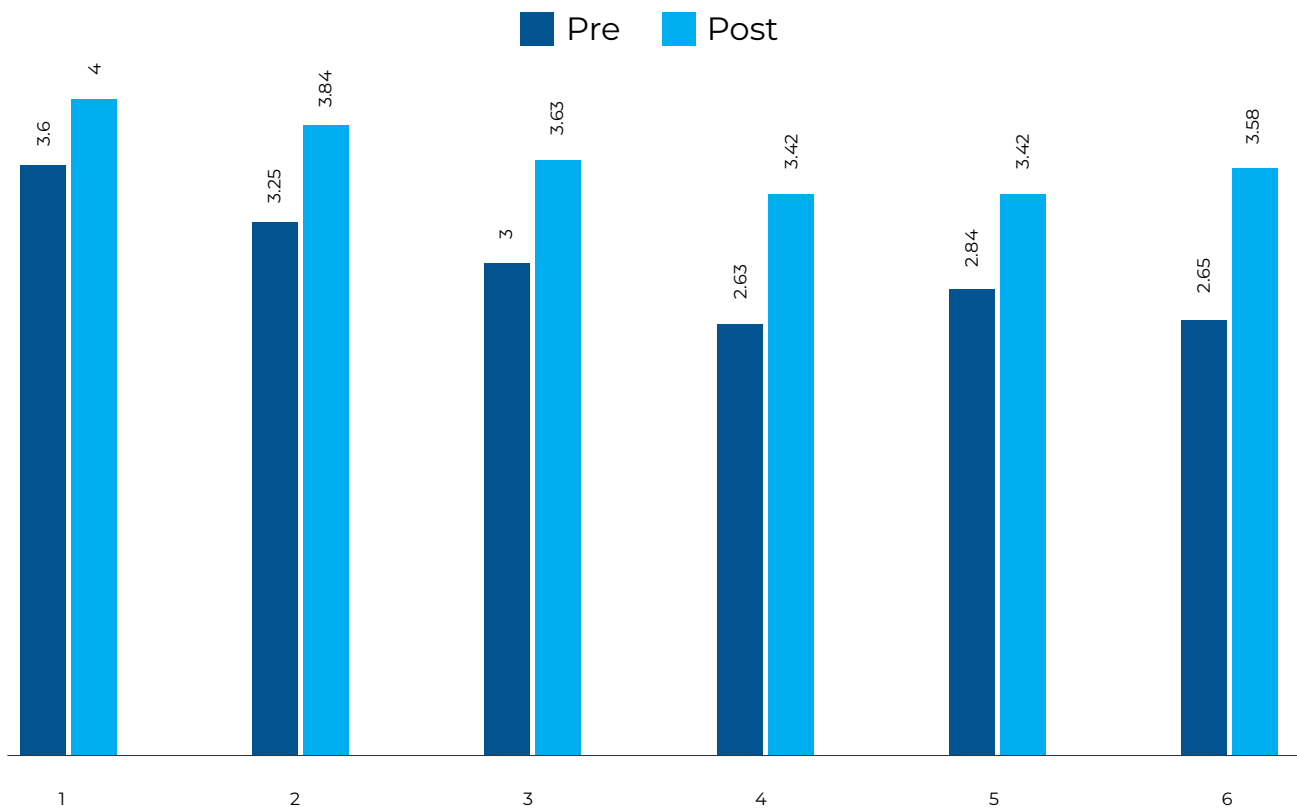
1. I understand how community engagement contributes value in health emergency response.

2. When tailoring communication to and engagement with a community, I consider the perspectives of all stakeholders, especially the most vulnerable, in an equitable manner.

3. I am able to recognize and engage community leaders and mobilize supporters by building trust and listening to their needs.

4. I can develop effective response and programme interventions based on the analysis of behaviours and risk perceptions.

5. I am able to effectively communicate the public health and biomedical response needs to the affected community.

6. I am able to effectively communicate the perspective and needs of the affected community to the response community and other stakeholders.

Community engagement

Within the capacities related to community engagement, values increased anywhere from roughly 10% to 35% (an increase of 0.4 to 0.95 on the 4-point scale) after the simulation exercise. The highest jump in self-assessed skills was seen in skills related to recognizing and engaging community leaders and mobilizing supporters by building trust and listening to their needs, developing effective responses and programme interventions based on the analysis of behaviours and risk perceptions, and effectively communicating the perspective and needs of the affected community to the response community and other stakeholders – all with an average increase of over 20–30%.
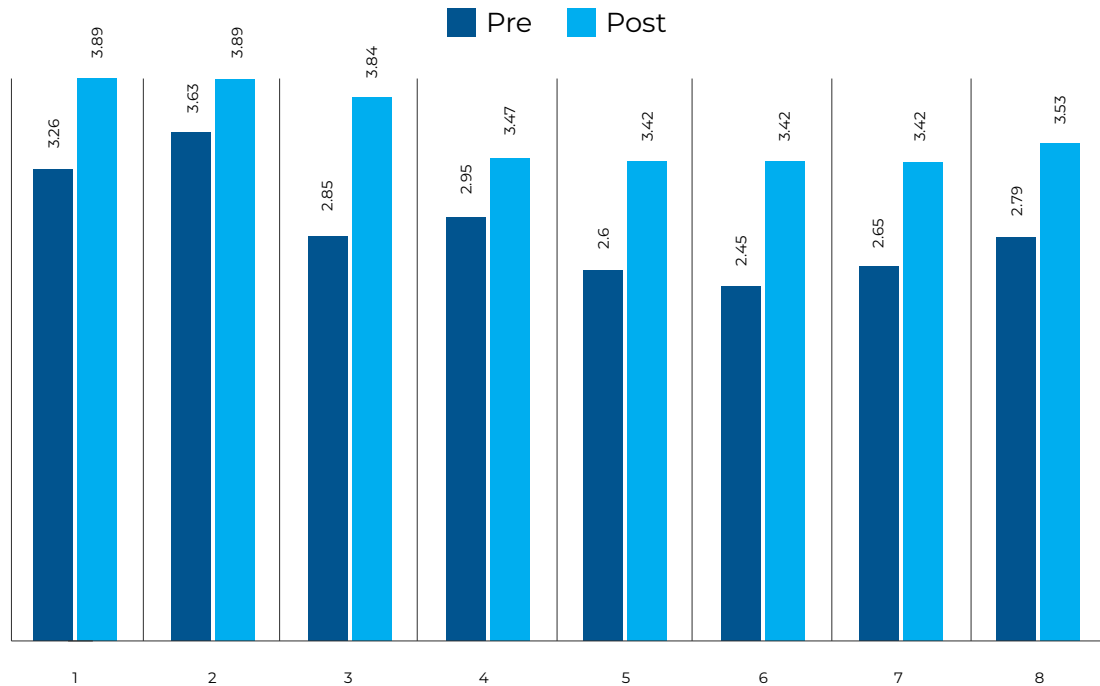
1. I understand how behavioural and social science approaches can contribute to the uptake of desirable health behaviour change and health outcomes.
2. I understand how knowledge, attitudes and behavioural factors can impact disease transmission and other health outcomes.
3. I can describe and consider how different gender, culture, religious or ethnic background or physical ability may result in different experiences of an outbreak.
4. I can explain the differences between qualitative and quantitative data and how each can inform an outbreak response.
5. I am familiar with different qualitative and quantitative data collection methods
6. I can design and implement qualitative data collection methods such as focus group discussions, intercept interviews and key informant interviews.
7. I can analyse quantitative data.
8. I am able to communicate data analysis outcomes in a clear and effective way to different audiences.

Behavioural and social science

Within the BSS competencies and those related to data collection and analysis, values increased anywhere from roughly 7% to 39% (an increase of 0.26 to 0.97 on the 4-point scale) after the simulation exercise. Most respondents noted a marked increase in self-assessed skills related to considering how different gender, culture, religious or ethnic background or physical ability may result in different experiences of an outbreak, the ability to explain different qualitative and quantitative data collection methods and design and implement qualitative data collection methods such as focus group discussions, intercept interviews and key informant interviews. Respondents also showed stronger agreement with the statement that they could now analyse quantitative data and communicate data analysis outcomes in a clear and effective way to different audiences.

Notably, the least change was seen in the BSS area of how knowledge, attitudes and behavioural factors can impact disease transmission and other health outcomes, but this area already had the highest pre-training value (3.63 of 4), and after the training showed a positive increase of approximately +7% from the pre-assessment baseline.

Emergency risk communication

The assessment on ERC skills and capacities was consistently showed increases in all areas, with the highest improvement in the capacity regarding application risk communication principles and tools to establish the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being. While the increase in the other ERC capacities ranged from 12% to 28% (an increase of 0.26 to 0.97 on the 4-point scale) after the simulation exercise, this capacity showed a

reported improvement of almost 40%. Based on responses from the pre-course assessment, ERC was the area of work where a large percentage of participants already had experience or had participated in previous trainings, and seemed the most knowledgeable.

Emergency risk communication skills

1. I have a clear understanding of how risk communication principles apply in health emergency response.

2. I know how to apply risk communication principles and tools to establish the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being.

