CCCM guidance on camp-level preparedness and response planning, Iraq

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Contents

This document contains technical inputs from, and has been reviewed by, the Health, WASH, Protection, and Shelter Clusters, GBV and Child Protection Sub-Clusters, and CwC/AAP Working Group. It links to technical guidance from other sectors, and is intended to be updated and recirculated as necessary.

Guidance documents relevant for CCCM in Iraq including technical documents can be downloaded here: https://tinyurl.com/CCCMIraqCOVID-19

Preparedness	Response			
Phase 1	**Scenario 2**	**Scenario 3**	**Scenario 4**	**Scenario 5**
Preventative measures	Confirmed case near to site	Suspected case in site	Confirmed case in site	Multiple cases in site

1. CCCM key activities at camp level

Phase 1 – Preventive measures

- Develop camp-level preparedness & response plan
  - Camp Management should lead the development of a **plan for each camp** covering preparedness activities (preventative measures) and response if cases are suspected or confirmed.
  - Plans must be developed in collaboration with Health, WASH, and Protection partners in the camp, with engagement of community representatives, and in coordination with local authorities
  - Plans should follow this guidance for CCCM partners, technical guidance from the Health and WASH Clusters, WHO/Ministry of Health national guidance, and IASC guidance on COVID response. Update plans as the context evolves.
  - Plans should be well communicated to all members of the community. This will help reduce panic and concern about the situation and increase efficiency of response
- Initial activities
  - Assess the demographics of camp population to identify high-risk groups as per WHO guidance:
    - Elderly persons, pregnant women, people with immune-suppressing illnesses or taking immunosuppressants, people with chronic illnesses e.g. diabetes, heart disease, chronic lung disease
  - Assess, and prioritize CCCM activities in consultation with community representatives and other service providers. Share and clearly inform all stakeholders of the prioritization criteria.
  - Update & re-share service mapping & referral pathway, ensuring all field staff and communities have access to relevant contacts and information.
- Staff protection
  - Ensure all CCCM staff and request that all partner staff and all community members/leaders engaged in activities are trained on COVID-19 self-protection and have access to necessary personal protective equipment (PPE). (Training requested from Health partner, where possible)

  - Staff that have been potentially exposed to risk of COVID-19 should self-isolate and not come to work in the site for 14 days after the potential exposure[1]
  - Follow organizational & Department of Health guidelines on wearing personal protective equipment
- Access analysis:
  - Understand potential access restraints to the camp for key COVID-19 preparedness and response activities, with WASH, Health, Protection partners
  - Report any potential access constraints impacting activities delivery to OCHA, the CCCM Cluster and other relevant Clusters / NCCI / Access Working Group
- **Business continuity / remote monitoring plan**
  - Ensure that key service delivery can continue (both COVID-19 preparedness & response, and regular vital service delivery to meet basic needs) in the case that external staff cannot be in the site due to either potential COVID-19 exposure or humanitarian access issues. Camp-based staff should be trained on key responsibilities, including self-protection.
  - Monitor delivery of key services against Iraq standards as per usual camp-level process (e.g. water trucking, desludging, hygiene kit distributions, food distribution, replacement of shelter & NFI following fire or flood damage, etc.). Report any concerns to CCCM and relevant Clusters.
  - Establish remote management monitoring protocol, if necessary. See example ***Monitoring SOPS in No Access Context.*** Ensure daily reporting from camp staff of: sufficient handwashing facilities & soap; areas with crowding e.g. communal water points; service & protection referrals made; water available to agreed standards; health partner presence; suspected COVID case referral; rumour circulation; any protection concerns. Ensure dissemination of IIC contacts to ensure feedback mechanism access.
- Community participation & engagement
  - **Success of preparedness and response relies on community understanding and compliance**
  - Ensure engagement of community representatives in response planning process, to help with community buy-in. E.g. request input from Sector Leaders / mukhtars on draft plan, and other key groups (e.g. women, youth, eldery people, persons with disabilities etc.)
  - Ensure wide dissemination among community of key points of preparedness activities & what will happen if cases are suspected. Camp-based staff/volunteers should be informed of the plan and able to help explain to the community, as well as disseminating awareness messaging.
- Mass information dissemination
  - Joint mass information campaigns should be conducted with CCCM and Protection supporting Health and WASH partners, coordinated with government efforts
  - Ensure two-way communication methods are in place, to respond to community concerns.
  - See ***Mass Messaging & Communicating with Communities section***, below
- Support Health & WASH preventive measures and contingency plans
  - Part of the preparedness planning, support Health and WASH activities to be established in line with Health and WASH Cluster technical guidance. This might include providing distribution or warehousing support, if needed and possible, and support with mass messaging
  - Report any concerns to the CCCM Cluster and other relevant Clusters
- All large gatherings should be stopped in the site
  - Distributions should shift to e.g. phased attendance or block-by-block distribution. **At least 1 metre (3 feet) distance between people must be maintained at all times.**
  - Activities requiring group attendance should change methods as possible
  - Information campaigns & mass communication should use other methods e.g. tent-to-tent
  - *Example **distribution guidance** is available in the Cluster GoogleDrive*
- Decongestion:
  - **Take any possible short-term camp decongestion measures**. Discourage large gatherings of community members. Stop consolidation activities so long as key service delivery is unaffected.
  - Individuals with chronic illnesses already living in the camps are advised to stay living in their shelters, and avoid contact with new arrivals during the 14-day isolation period [Health Cluster]
- Market monitoring
  - Basic market monitoring to be undertaken by CCCM teams, using ***Camp basic market survey*** tool