3. I am ready to work with the media and speak at press conferences.

4. I am aware of and familiar with existing risk communication plans in my country.

Legend: ■ Pre ■ Post
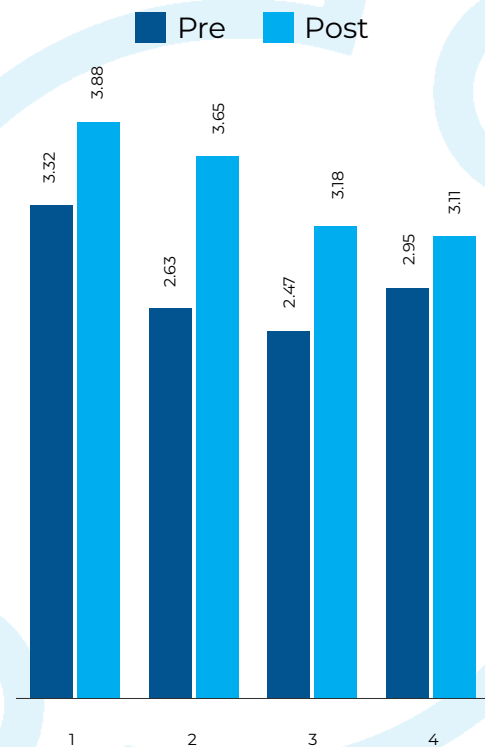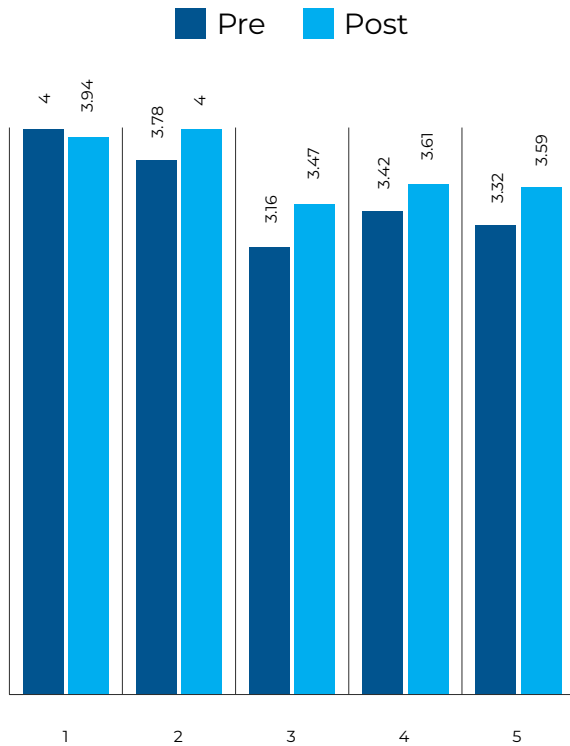
1. I value the input of those around me and learn from their experiences.
2. I am able to recognize and address specific needs of my colleagues by listening and showing empathy.
3. I can effectively manage and resolve conflict in a diverse and dynamic environment.
4. I am confident in my ability to develop and strengthen relationships with different peers and ad-hoc teams.
5. I am able to recognize and mitigate potential threats to the mental and physical health of others and myself.

> "I think we could all see the difference when we came on Day 1 and now as were leaving, not with just technical bits but with real life experience. We can actually feel the change we've had in this week."
>
> SocialNet participant

Emotional intelligence and interpersonal skills

This section is the only one in which one value saw a small reduction. The weighted average for responses went down for the capacity for valuing the input of those around and learning from the experiences of others. This decreases may be due to a variety of reasons, it could, however, show an increased self-awareness among participants who are re-assessing their own actions and engagement. As a result of the training, 100% of respondents agreed strongly with the statement that they could now recognize and address the specific needs of colleagues by listening and showing empathy, followed by strong agreement with capacities related to confidence in their own ability to develop and strengthen relationships with different peers and ad hoc teams, recognizing and mitigating potential threats to the mental and physical health of others, and effectively managing and resolving conflict in a diverse and dynamic environment.

SocialNet training assessment

Following the training, participants were questioned on whether they had found the pre-learning courses useful and adequate, if the information circular contained the right amount and kinds of information for preparation, and whether the information shared during the invitation/nomination process gave a clear and realistic expectation of the training course. Overall, the majority felt that the materials were enough or more than enough to substantiate their learning and provide background to the topics they would be learning about more in depth. This provided a strong platform for the work to be done and allowed the attendees to become familiar with general concepts and prepared them for intensive learning.

Participants answered questions on the content of the session and how it contributed towards their personal growth. These areas included questions and reflections on personal development, professional development and general perceptions on training structure and content. Another attendee acknowledged specific areas of improvement, saying "although it was challenging, after a few days ... I realized how much I had learned and how much I had improved my skills regarding emergency risk communication and community engagement".

■ Strongly disagree   ■ Somewhat disagree   ■ Somewhat agree   ■ Strongly agree
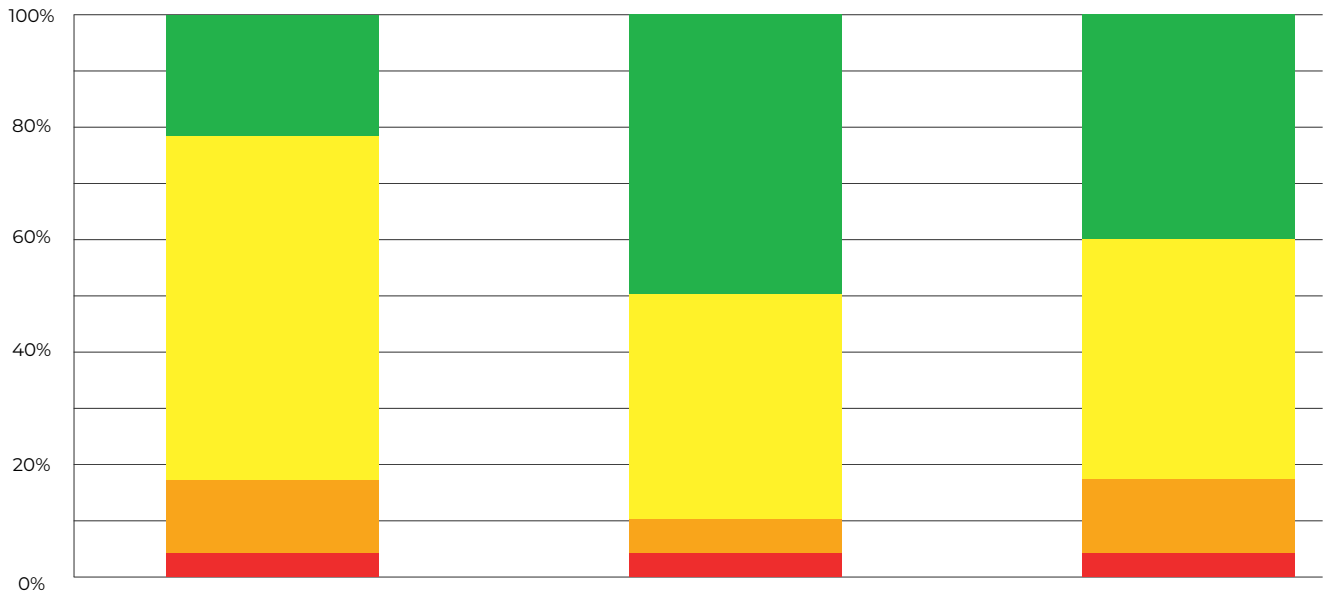
The pre-learning courses were useful and adequate

The information circular contained the right amount and kinds of information.

The information shared during the invitation/nomination process gave me a clear and realistic expectation of the training.

■ Strongly disagree   ■ Somewhat disagree   ■ Somewhat agree   ■ Strongly agree
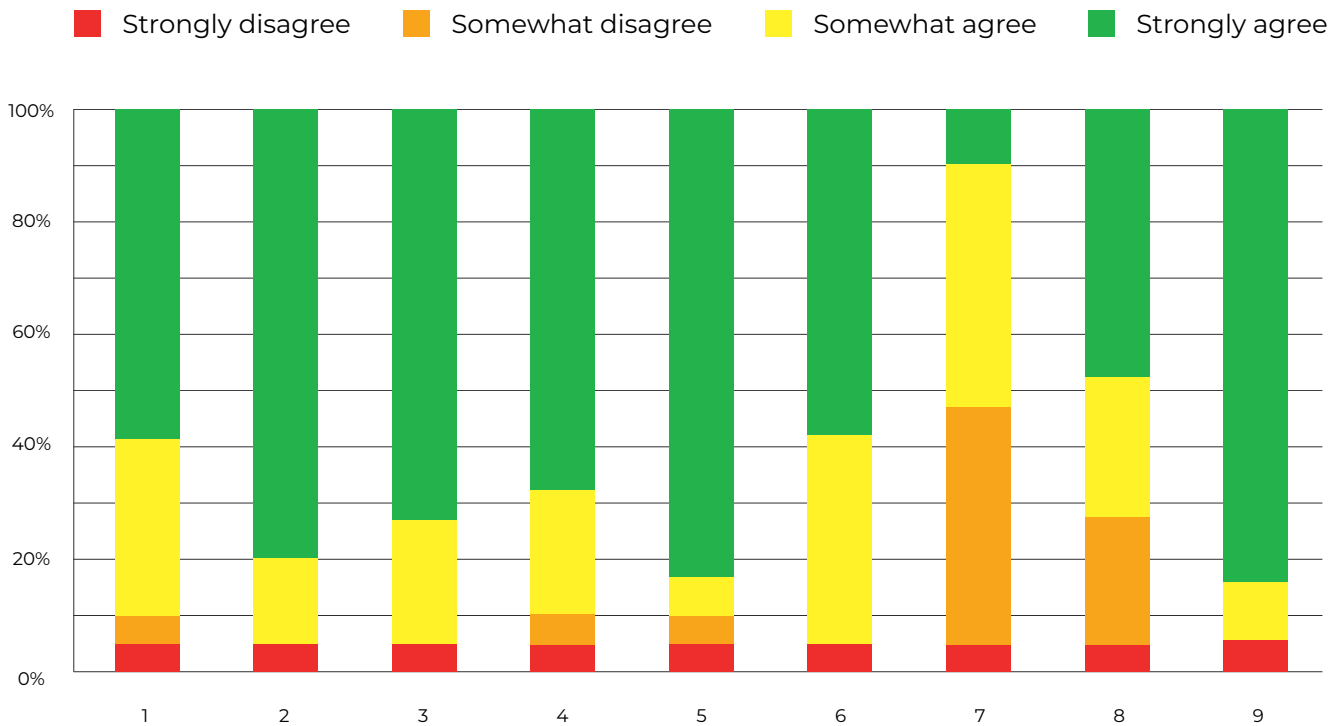
1. The training improved my understanding of my role and function during an emergency response.

2. The scenario was realistic.

3. The training helped me to identify some of my strengths as well as some of the gaps in my understanding of social science, community engagement and risk communication in public health emergency response.

4. At the end of the training, I think we are better prepared for a health emergency.

5. The training was well structured and organized.

6. The classroom sessions were interesting, interactive and relevant for me.

7. The classroom programme was balanced and not too intense

8. The field simulation exercise programme was balanced and not too intense

9. The team mentors added important value and expertise.

Of importance, many participants took the simulation exercise to truly evaluate their level of knowledge and readiness for national or international deployment in an emergency. As one participant shared in the post-training evaluation that the activities required them to step back and take a critical look at their skills, and that the training format was "new, very interesting and interactive. It raised some questions about what I would be able to handle during a real emergency".

"I personally really enjoyed (the teamwork aspect), it was authentic. Suddenly, you are crammed together with all different kinds of people and you need to find a way to work effectively with them. We went through the whole group dynamics and faced some challenges and overcame them – which was a really great experience."

SocialNet Participant

The audience overwhelmingly expressed an appreciation for the direct mentorship, teamwork dynamics, and broadly mentioned the simulation exercise itself and the ability to apply and practice learned skills immediately after the plenaries and educational sessions. Participants noted that they were able to test their boundaries and gain powerful knowledge to help them on the spot, with one stating that the simulation provided an "overall and uncanny chance to test our expertise and I learned a lot more than sitting in a meeting room".

"A very well-organized and worthwhile training: objectives were met, the content was easy to follow, trainers were well prepared, the materials distributed were helpful and the 2-day exercise made the difference."

SocialNet Participant

SocialNet attendees rated the following capacities as a result of the simulation exercise with very positive reviews. Nearly all respondents agreed or strongly agreed with the following statements regarding the field exercise and activities, including application of skills, aspects of teamwork and personal experiences and competencies.

Legend: ■ Strongly disagree ■ Somewhat disagree ■ Somewhat agree ■ Strongly agree
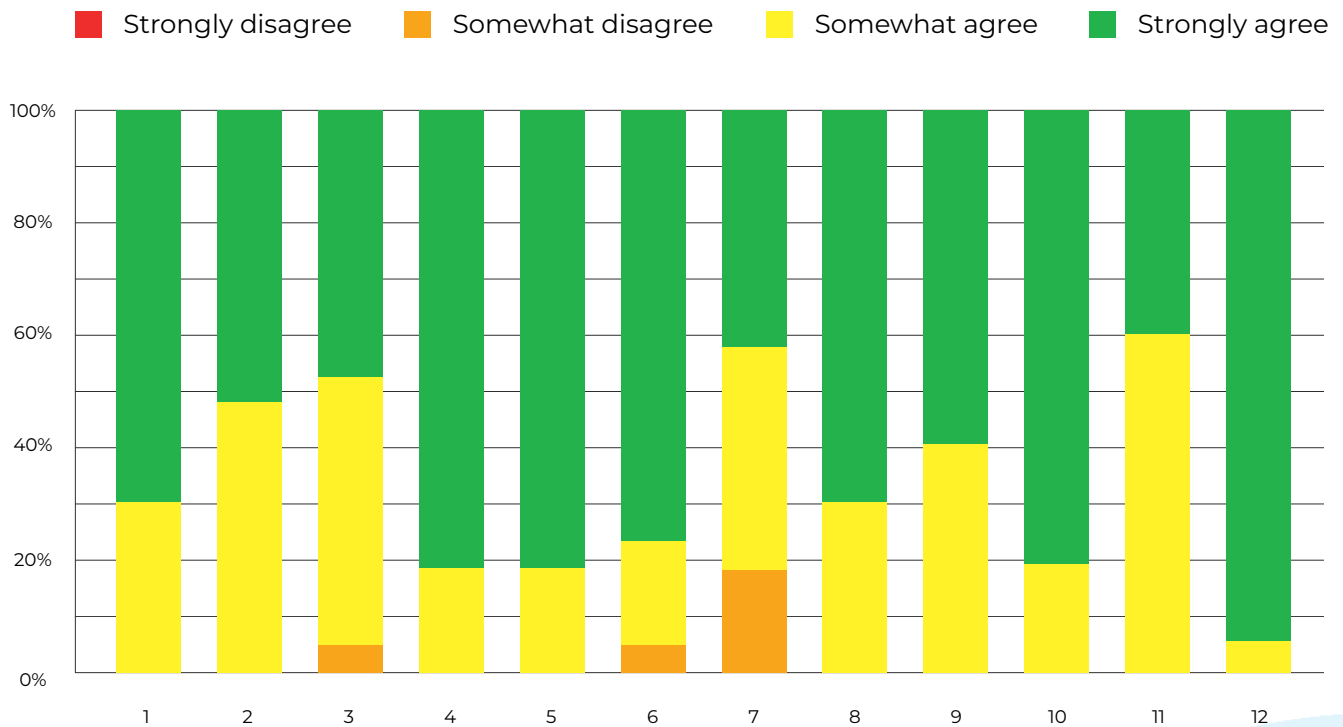
1. Applied learned knowledge and skills in a series of emergency-like scenarios.

2. Practiced different qualitative and quantitative data collection methods (focus group discussion, interviewing, designing a simple KAP survey).

3. Practiced data analysis of the data I collected.

4. Practiced the principles of community engagement.

5. Practiced the principles of risk communication.

6. Exercised specific considerations such as social media, vulnerable populations, accountability, behaviour change and evaluation.

7. Practiced responding to security threats and ensuring my own and colleagues' physical safety and security.

8. Exercised my emotional intelligence skills, both in engaging with the different communities and in working with my team.

9. Exercised my competencies and skills in relation to communication, teamwork and leadership.

10. Experienced a realistic simulation of what it is like to deploy to a public health emergency as social science and community engagement expert.

11. Exercised specific functions of the Incident Management System.

12. The feedback/debriefing provided after each role-play session was helpful and educational.

Overall participants had a positive take on the demanding nature of the training and. in particular, the simulation exercise and the mentors. The most recognized benefits, according to participant responses, were the ability to be immersed and work in the real-feel emergency setting; teamwork and collaboration with other cultures, countries and disciplines; learning to solve problems and develop plans in fluctuating scenarios; and having informed and expert mentors to educate and guide them through the various lessons and capacities. Many attendees appreciated having the opportunity to learn directly from facilitators and mentors during workshop exercises and panels, where they shared their technical and practical experiences from the field, as well as candidly discussing challenges and professional perspectives.

All participants acknowledged that in the beginning they were working as individuals, but in the end they had a greater sense of being part of a team and working for a common goal. Facilitator echoed this sentiment, reflecting on the importance of the teamwork skills they saw

developing among their groups and the natural dynamics of each team becoming more cohesive. Almost all participants indicated an interest in future deployments, and many noted that following the training, they would like additional training in this area to continue to improve skills.

> "We are all technical people … thanks for teaching us how to be human in a situation like this, I think we forget that. You go to a training course like this and think it's all going to be learning how to do it, but it is really about teaching humans how to be humans."