[1] IASC Interim Guidance on Scaling Up COVID-19 Readiness and Response, v1.1 March 2020

- **New arrivals quarantine**
  - For camps that accept new arrivals / returning individuals a protocol should be established in agreement with relevant local authorities, camp security, and key partners (Health, WASH, Shelter/NFI, Protection, Food).
  - Health Cluster guidance is that **new arrivals to camps should stay in quarantine at least 10 metres distance from other individuals for 14 days**
  - In line with this guidance, camps that accept new arrivals should establish facilities or protocols to allow for new arrivals to undertake quarantine:
    - It is recommended that new arrivals NOT use shared communal facilities including WASH facilities, markets, attend distributions, or meet existing camp residents during this time.
    - It is recommended that new arrivals NOT stay with family members already living in the camp. If reunification with family members is necessary for protection reasons, all reunified individuals should also undertake quarantine.
  - If space allows:
    - 1) Identify and establish a quarantine area. This could be an un-used sector, or re-purposing of other unused facilities inside the camp
    - 2) Shelters and WASH facilities should be set up with at least 10 metres distance from shelters and facilities used by other families. (WASH facilities should meet minimum standards to ensure privacy and dignity)[2];
    - 3) Coordinate service delivery and distribution with Shelter/NFI, Food, Health, WASH, and Protection partners. Individuals will require shelter provision, possible NFI distribution, hygiene kits, food distribution so they can avoid markets during this time.
  - If there is no space to set up new arrival quarantine areas:
    - 1) New arrivals should be requested to self-quarantine inside existing tents for 14 days
    - 2) WASH facilities should not be shared with other families[2]
    - 3) Coordinate service delivery and distribution with Shelter/NFI, Food, Health, WASH, and Protection partners. Individuals will require possible NFI distribution, hygiene kits, food distribution so they can avoid markets during this time.
  - Messaging
    - Clear information about the reasons, duration, and process of the request for quarantine – as well as the services and assistance which will be provided – must be clearly communicated to the individuals in quarantine and family members.
    - Requesting new arrivals to stay in quarantine will require mass messaging in the camp as it risks creating stigma towards the new individuals.
    - It should be emphasised that quarantine is merely a precautionary health measure and does not result from any wrongdoing or any other social issue.
    - As for mass awareness campaigns, messaging should be coordinated between WASH, Health, CCCM, and Protection actors to ensure consistency of message and no duplication
  - Protection & CCCM monitoring
    - PSS should be provided throughout the quarantine period as necessary, possibly remotely by phone as required by health protocols. Consider facilitating communication with family members through e.g. phone calls.
    - Monitor the quarantine protocols and area and to ensure safety of individuals and that no discriminatory practices or policies are applied against any specific groups or individuals
  - Following the end of the quarantine, new arrivals or individuals returning to the camp should be supported to integrate in the camp as normal.
  - The recommendations for new arrival quarantine are made in order to ensure individuals can still choose to move into camps, while respecting Health Cluster and national and international guidance on COVID-19. Any incidents or concerns related to admission or readmission should be raised with CCCM & Protection Clusters for advocacy purposes.

- **Isolation of suspected & confirmed cases**
  - *As much as possible, setting up of an isolation area for suspected COVID-19 cases in each camp must be sought after. This is subject to availability of space and resources by the humanitarian*

[2] Given space limitations, access issues, and time sensitivity, construction of new WASH facilities is unlikely to be possible in the immediate term. Enabling setup of facilities for new arrivals that are not shared will likely require temporary camp-level solutions agreed between camp management, WASH, and existing community members.

partners supporting the camp. This should be in discussion with CCCM, WASH, Protection and other key partners (as for new arrival quarantine), with the Health partner advising on requirements. Note that discussion on guidance for isolation area set up is ongoing and will be released shortly

- If setting up separate isolation areas is not possible:
  - Individuals with suspected and confirmed COVID-19 should be requested to isolate to the maximum extent possible in their existing tents. This will enable unwell individuals to be cared for by family members.
  - Individuals should be encouraged to stay in a separate tent, if the family has multiple tents
  - WASH facilities should not be shared with neighbouring families, if possible to arrange at block level. Cleaning of facilities as advised by the WASH Cluster should be followed.
  - Individuals with confirmed COVID-19 should be requested to isolate for at least 7 days and 3 days without fever, whichever is longer.
  - Family members and people who have been in contact with suspected cases should self-isolate for 14 days

Note that the Government of Iraq Ministry of Health Directive on COVID-19 of 25 February 2020 puts provision in place for possible camp-level measures by the local authorities including:

- Camp residents being not permitted to leave the camps except for emergency health reasons
- Camp visits being not permitted except to service providers and aid workers

Please update the CCCM and Protection Clusters on whether and how this is being implemented at camp level.

Please report access issues for any humanitarian partners in the camp to the CCCM Cluster as well as to other relevant Clusters / NCCI / Access Working Group. Please report any issues with emergency health cases being allowed to leave the camp to the CCCM Cluster, as well as working to resolve this at local level.

Scenario 2 – confirmed case near to site

Confirmed cases nearby to the site may result in government increasing movement restrictions in the area – both restriction on humanitarian movement, and movement of families and goods in and out of camps. **Camp-level contingency planning must include plans for essential service continuity in the case of such local lockdown**.

- Activate remote monitoring plans to ensure continuation of essential service delivery
- Ensure reporting of access issues, service delivery, and food market availability issues to the relevant Clusters, CCCM Cluster, OCHA
- Continue with preparedness activities and response planning activities, as is possible

Scenario 3 – suspected case

In addition to Phase 1 measures:

- Refer the suspected case to the Health actor in the camp.
- Request family members and people who have had close contact with the individual suspected case to self-isolate in their tents.
- Request families to not move in and out of the sector with a suspected case. Humanitarian actors and registered service provider working in the sector and the rest of the camp but must undertake self-protection measures (1 metre / 3 feet distancing, regular handwashing, etc.)
- Re-inform all camp residents to stop gathering.
- Non-essential distributions should be put on hold. For essential items (e.g. food assistance, hygiene kits), a distribution modality that minimizes crowding should be used.
- Follow Health/WASH partner / Department of Health guidance on disinfection
- Follow Health partner / Department of Health guidance on case surveillance
- Coordinate with the Child Protection actors in the camp in case of isolation of suspected cases results in children being alone in a tent. Refer to *AC/Alternative Care Guidance for the COVID-19 Situation* of the Iraq Child Protection Sub-Cluster.

- Upscale mass messaging campaigns on prevention measures. Monitor for rumours and stigma against affected families and address through community engagement in coordination with Health, WASH, Protection. Information about the affected individuals and families should be kept confidential.
- Request Protection partner to follow up with concerned families on possible Psychosocial Support (PSS) to, e.g. through remote support over the phone if required by health protocols

Scenario 4 – confirmed case

As Scenario 3 measures, plus:

- For positive cases not requiring hospitalization on the advice of the Health partner, either relocate the individual to an isolation area inside the camp or request the individual to self-isolate in their tent for at least 7 days and 3 days without fever, whichever is longer.
- Request relatives of the confirmed case, and individuals who had contact with the confirmed case, to self-quarantine inside their shelters for 14 days, and use separate WASH facilities to neighbours if possible. Coordinate with WASH and food partner to ensure access to essential items.
- Coordinate with WASH partner for disinfection protocol / cleaning kit distribution to households and surrounding households
- Conduct mass messaging to reach all camp population on COVID-19 awareness & prevention measures. Tent to tent messaging should only be conducted if staff are able to undertake proper self-protection measures. Mass messaging through other means (e.g. SMS, social media, etc.) should be maximized
- Monitor for rumours and stigma against affected families and address through community engagement in coordination with Health, WASH, Protection.