SocialNet participant

2.5
Feedback and future SocialNet training courses

Best practices

Facilitators and participants were encouraged to continually provide feedback throughout the training course, both positive observations and feedback on ways to improve the sessions. Feedback was overwhelmingly positive, with a majority stating:

- they enjoyed the pace of the training because there was no chance to get bored, they were always active: "I was never bored, and always learning during the whole process, but the best thing … is we get immediate feedback from you for everything we did wrong or right, and even suggestions like what we could do better or different so it was learning very minute."

- the structure, interactiveness and dynamic field exercise provided direct application of lessons learned, self-reflection and opportunities for discussion.

- with the hard SimEx, all the lessons given indoors –were now translated into practical work outdoors, including interviewing community stakeholders, simulation exercises development and updating the community engagement plan.

- the different methodologies used contributed significantly to success and the dynamic of the event. The combination of theory and practice used during the training was facilitated in a smooth way.

- One facilitator expressed that the community engagement went beyond engaging external communities and contributed to inter-team and interagency community dynamics, stating that "beside the expertise and knowledge that we all witnessed, the event itself led to creation of the team spirit that is *condicio sine qua non* [a condition without which one cannot succeed] for being successful when deployed and working on the field. For me it was a privilege to be part of this training and to contribute with Red Cross of Serbia experience in working with communities".

- Another facilitator noted that the simulation exercise had major advantages, advocating for social sciences and compelling people to think about them. "Overall it was an amazing opportunity to get people to think differently, make connections with applied public health, combining skills and thinking about real life skills and situations."

Lessons learned

Based on the combined feedback of both the participants and facilitators, the most important or frequently mentioned, ideas and concepts to integrate for future SocialNet training sessions include:

- More context about emergency framework and setting up the situation, allocation of roles, responsibilities and the principles of engagement – particularly for working with UN agencies.

- Stronger focus on community engagement with (brief) theory and techniques, security implications, clinical, communications etc.

- Many participants enjoyed the expert panel session and requested even more personal, real stories. It was noted that it would be great to have another discussion or place the single panel discussion midweek, especially after having taken part in the training session and workshops and identified specific questions to ask.

- Broader interaction with other participants and more inter-team activities so individuals have the opportunity to connect outside of their teams.

- More lectures on complex concepts, with more balance between lectures and corresponding activity sessions.

- The sessions were long and intensive. While a worthwhile experience, it would be ideal to prepare and inform participants in advance about demands and complexity and ask for patience to ensure everyone is prepared.

- One core facilitator noted that it is necessary that content is always tailored to the audience as much as possible. The group that attended the training was diverse and included WHO staff as well as staff from national institutions, governments and stakeholders. SocialNet should ensure that those who will deploy through WHO are trained and educated in that context, while those working in their home country or on more localized emergencies have training specific to their context.

Annexes

The Annexes include useful background and reference materials including the agenda for SocialNet 2019, list of participants and facilitators, the SocialNet Competency Framework, and a bibliography of resources for further reading.

Annex 1
SocialNet 2019 agenda

DAY 0 Sunday 08 December			
Time	**Activity**	**Presenter(s)**	
17:00–18:00	Registration		
19:00–20:00	Welcome, opening ceremony and group photo	Dr Marijan Ivanuša WHO Representative in Serbia and Head of Country Office Verica Jovanović Acting Director of the Institute of Public Health of Serbia Milan Jovanovic Batut Ms Cristiana Salvi Ms Melinda Frost	
20:00–21:00	Session 1: Opening SocialNet Training	Cristiana Salvi Melinda Frost Martha Scherzer Simon van Woerden	Session Plan 1
21:00–22:00	Evening meeting and evaluation		

DAY 1 Monday 09 December Engaging with communities and collecting data			
Time	**Activity**	**Presenter(s)**	
08:00–09:00	Morning meeting, setup and preparation		
09:00–09:30	Daily briefing		
09:30–12:00	Session 2: Community engagement Principles of community engagement	Aphaluck Bhatiasevi Naureen Naqvi Branimir Knežević	Session plan 2
12:00–13:00	Lunch		

Time	Activity	Presenter(s)	
13:00–15:00	Session 3: Data collection Why collect data or "who needs to know what and why?" Types of data and what each can tell us. Key actions/skills required for data collection	Christine Prue	Session plan 3
15:00–15:30	Coffee break		
15:30–17:45	Session 3: Data collection (cont.)		
17:45–18:00	Daily debrief		
18:00–19:00	Dinner		
19:00–20:00	Prue's Clues	Christine Prue	
20:00–21:00	Q&A with our Experts	Christine Prue John Kinsman Naureen Naqvi Sergiu Tomsa Branimir Knežević Fernanda Falero Cusano	
21:00–22:00	Evening meeting and evaluation		

DAY 2 Tuesday 10 December Operationalizing data			
Time	Activity	Presenter(s)	
08:00–09:00	Morning meeting, setup and preparation		
09:00–09:15	Daily Briefing		
09:15–10:00	Session 4: Data analysis	John Kinsman	Session plan 4
10:00–10:30	Coffee break		
10:30–12:00	Session 4: Data analysis (cont.)		
12:00–13:00	Lunch		

Time	Activity	Presenters	
13:00–15:00	Session 5: Intervention design considerations Teams rotate through six mini sessions on: Principles of behaviour change Community preparedness Evaluation Groups of special concern Social media Accountability to affected populations	John Kinsman Jetri Regmi Christine Prue Branimir Knežević Fernanda F Cusano Naureen Naqvi	Session plan 5
15:00–15:30	Coffee break		
15:30–16:30	Session 5: Intervention design considerations (cont.)		
16:30–17:45	Session 6: Training social science and community engagement teams		
17:45–18:00	Daily debrief		
18:00–19:00	Dinner		
19:00–21:00	Surprise: evening off!		
19:00–20:00	Evening meeting and evaluation		

DAY 3 Wednesday 11 December			
Time	**Activity**	**Presenters**	
08:00–09:00	Morning meeting, setup and preparation		
09:00–09:15	Daily briefing		
09:15–10:00	Session 7: Risk communication Community-led approaches to risk communication	Simon van Woerden, Cristiana Salvi	Session plan 7
10:00–10:30	Coffee break		
10:30–12:00	Session 7: Risk communication (cont.)		
12:00–13:00	Lunch		
13:00–14:00	Session 7: Risk communication – rumour management	Melinda Frost and Fernanda F Cusano	
14:00–15:00	Session 8: Preparing field action plan	Fernanda F Cusano	
15:00–15:30	Coffee break		
15:30–16:15	Session 8: Preparing field action plan (cont.)		

16:15–16:45	Session 9: Security briefing		
16:45–17:45	Session 10: The ideal deployee and emotional intelligence		
17:45–18:00	Daily debrief		
18:00–19:00	Dinner		
19:00–21:00	Finalizing plan and Dragan's Den		
21:00–22:00	Evening meeting and evaluation		

DAY 4 Thursday 12 December
Simulation exercise

DAY 5 Friday 13 December SimEx			
Time	**Activity**	**Presenters**	
13:00–14:00	Lunch	13:00–14:00	Lunch
14:00–15:00	Back to hotel, freshen up	14:00–16:00	Back to hotel
16:00–18:00	Self-evaluation and personal learning plan Team discussion and theme analysis. Individual self-assessment and mentor evaluation.		
18:00–19:00	Certificates and Smiles	Abebayehu Mengistu, Cristiana Salvi	
19:00–20:00	Evening meeting and evaluation		
20:00–22:00	Dinner and final celebration		

Annex 2
List of participants and facilitation team

Participants

Albania
Jonida Haxhiu
Specialist, Promotion Sector, IPH

Bosnia and Herzegovina
Romina Hala
Specialist, Promotion Sector, IPH
Bosnia and Herzegovina

Branka Subotić
Epidemiologist, Public Health Institute
of the Republika Srpska

Dušan Kojić
Ministry of Civil Affairs of Bosnia and Herzegovina

Jelena Vujić
Ministry of Health and Social Welfare of the
Republika Srpska

Zlatan Peršić
Ministry of Health of the Federation of BIH,
Bosnia and Herzegovina

Bulgaria
Ani Kevorkyan-Sariyan
Department of Epidemiology and Disaster
Medicine, Medical University, Plovdiv

Olga Sotirova
WHO National Counterpart, State Expert at
European Coordination and International
Cooperation Directorate, MoH

Croatia
Lovro Bucić
Epidemiology Resident, Environmental Health
Service, Croatian Institute of Public Health

Nataša Janev Holcer
Environmental Health Service,
Croatian Institute of Public Health

Czechia
Markéta Galiová
Emergency Preparedness Unit, MoH

Renata Povolná
Head of Press Unit, Department of Public Relations,
Ministry of Health of the Czech Republic

Estonia
Martin Kadai
Head of the Emergency Medicine Department,
Estonian Health Board

Simmo Saar
Head of Communication Unit,
Estonian Health Board

Greece
Panagiota Manti
Department of Designing, Planning and
Communication for Health Emergencies

Hungary
Veronika Eitler-Gál
National Public Health Centre, Head of
Communication Unit

Zsuzsanna Molnár
National Public Health Centre, Head of Unit

Israel
Ran Adelstain
Logistics Department of the Emergency Services
Division of the Ministry

Latvia
Elīna Jurēvica
Chief Communication Specialist,
State Emergency Medical Service

Oskars Šneiders
Head of Communication Division, MoH

Lithuania

Diana Sebeščiuk
Chief Specialist, Emergency Prevention Division,
Health Emergency Situations Center of the MoH

Odeta Vitkūnienė
Director of Personal Health Department,
Acting Chancellor of the Ministry, MoH

Montenegro

Jelena Orović
Ministry of Health

Jelena Rabrenović
Ministry of Health

North Macedonia

Jovica Uzunov
Macedonian Red Cross

Nadica Totikj
Institute of Public Health of the Republic
of North Macedonia, Department for Health
Promotion, Analysis and NCD Prevention

Romania

Elena Silvia Teodorescu
Public health specialist, National Institute
of Public Health

Viorica Elena Alina Dumitrescu
Senior Scientist, National Institute of Public
Health Physicist, National Institute of Public Health

Serbia

Dejan Ivanović
Institute for Public Health of Serbia "Dr Milan
Jovanovic Batut"

Snežana Pantić Aksentijević
Ministry of Health of Republic of Serbia

Vladimir Čakarević
Ministry of Health of Republic of Serbia

Slovenia

Manja Grašek
National Institute of Public Health

Simona Perčić
National Institute of Public Health

Turkey

Sukru Yorulmaz
Director of Emergency and Disaster Management
Department/Directorate General of Emergency
Health Care Services

UNMIK

Head of UNMIK delegation
Isme Humolli

Observers UNMIK

Florije Miftari Basholli
Genc Bajraktari

Representatives of other organizations

Center for Disease Control and Prevention (CDC)

Christine Prue
Associate Director

European Centre for Disease Prevention and Control (ECDC)

John Kinsman
Expert Social and Behaviour Change
Communication

Red Cross in Serbia (RCS)

Djula Lošonc
Head of RCS Department for Humanitarian
Disasters & Emergency Preparedness and
Response

Branimir Knežević
Organisational Development Coordinator,
Red Cross of Serbia

UNICEF in Europe and Central Asia

Sergiu Tomsa
Regional Communication for Development
Specialist at UNICEF (UNICEF Regional Office
in Europe and Central Asia)

World Health Organization Regional Office for Europe

Petra Hongell
Communications Officer

Ramy Srour
Communications Officer

Country offices

Bosnia and Herzegovina
Mirza Palo
National Professional Officer

Bulgaria
Michail Okoliyski
Public Health Officer

Greece
Ioannis Micropoulos
National Professional Officer,
Migration and Health

Slovenia
Aiga Rurane
WHO Representative

Latvia
Laima Bauvare
Administration Assistant

Romania
Cassandra Butu
Public Health Officer

Miljana Grbić
WHO Representative

Serbia
Abebayehu Mengistu
Coordinator for the WHO Health
Emergencies Hub in the Balkan region

Marijan Ivanuša
WHO Representative

Miljan Rančić
National Professional Officer

WHO Turkey
Çelik Özüduru
Communications Officer

Murat Simsek
National Professional Officer

Facilitation team

Core team
(alphabetical order by first name)

Cristiana Salvi

Cristiana is the Programme Manager, External Relations, Health Emergencies and Communicable Diseases, World Health Organization Regional Office for Europe, where she leads the formulation and implementation of communication and advocacy strategies for health emergencies and communicable diseases at the WHO Regional Office for Europe, bridging to resource mobilization.

She has over 24 years' experience in communications, including 18 years with the WHO, ranging from communicable and noncommunicable diseases to environmental risks and humanitarian crisis. Her work also includes country support in coordination with a wide range of partners for emergency preparedness and response. She has been deployed in health emergency settings in Europe, Asia and Africa over the last 5 years, supporting countries' response on risk communication and community engagement. This experience has been translated into building capacity in the European Region: Cristiana launched a tailored and sustained emergency risk communication (ERC) package to support countries through five steps in developing, testing and adopting ERC plans that has been rolled out globally.

Her specialties are emergency risk communications, media, advocacy, community engagement, training and health diplomacy. Cristiana's background is in languages and literatures and international studies. She speaks Italian as mother tongue, English, French and Spanish.

Djordje Novakovic

Djordje is a communications professional with over 16 years of experience, 10 of those within the United Nations. He is currently working as Communication Consultant for the WHO Health Emergencies Programme in the WHO Regional Office for Europe. Over the course of his career, he has managed complex projects and portfolios internationally within the public and private sectors, including leadership of external communications for two dozen UN agencies and global financial institutions in Serbia.

His areas of expertise cover both emergency and non-emergency settings, as well as diplomacy. He is proficient in are strategic communication and advocacy, risk communications, reputation management, marketing, public and media relations. Djordje also has extensive experience with the development of corporate identities and brands, leading marketing and creative teams and the successful execution of traditional and social media campaigns. He is well known for his original use of audio, video and motion graphics to create compelling stories. Born and raised in Serbia, Djordje has an academic background in Economy and Information Technologies, and speaks English, Russian, Serbian and the rest of the Balkan languages.

Elena Chulkova

Elena is currently working as Programme Assistant in the Director's Office of Health Emergencies and Communicable Diseases, in the WHO Regional Office for Europe, where she has been since 2016. This includes supporting the External Relations Programme through administration, procurement and financing. She has a Master's Degree in Business Administration from the Henley Management College, UK. Elena has led projects for setting up business operations in Russia, India and Kazakhstan with focus on administration, local operations and implementation of the enterprise resource planning tool SAP and has extensive experience in procurement, supply chain and project management in pharmaceutical industry.

Kristina Ronsin Novakovic

Kris is currently at WHO Regional Office for Europe as a technical consultant for the Global Outbreak Alert and Response Network (GOARN) and the External Relations Programme, as well as providing regional support for the WHO Emergency Medical Teams Initiative. She has 8 years of international health experience, 4 of which have been with WHO working in emergencies where she has worked for the World Health Emergencies Programme at the country-level and at the regional office. Kris has a professional background in the public and private sector across project coordination, communications and research and her work spans emergency and non-emergency settings, clinical settings, academia and the policy space. She is a co-founder of Women in Global Health and previously served as Director of Operations.

Kris was born and raised in California, and has an MPH in Global Health Management and Policy. Her bachelors in nutritional biochemistry and work in malnutrition research brought her into the emergency sector and international experience has taken her from India and Nepal to Ukraine. She speaks English, German and is working on her Serbian.

Martha Scherzer

Martha is a global health and development professional with over 20 years' experience in east and southern Africa, the USA and South-East Asia, working for international non-governmental organizations, the United Nations and the United States Centers for Disease Control and Prevention. She specializes in health communication and community engagement for both emergency and non-emergency activities as well as narrative interventions for HIV prevention and gender equality. As Director of Global Health Communication, she designed and managed a 5-year project in Mozambique and now consults internationally.

Melinda Frost

Melinda Frost is the Lead for Risk Communication and Community Engagement capacity-building for WHO under the Pandemic Influenza Preparedness Framework since January 2019. She has directly helped more than 40 countries build their emergency risk communication (ERC) preparedness and response capabilities under the International Health Regulations.

She helped design the WHO European Region's Emergency Risk Communication Five-step capacity-building package and is currently finalizing the globalized version titled The Fundamentals of Emergency Risk Communication and Community Engagement (The FoRCCE) package.

Melinda is a leader in global public health communication and education with over 25 years of experience and a focus on infectious disease, immunization, noncommunicable disease and health security. She was the Director for Health and Risk Communication for the US Centers for Disease Control and Prevention (US CDC) for 8 years in Beijing, China and developed and led new communications programmes at the agency for more than 16 years. Melinda has also worked with other international agencies such as UNICEF, FAO and IFRC to assess national existing communication capacity, coordinate multi-sector partnerships, develop communication strategy and support community resilience guidance. She then worked to design and facilitate programmes to strengthen national level communication response. She has directly conducted these activities in more than 40 Member States.

She holds a Bachelor's degree in Communications, a Master's degree in Global Public Health and a Master's degree in Educational Psychology.


Simon van Woerden

Simon is the Risk Communication Officer in the Health Emergency Programme of WHO's Regional Office for Europe. As focal point for building emergency risk communication capacity, he leads the implementation of WHO Europe's flagship Emergency Risk Communication five-step capacity-building package.

Previously, Simon served for 2 years as risk and external communications expert in WHO's Regional Office for the Eastern Mediterranean and WHO Sudan, developing creative solutions like a board game for cholera risk communication among school children. He also worked with UNDP's Bureau for External Relations and Advocacy in New York, co-founding the innovative Global Goals Jam and coordinating 109 UNDP Country Offices in the Social Good Summit.