Scenario 5 – multiple cases and rapid spread in the camp

As Scenario 4 measures, plus:

- Recommend movement of humanitarian staff into and within the camp to be limited to delivery of essential, lifesaving services only
- Closely monitor delivery of essential services (including water supply, access of health partner to the camp, access of camp residents to health facilities outside the camp), activating contingency plans if necessary
- Assess with health, WASH and CCCM partners if widespread hygiene kit or cleaning kit distribution is necessary based on number of cases and spread throughout camp.
- Request movement of residents within the camp to be kept to a minimum
- Continue to isolate and treat cases of COVID-19 while referring complicated cases to pre-identified hospitals within the governorate

CCCM reporting of suspected cases & response

Suspected or confirmed cases of COVID-19 are reported by Health actors through the established EWARNS health surveillance system.

To support information sharing within the humanitarian community, and reduce requests to camp-level Health partners, CCCM partners will be requested to report suspected COVID-19 cases (as reported by the Health partner), follow up made, and whether cases are confirmed (again, as reported by the Health partner), to the CCCM Cluster. The CCCM Cluster will then make this information available to other Clusters and necessary humanitarian actors. A simple reporting tool will be developed in agreement with partners, and updates circulated in agreement with ICCG/OCHA.

2. Multi-sectoral camp-level preparedness & response planning

The following is a guideline (and non-exhaustive) list of key activities by sector, to support partners to **develop a camp-level preparedness and response plan**.

The list of activities should be discussed and agreed with partners in the camp. It is provided in template form so the list could be used as a framework for a site-level plan, if CCCM partners wish to do so.

CCCM

Activity	Status / Notes
Camp-level preparedness & response plan in place *including access / remote management plan*	
Regular coordination with key humanitarian & government actors continues	
High-risk groups identified	
Referral pathways shared with all partners & community members	
All CCCM staff & appropriate community leaders trained on COVID-19 self-protection, and can access any appropriate PPE	
All CCCM staff & appropriate community leaders trained on COVID-19 key messages	
Mass information campaigns are coordinated between WASH, Health, CCCM, and Protection partners & are underway	
Monitoring and reporting of access issues for key humanitarian partners + supplies/contractors for essential services	
Large gatherings are stopped & alternative distribution modalities are in place	
Internal decongestion measures taken, if possible	
New arrivals quarantine area or protocol is established	
Isolation areas and/or protocol is established with Health partner	
Suspected cases & follow-up reported to the CCCM Cluster	
Market monitoring being conducted	

WASH

See: *National WASH Cluster Iraq COVID-19 Guidelines*

Activity	Status / Notes
Water can be supplied in line with Cluster minimum standards, even if access constraints	
Regular service management continues e.g. desludging, garbage collection	
Hygiene promoters in camp are identified and trained on messages in line with health and CCCM partner guidance	
Hygiene promotion for COVID-19 underway (in coordination with Health, CCCM)	
Hygiene kit top-up distribution in line with Cluster guidelines	
Hygiene kits pre-positioned for follow up distributions or outbreak response	
For communal WASH facilities: cleaning kits are distributed	
For HH WASH facilities: cleaning kits are pre-positioned	

Health

Activity	Detail	Status / Notes
Inform all partners of what to do if a case is suspected	Provide COVID-19 hotline numbers to the camp management and health partners providing services in camps	
Awareness creation and IEC material distribution	Conducting periodic awareness sessions targeting field-level staff (CCCM/Health/WASH) Distribution of IEC materials (cleared by WHO/MoH -Iraq) on COVID-19 including community case management guidance	

Prevent over-crowding in camp PHCCs	Maintain a crowd control mechanism that allows a limited number of cases for each type of diseases, (no common waiting area, particularly a separate section for respiratory tract infections	
Infection Prevention and Control (IPC) as per WHO guidelines: https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125	Strict infection prevention procedures and improve natural ventilation to all rooms	
On-the-job training of health workers at PHC level	Training of health workers providing services in the Primary Health Care centers in IDP camps supported by UN agencies/NGOs on infection prevention, most up-to-date methods of management of mild/moderate cases in an assigned isolation facility and referring confirmed severe cases of COVID-19 to referral hospitals	
Timely EWARN reporting	Regular reporting of all unusual infectious diseases to the Early Warning, Alert and Response (EWARN) system to identify cases and respond on time	
Complete case recording	Ensuring that complete medical records of all suspected/confirmed cases are maintained as per the WHO recommended case registration form in the PHCCs in partner-supported camps	
Technically support isolation mechanisms in camps and camp settings to manage suspected COVID-19 cases	Supporting isolation units (in coordination with CCCM, NFI, FS and government) in smaller camps that have adequate space and facilities (share dedicated resources from each camp/PHCC) for a cluster of camps to manage patients until they are referred outside the camps	