Prior to his UN career he was a foreign correspondent in Argentina and until recently spent his summers leading windsurf camps for children in the Netherlands, using the power of participatory game-play, storytelling, theatre, music and other creative arts for theoretical and physical education and training. Simon holds two Master's degrees, in Humanitarian Studies and Journalism, speaks English, Spanish, Dutch, French and German and is currently working on Russian.
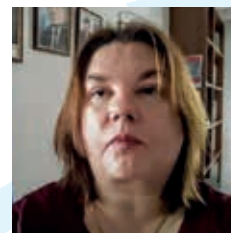
Slavica Stojkovic

Slavica is the Programme Assistant for the Emergency Balkan Hub priority countries with the main office in WHO Country office Belgrade, Serbia. She joined WHO beginning of 2018 with a working experience of over 25 years in the field of administration, logistic and office management support. She has a BA in Economy and holds a Master's degree in International Business Management. Her mother tongue is Serbian; Slavica is fluent in English and can correspond in Spanish.

Slavica has so far organized and executed large and demanding Regional training workshops such as; GOARN – Global Outbreak Alert and Response Network. Belgrade, Serbia; Operationalizing health emergency preparedness and response, Skopje, North Macedonia; Preparedness and response Workshop, Assessment Tool for Core Capacity Requirements at Designated Airports, Ports and Ground Crossings, Tirana, Albania; and many more related to the Health Emergency Programme, providing assistance to more than 2 000 participants. Her main characteristic is efficiency and productivity making each guest feel special and welcome.

Facilitators and mentors
(alphabetical order by first name)

Aphaluck Bhatiasevi

Aphaluck is the acting team lead for Social Science Interventions and Risk Communication in the World Health Organization's Health Emergencies Programme (WHE) in WHO headquarters in Geneva. Her job is to ensure that the risk communication and community engagement support WHO provides to countries in any response to outbreaks of infectious diseases is guided by evidence from social science research and epidemiological intelligence. Her main responsibilities include networking with partner institutions and experts in the workstream ranging from social science interventions to health promotion, social mobilization, risk communication and community engagement.

Aphaluck is the focal point for Country Preparedness risk communication for the International Health Regulations (IHR) Secretariat and is currently a PhD candidate in Social and Medical Anthropology in the University of Edinburgh, United Kingdom.

Branimir Knežević

Branimir is the Organisational Development Coordinator for the Red Cross of Serbia. He has extensive experience gained from working nearly 30 years within the Red Cross Red Crescent Movement. He began in 1989 in the Belgrade city branch of the Yugoslav Red Cross. He gained operational and strategic experience of working in different fields and at the peak of the humanitarian crisis in the Balkans, he moved to the Headquarters of Yugoslav Red Cross in 1996, where he became involved in the organizational change process as an Organisational Development Coordinator.

His first international missions took place in 2000 and 2001 as part of the IFRC teams reviewing the IFRC's assistance extended to Central Asian National Societies (2000 and 2001). Branimir moved to the Regional Delegation of the IFRC in Budapest in 2004 where he was working until the end of March 2016.

As an IFRC Organisational Development Coordinator, Branimir was instrumental in providing advice and support to National Societies undergoing major change processes during the past 10 years; mainly in Romania, Macedonia, Georgia, Italy, Ireland, Iceland, Greece, Bosnia and Herzegovina, and he also assisted many other National Societies in capacity-building (Poland, Latvia, Lithuania, Malta, Bulgaria etc.)

Christine Prue

Christine Prue is the Associate Director for Behavioral Science at CDC's National Center on Emerging and Zoonotic Infectious Diseases. She works to apply and advance the science of health behaviour and health communication to prevent and control infectious diseases that result from the interaction of people, animals and the environment.

Chris has a diverse portfolio of applied research projects supporting programmes addressing food safety, vaccine safety, One Health, Lyme disease and viruses including rabies, Ebola and Zika. Chris has expertise in programme evaluation, risk communication, community engagement and scientific and health literacy. She is the co-author of CDC's Clear Communication Index. Chris uses her evaluation expertise to help CDC's programmes build in feedback loops to ensure that interventions meet community needs and are working as planned. She has held positions in local, state, and federal public health agencies and has deployed internationally working with WHO and UNICEF to help stop outbreaks of polio, Zika and Ebola viruses.

Jetri Regmi

Jetri is a physician and medical epidemiologist who has worked in the field of Global Health for the last 10 years. She has served at all three levels in WHO – from the country office, to regional and headquarters. During the span of her career, she has worked in disasters and conflict-affected areas of Nepal, was deployed as surge staff in 2014–2016 Ebola Virus Disease Outbreak.

Jetri has worked in the health security interface, supporting preparedness for high visibility-high consequence events and mass gatherings. Currently, she is working as Technical Officer for Preparedness at the WHO Regional Office for Europe in the Country Preparedness and International Health Regulations (IHR) division.

John Kinsman

John is an anthropologist with over 25 years of experience working with infectious diseases. Has worked on three recent WHO-declared Public Health Emergencies of International Concern: Polio (preparedness in the EU, and enhancing vaccine uptake in Somalia), Ebola (message development in Sierra Leone) and Zika (message development in Brazil). He was lead social scientist on the ABACUS study on antibiotic access and use in three African and three Asian countries, 2016–2019. Extensive previous research experience in Africa on health systems, behavioural HIV prevention, ART adherence, AIDS policy, and HIV testing and counselling (Uganda, Ethiopia, Zambia and South Africa). John has over 5 years working with preparedness and response to health threats (MERS, polio, measles, emerging tick-borne diseases, and acute gastroenteritis) within the EU.

He is currently working at European Centre for Disease Prevention and Control (ECDC) on Social and Behaviour Change Communication, serving as the in-house social and behaviour change communication adviser with a focus on communicable diseases, specifically vaccine acceptance, antimicrobial resistance, health care-associated infections and sexually transmitted infections. Prior to his time at ECDC, he spent 9 years as an Associate Professor in Global Health, Department of Public Health and Clinical Medicine, Umeå University, Sweden.
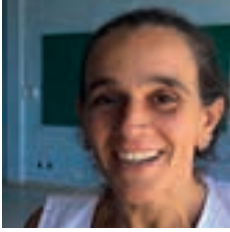
Maria Fernanda Falero Cusano

Fernanda is WHO Lead for Social Sciences, Community Engagement and Risk Communications for the Ebola response in the DRC. She is an anthropologist with post-graduate studies from the Liverpool School of Tropical Medicine and Hygiene and the Humanitarian Conflict Response Institute at the University of Manchester. Her academic work focuses the intersection of humanitarian aid and social sciences. She has worked in the aid sector since the late nineties, mainly with Doctors without borders (MSF), and been deployed in different contexts in coordination, logistics, anthropologist and as an engagement specialist, responding to outbreaks, consequences of conflict and violence, and natural hazards.

While holding the position of adviser for Humanitarian Anthropology, Community Engagement and Health Promotion in MSF, she developed a guideline, SOPs and training packages for the implementation of these in areas as well as providing direct support to field operations. With WHO, she continues working on a framework to systematize the collection and use of qualitative data from a humanitarian operational perspective. She is working to define a "fit for purpose" simplified tool to be of use at field level to result in approach change within the humanitarian system that ensures accountability towards affected communities and their participation at all stages of the project cycle.

Myrna Charles

Myrna Charles serves as a Medical Epidemiologist in the Influenza Team at the Pan American Health Organization (PAHO). In her current position, she assists countries in the Region of the Americas to improve their control and prevention of seasonal and novel influenza infection and improve influenza pandemic preparedness and response.

As part of PAHO's PHE Division, she has provided post-disaster surveillance support to Haiti following Hurricane Matthew (2016), deployed to Dominica following Hurricane Maria (2017), and provided support to The Bahamas following Hurricane Dorian (2019).

Serving as a medical officer in public health for over 15 years, she has worked with the Centers for Disease Control and Prevention (CDC), PAHO, the American Red Cross and was the Chief of Epidemiology for the US Peace Corps. She has been involved in rapid response to global health emergencies, including the 2010 earthquake in Haiti, the Ebola virus outbreak in Guinea in 2014, and the measles outbreak in the Ukraine in 2015.

Dr Charles earned her DO from the New York College of Osteopathic Medicine, has a specialization in Preventive Medicine from the CDC, an MPH in Epidemiology from Columbia University, and an MBA in Finance from the University of Maryland, College Park.

Naureen Naqvi

Naureen is from UNICEF New York HQ and is the global lead of Social and Behavior Change and Community Engagement in humanitarian actions within the C4D section. She manages partnerships on capacity development through disease outbreak course with New York University and CDAC Network, and the formulation and implementation of communication and advocacy strategies for health emergencies and communicable diseases at the WHO Regional Office for Europe, bridging to resource mobilization.

Naureen has over 20 years' experience in policy and planning with academia, working with the Government of Pakistan as Deputy Secretary and the Asian Development Bank as Gender & Governance Advisor. She has worked with UNICEF in Pakistan and West Africa and has worked globally in various emergencies including disease outbreaks, earthquake, refugee crisis and conflict. Ove the course of these experiences, she has engaged in designing trainings for many countries. Her expertise are behaviour change communication & community engagement, preparedness and resilience, capacity development, training facilitation, gender policies development and interactive materials development.

Naureen is UNICEF Focal Point on Migration flow crisis and she collaborates with Disability, Adolescent, Nutrition, WASH and Health and Emergency Programme Divisions for development of guidelines and tools and documentation of case studies.

Sebastian Oliel

Sebastian is a Media and Communication Specialist on the Public Affairs team at the Pan American Health Organization's headquarters in Washington, DC. He leads the development of communication and advocacy content for a variety of technical areas throughout the organization. This includes managing media enquiries, reputational and crisis issues, media monitoring and developing training sessions for technical experts, ministries and the media. He is also responsible for creating communication plans, campaigns and other visibility actions.

Sebastian has worked in communication for more than 18 years, including 7 years at PAHO/WHO HEADQUARTERS in DC, and 2.5 years in the PAHO/WHO office in his native Argentina. Prior to joining PAHO/WHO, Sebastian worked as a journalist for media outlets in Argentina, specializing in social issues for a news agency and a magazine. He has provided support and advice during several emergencies in the Region of the Americas at both regional and country-level. During the recent Hurricane Dorian in the Bahamas, Sebastian was deployed to support communications at the Ministry of Health and to enhance PAHO/WHO visibility from the field.

Sebastian holds a Bachelor's degree in journalism and an MA in Organizational Communication. He speaks fluent English as well as native Spanish.

Sergiu Tomsa

Sergiu Tomsa is the Communication for Development and Social Change Specialist with UNICEF Regional Office in Europe and central Asia. Sergiu is providing technical advice, guidance and support to 21 UNICEF country offices in designing and conducting research and developing and implementing behaviour and social change strategies in the areas of immunization, early childhood development, inclusion of children with disabilities and Roma children, child marriage, violence against children, parenting and other.

In his almost 12 years with UNICEF, Sergiu has also worked with UNICEF Office in Kosovo (UNSCR 1244) and UNICEF in Moldova. Prior to joining UNICEF, Sergiu has worked with the Organization for Security and Cooperation in Europe (OSCE) on human rights and anti-trafficking, and with a child's rights non-government organization in Moldova, leading the first initiatives on child participation (Children's Parliament; Local Children and Youth Councils) in the country. Sergiu is a national of the Republic of Moldova. His background is in Political Sciences and Law and Social Psychology.

Viviane Bianco

Viviane is part of the Risk Communication and Community Engagement (RCCE) team in WHO Headquarters. With an educational background in social communication, marketing and global health, Viviane has more than 8 years of work experience in communication and marketing, including 3 years in WHO.

Recently, she has been involved in developing and conducting training and tabletop simulation exercises, mainly on risk communication and community engagement aspects for Pandemic Influenza Preparedness. Her primary areas of work are media, social media, graphic design, video creation and editing and risk communication. She speaks Portuguese as mother tongue, English, French and Spanish. Viviane loves travelling and runs a travel blog, written in Portuguese.

Annex 3
SocialNet2019 Competency Framework
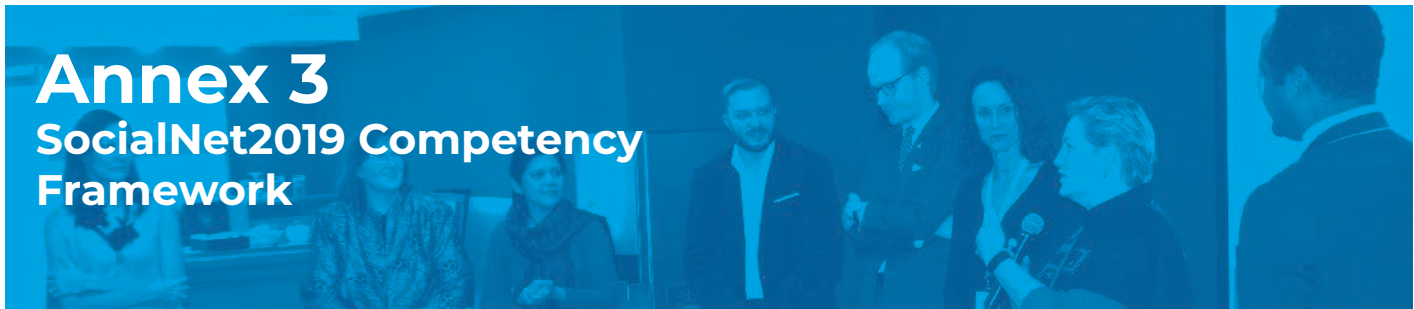
In addition to technical skills and knowledge, SocialNet trained and tested three key competencies in each of the learning activities: communication, teamwork and leadership. The competencies are based on the Enhanced WHO Global Competency Model, the WHO Health Emergencies Programme (WHE) Competency Framework,[27] and adjusted to match the overall goal and specific learning objectives of SocialNet.

1. COMMUNICATION	
WHO definition: Expresses oneself clearly in conversation and interaction with others; actively listens. Produces effective written communications. Ensures that information is shared. SocialNet definition: Listens and communicates clearly while ensuring that the voices of crisis-affected people and communities are incorporated and heard. Applies risk communication techniques and community engagement approaches to ensure positive health outcomes. Uses social science data to inform and influence decision-making processes.	
EFFECTIVE BEHAVIOURS	**INEFFECTIVE BEHAVIOURS**
1.A. Actively listens to community needs and understands community dynamics. Applies social science listening skills, including various data collection methods, to identify and address gaps and concerns related to risk communications in emergency response. Ensures best practices for approaching and engaging communities, stakeholders and partners involved.	1.A. Does not listen to, consider or integrate community feedback or perspective into rapid research findings; Is unaware or un-inclusive of specific cultural, social, political economic or linguistical context when planning engagement with community, partners or stakeholders.
1.B. Communicates social science data and findings in a concise, clear and timely manner. Contributes proactively to the flow of clear internal and external communications.	1.B. Relies on jargon and buzzwords to communicate with others. Communication style often impedes progress and transparency, is confusing or overly technical.
1.C. Is analytical in thought and communications. Demonstrates capacity to capture and summarize relevant emergency information to inform evidence-based decision-making.	1.C. Does not analyse or interpret data to communicate findings to target audiences and stakeholders in a tailored manner.

27   WHO. WHO health emergencies programme learning strategy. Geneva: World Health Organization; 2018. (https://www.who.int/emergencies/publications-resources/training/tools/whe-learning-strategy-companion-documents.pdf?ua=1, accessed 20 April 2020).

1.D. Uses social science data to identify gaps and concerns in the response; uses community engagement and risk communication principles to recommend and advocates for social science-informed interventions to address identified gaps.

Develops targeted recommendations and interventions adapted to the specific cultural, social, political, economic or linguistic needs of different communities and stakeholders.

1.D. Addresses issues indirectly using a generalized approach that does not consider the needs of communities and stakeholders.

Data and information gathered does not substantiate or directly inform the decision-making process.

1.E. Applies risk communication and community engagement principles during intervention design, implementation and evaluation, to negotiate positive health outcomes for the most vulnerable.

Handles sensitive information appropriately.

1.E. Uses risk communication and community engagement principles in an uncritical, uncontextualized or unethical manner.

Does not utilize practices of social and behavioural sciences to customize engagement with the population and further improve emergency risk communications.

Breaches confidentiality and does not respect principles of privacy and sensitivity regarding information or data.

2. TEAMWORK

WHO definition: Develops and promotes effective relationships with colleagues and team members. Deals constructively with conflicts.

SocialNet definition: Integrates rapidly into emergency ecosystem, builds trust with fellow team members and quickly establishes means to contribute in a positive, productive and effective way while working in a multicultural environment. Functions based on greatest opportunity to add value, regardless of seniority or rank outside of emergency response.

EFFECTIVE BEHAVIOURS	INEFFECTIVE BEHAVIOURS
2.A. Recognizes value and implications of a multicultural environment, is effective in working in a multicultural team, is aware of own limitations and lenses stemming from cultural background. Actively contributes to team objectives. Builds trust with affected communities and all stakeholders, with a focus on common goals, purpose, values and mission of the team.	2.A. Utilizes an independent approach to work that is not inclusive of the practices, opinions and perspectives of others and the team. Prioritizes own objectives over collective decisions and focuses only on outcomes, ignoring team and community dynamics and trust. Makes judgements based on stereotypes and does not work well in multicultural settings.
2.B. Coordinates and works collaboratively, supporting fellow team members by establishing collective and individual roles and responsibilities with team members. Respects the chain of command within the team while also contributing to solution-oriented decision-making. Works cross-functionally as needed, seeing beyond one's seniority or grade level outside of the emergency response.	2.B. Does not make the effort to organize and coordinate teamwork, leading to undefined roles and confusion. Does not support work of other team members or stakeholders to facilitate team success. Maintains a strict culture of status- or grade-based hierarchy.
2.C. Solicits inputs from all team members, stakeholders and affected communities. Is willing to learn as much as teach. Accepts joint responsibility for team's successes and shortcomings. Moves ahead with ideas without consulting input and experience of others and does not create a positive space for the sharing of ideas.	2.C. Takes credit when things go well, but deflects blame onto others when mistakes are made.