Protection

Activity	**Status / Notes**
Services referral pathways are updated with contingency referral pathways for phases 2,3 & 4 that factor in restricted access and include alternatives modalities of services delivery	
Field staff and community volunteers are trained on PFA to ensure minimum PSS capacities within the camp in case of restricted access	
PSS staff are prepared for remote counselling modalities and for COVID-19 specific PSS support using the IASC guidelines	
Community focal points or groups (and CCCM if relevant) are trained or informed on the basics of protection monitoring/assessment, and contingency plans are in place – including remote communication and monitoring - to ensure the effective reporting of protection concerns	
Existing caseload of individual cases are reviewed and critical cases prioritized for case management follow-ups. Alternative modalities for remote case management support are in place and communicated to concerned individuals.	
Staff know how to report incidents using the 'Civilian character of camp matrix' and the 'Right violations matrix for people with perceived affiliation'	
Engagement with WASH, Heath, CCCM and Food actors to ensure that new delivery modalities are adapted to persons with special needs, including persons with disabilities	
Contingency plans for cash liquidity are in place to respond to emergency protection cases and referrals	

Child Protection

See: *Unaccompanied Children Alternative Care Guidance for the COVID-19 Situation // Awareness Raising for Children, Parents and Community Members During Disease Outbreak // Case Management guidance for Disease Outbreak // Psychosocial Support and Learning kits for Infectious Disease Outbreak*

Activity	Status / Notes
All CP staff trained on COVID-19 self-protection	
All CP staff trained on COVID-19 key messages related to PSS and CP (recommended messages & modality in the above guidance)	
The critical messages for display / distribution is agreed with CCCM, Health, WASH, GP and GBV actors	
Case Management actors review referral pathways, check services accessible	
Case Management actors identify/confirm community based focal points	
Case Management actors review their "high risk (level 1) cases and ensure remote communication (ex: exchange phone numbers)	
In case of isolation/ quarantine, unaccompanied children protocol in place & included in referral pathways	
PSS actors are trained on tailored PSS and learning kits for disease outbreak	
Children and family members have access to PSS kits in Arabic/Kurdish	

GBV

Note that GBV risks may heighten, including as a result of confinement within the household (domestic violence), loss of livelihood opportunities (transactional sex), increased stress & anxiety, lack of access to safe shelter for survivors etc.

Activity	Status / Notes
Ensure referral pathways updated & service providers aware of safe referral mechanisms	
Disseminate information on GBV hotlines for reporting incidents.	
Coordination with other actors in camp to address multi-sectoral needs of GBV survivors during possible reduced presence (e.g. Health, law enforcement, women's organizations, cash)	
Follow-up is in place for the existing and emergency GBV cases.	
Consider remote case management & PSS services with limited or no face-to-face case management services.	
Regular review of survivors' safety plan.	
Regular wellbeing check-ins for all staff.	
GBV partner to support to ensure any quarantine or isolation facilities adhere to IASC GBV guidelines and risk prevention/mitigation measures.	

Food

Activity	Status / Notes
Monitor market prices & item availability	

Shelter/NFI

Activity	Detail	Status / Notes
Tent & NFI stock prepositioned in each camp	In case of damaged tents/NFI that need replacement. Temporary shared accommodation must be avoided by all means	
Kerosene distribution	Since rainy season is ongoing and temperatures low, advocacy for regular distribution, with MoH & MoMD. Regular reports on date of distribution and quantities shared with Shelter Cluster[3]	

[3] Use the usual Shelter Cluster tool to report kerosene distribution in IDP camps: https://enketo.unhcr.org/x/#uBtpQ8kD

3. Mass messaging & Communicating with Communities

Camp CwC

- ONLY the approved WHO/Ministry of Health messages should be used
- CCCM should coordinate camp-level messaging/CwC campaigns with Health, WASH, and Protection partners to ensure one effort. This might include joint teams, e.g. CCCM Community Mobilisers supporting Health teams.
- Multiple methods of communication should be used, and efforts must ensure to reach community members who are illiterate, elderly persons, persons with disabilities, and children.
- All CCCM staff should be trained on the key messages, and be able to answer community questions and report questions/rumours to CCCM management
- All community representatives should be trained on the key messages
- Ensure **two-way communication methods** are in place. CCCM must be able to **receive and respond to community concerns**. This might include ensuring community mobilisers are able to answer questions, use of hotlines, monitoring of camp social media to adapt key messages
- Ensure dissemination of IIC contact information, to ensure access to a feedback mechanism in case of limited organizational access, and a PSEA reporting mechanism
- Listen to community rumours. Adapt messaging campaign methods to address rumours or misinformation.