2.D. Identifies and addresses conflict proactively; shows awareness of own shortcomings and needs; shares and accepts constructive feedback. Demonstrates awareness of and balances one's own challenges and needs with those of team members, stakeholders and affected communities. Seeks common ground to establish trust.	2.D. Avoids conflict, is unwilling to mediate when needed; is unaware of own shortcomings and needs; does not listen, receive or becomes combative or hostile when faced with constructive feedback. Is unaware or uninterested in other people's challenges and needs.
2.E. Manages oneself emotionally, mentally and physically to effectively contribute to team efforts, safety and well-being.	2.E. Avoids responsibility for one's assigned tasks or negative consequences of one's actions.

3. LEADERSHIP

WHO definition: Positions the Organization as a leader in health. Gains support for the Organization's mission. Coordinates, plans and communicates in a way that attracts support from intended audiences.

SocialNet definition: Builds, manages and leads multicultural teams which are created ad hoc. Adapts to uncertain and rapidly changing situations, maintaining the highest professional standards and ensuring the well-being of its team. Applies deep listening skills to understand and account for mental health impact of emergencies on affected communities, stakeholders and team members and implications for the response.

EFFECTIVE BEHAVIOURS	INEFFECTIVE BEHAVIOURS
3.A. Directs emergency response activities in a manner that is consistent with WHO's documentation on the Incident Management System (IMS), Emergency Response Framework (ERF), and International Health Regulations (2005). Conducts themselves, and in management roles their team, in line with WHO and UN guiding principles and values, humanitarian principles, international humanitarian law and other relevant guidelines, even in the face of resistance or challenges.	3.A. Does not follow or demonstrate awareness of IMS, ERF, IHR and other key operational documents. Behaviour and/or management approach does not reflect guiding principles, values and core competencies laid down in WHO, UN and other guiding documents.
3.B. Negotiates effectively, building on social science data, principles and methodologies. Works to access and strengthen relationships with affected communities, stakeholders and partners.	3.B. Does not use a social science-informed approach to negotiation or building relationships.
3.C. Provides a coherent vision for activities, identifies and takes strategic decisions, and delegates authority appropriately. Plans and directs activities in a manner that achieves results for the most vulnerable, affected communities generally, the Organization and all other stakeholders.	3.C. Fails to develop or track workplans for self or others, does not delegate work appropriately or over-delegates to others without taking responsibility. Sets conflicting priorities and sees each team member or department/project as stand-alone and not part of a whole. Fails to connect work within the organization and the community.
3.D. Builds, develops and maintains ad hoc teams while ensuring safety of and support to team members. Adapts leadership style to address specific gaps in capacities and challenges that the team may face in a manner that ensures support and trust of team members.	3.D. Is dismissive of team concerns and issues, and does not address problems raised, lacking empathy and sincerity when dealing with others. Disregards or does not prioritize staff well-being, social bonds and trust.
3.E. Continuously monitors risk to the work/operation and to the Organization, and proactively develops mitigating measures. Ensures that organizational requirements for human resources, financial and administrative management are followed.	3.E. Does not take risk-informed decisions and has limited understanding of community risk perception. Lacks vision and understanding for the specific requirements of the team's capacities, disregards feedback and constructive input.

3.F. Creates strong relationships and partnerships with affected communities, colleagues and external entities, represents the Organization with credibility and authority to promote its activities, and proactively anticipates and manages conflict.

Does not promote or represent the Organization accurately or reflect importance of the internal and external communities.

3.F. Is ineffective in managing relationships and partnerships, avoids or does not mitigate conflict.

Annex 4
References

All references to "Kosovo" should be understood as "Kosovo" (in accordance with Security Council resolution 1244 (1999)).

CDC. 1 in 3 adults don't get enough sleep. In: CDC Newsroom [website]. Atlanta: Centers for Disease Control and Prevention; 2016. (https://www.cdc.gov/media/releases/2016/p0215-enough-sleep.html, accessed 17 April 2020).

CDC. Framework for program evaluation in public health. MMWR. 1999;48(RR-11). (https://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf, accessed 20 April 2020).

CDC. The Social-Ecological Model: A Framework for Prevention. In: CDC/Violence prevention [website]. Atlanta: Centers for Disease Control and Prevention; 2020. (https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html, accessed 16 April 2020).

Michie et al.: The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science 2011 6:42. (https://www.researchgate.net/publication/51070630_The_Behaviour_Change_Wheel_a_new_method_for_characterising_and_designing_behaviour_change_interventions, accessed 22 April 2020).

Sandman PM. Introduction to risk communication and orientation to this website. In: The Peter M. Sandman Risk Communication Website; 2020. (https://www.psandman.com/index-intro.htm, accessed 17 April 2020).

Sandman PM. Twelve principal outrage components. In: The Peter M. Sandman Risk Communication Website/Handouts; 1991. (http://www.psandman.com/handouts/sand58.pdf, accessed 17 April 2020).

UN. Sendai Framework for Disaster Risk Reduction 2015–2030, Geneva, United Nations Office for Disaster Risk Reduction; 2015. WHO. A strategic framework for emergency preparedness. Geneva: World Health Organization; 2016.

Ushahidi. How the Ushahidi platform works, and what comes next. In: Ushahidi/Blog [website]. (https://www.ushahidi.com/blog/2018/11/05/how-the-ushahidi-platform-works-and-what-comes-next, accessed 16 April 2020).

WHO About IHR. In: WHO/ Strengthening health security by implementing the International Health Regulations (2005) [website]. Geneva: World Health Organization; 2017 (https://www.who.int/ihr/about/en/, accessed 20 April 2020).

WHO. A strategic framework for emergency preparedness. Geneva: World Health Organization; 2016.

WHO. Capacity-mapping package: Four-core capacity method. Copenhagen: WHO Regional Office for Europe; 2018. (http://www.euro.who.int/__data/assets/pdf_file/0004/380254/02a-erc-eng.pdf?ua=1, accessed 17 April 2020).

WHO. Effective communications participant handbook. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/249241/9789241509466-eng.pdf?sequence=3&isAllowed=y, accessed 17 April2020).

WHO. Emergency Response Framework, 2nd edn. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. (https://apps.who.int/iris/bitstream/handle/10665/258604/9789241512299-eng.pdf?sequence=1, accessed 16 April 2020).

WHO. Emergency risk communication (ERC) 5-step capacity-building package. In WHO Euro/ Health topics/Health Emergencies [website]. (http://www.euro.who.int/en/health-topics/ health-emergencies/pages/whos-work-in-emergencies/risk-communication-in-emergencies/ emergency-risk-communications/emergency-risk-communications-tools/national-health-emergency-risk-communication-training-package; accessed 16 April 2020).

WHO. IHR core capacity monitoring framework questionnaire for monitoring progress in the Implementation of IHR core capacities in States Parties. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. (https://apps.who. int/iris/bitstream/handle/10665/255756/WHO-WHE-CPI-2017.41-eng.pdf?sequence=1/, accessed 20 April 2020).

WHO. Joint external evaluation tool: International Health Regulations (2005). Geneva: World Health Organization; 2016. (https://apps.who.int/iris/ bitstream/handle/10665/204368/9789241510172_ eng.pdf?sequence=1, accessed 20 April 2020).

WHO. Joint external evaluation tool: International Health Regulations (2005), second edition. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO (https://extranet. who.int/sph/sites/default/files/document-library/ document/9789241550222-eng.pdf, 20 April 2020).

WHO. Risk communication: Frequently asked questions. In: WHO/Risk communication [website]. Geneva: World Health Organization; no date. (https://www.who.int/risk-communication/faq/en/, accessed 17 April 2020).

WHO. WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017 (WHO/HIS/SDS/2017.15).

WHO/OHCHR. A human-rights based approach to health. Geneva: World Health Organization; 2009. (https://www.who.int/gender-equity-rights/ knowledge/hrba-to-health-en.pdf?ua=1, accessed 16 April 2020).

Wikipedia contributors. Forgetting curve [website]. Date of last revision 16 April 2020 11:30 UTC. Wikipedia, The Free Encyclopedia. (https:// en.wikipedia.org/w/index.php?title=Forgetting_ curve&oldid=951280818, accessed 17 April 2020).

Notes

World Health Organization

REGIONAL OFFICE FOR Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania	Norway
Andorra	Poland
Armenia	Portugal
Austria	Republic of Moldova
Azerbaijan	Romania
Belarus	Russian Federation
Belgium	San Marino
Bosnia and Herzegovina	Serbia
Bulgaria	Slovakia
Croatia	Slovenia
Cyprus	Spain
Czechia	Sweden
Denmark	Switzerland
Estonia	Tajikistan
Finland	Turkey
France	Turkmenistan
Georgia	Ukraine
Germany	United Kingdom
Greece	Uzbekistan
Hungary	
Iceland	
Ireland	
Israel	
Italy	
Kazakhstan	
Kyrgyzstan	
Latvia	
Lithuania	
Luxembourg	
Malta	
Monaco	
Montenegro	
Netherlands	
North Macedonia	

SocialNet 2019

Community engagement training

Integrating social science-based interventions
in health emergencies response
Belgrade, Serbia, 8-13 December