Guidance documents on Risk Communication & Community Engagement for COVID-19 here:
https://tinyurl.com/CCCMIraqCOVID-19

Iraq WHO COVID-19 materials in Arabic, Kurdish and English, for printing, here:
https://drive.google.com/drive/folders/1PB90ELMHOaQmDYRY8rcUvtNlOOeA78sU

Effective methods of mass information dissemination:

- Information campaigns must be **ongoing**, and **use multiple ways of information dissemination to reinforce the messages**
- Bear in mind that communities in Iraq report **preferring to receive information face-to-face**, with few preferring to receive information from leaflets or posters[4]. When face-to-face methods are not possible, mass information dissemination may require use of multiple communication methods.
- **Methods of mass information dissemination** could include:
  - Tent-to-tent by humanitarian teams, if considered safe;
  - Messaging through mukhtars, sector leaders, & camp committees;
  - Posters, leaflets, & information boards;
  - Loudspeakers/megaphones used by humanitarian teams on a scheduled basis;
  - Mosque loudspeakers in coordination with leaders;
  - Social media messages (e.g. Facebook or WhatsApp groups popular in the camp)
- Iraq Information Centre will send bulk SMS awareness messages to phone numbers shared by CCCM
- Ensure to include methods that can reach illiterate, children, and elderly community members
- Bear in mind that a lot of information is transferred among the camp communities by word of mouth, and through social media. This may lead to inaccurate information being circulated.
- Maximise **reach** (number of people that hear the message) and **frequency** (number of times that they hear it)

Guidance on rumour tracking & social media monitoring at camp level

Listening to and being able to address questions and rumours/misinformation will increase success of the information campaign. The usual feedback mechanisms in the camp (information desks) are less appropriate due to social distancing and limited humanitarian access. A straightforward alternative method of collecting and addressing questions and rumours is through Outreach Workers/Community Mobilisers and community leaders.

[44] GroundTruth Solutions, December 2019 “Iraq: Strengthening accountability to affected people”

Camp-based staff and volunteers can be requested to:

- Write down the questions and rumours they hear or receive on a daily basis
- Monitor camp WhatsApp and Facebook groups for questions, rumours, and misinformation

Shared back with senior staff, any questions can be clarified with the Health partner/Cluster or other appropriate Cluster. Key messages for the next day are then updated, with new messages included and existing messages re-emphasized if needed. Mass messaging can then be done through non-face-to-face methods e.g. scheduled mass information dissemination block-by-block through loudspeaker/megaphone.

Key Principles of Risk Communication[5]:

- **Concise and focused:** When people are scared or anxious, they have a hard time taking in and remembering lots of information.
- **Give action steps in positives:** Say “in case of fire, use stairs” instead “of do not use the elevator”. E.g. If you repeatedly say, “don’t take amoxicillin, don’t take amoxicillin, don’t take amoxicillin” people eventually are just going to remember amoxicillin.
- **Repeat the message:** *Reach and frequency.* Research suggests that messages are more likely to be received and acted upon when the number of people (reach) and the number of times each person hears the message (frequency) go up.
- **Personal pronouns:** Pronouns personalize the message and help with credibility and identification. “We are committed to...” or “We understand the need for...”
- **Use Plain Language:** Jargon creates barriers. Instead of “People may suffer morbidity and mortality” say “People exposed may become sick or die”. Instead of epidemic or pandemic say outbreak or widespread outbreak. Instead of deployed say sent or put in place.
- **Avoid speculation and assumptions:** Avoid worst case scenario, stick to known facts. Don’t fall for “what if”.
- **Avoid humor:** People rarely get jokes when they are feeling desperate and vulnerable. Remain sensitive.

Mass media

For partners interested in using mass media campaigns, such as radio, social media, television or text messages, all campaigns should be coordinated through the Health and WASH Clusters to prevent overlap or duplication, ensure synchronization of messages, and facilitate coordination with government messaging.

[5] Risk Communication and Community Engagement Strategy Coronavirus Disease 2019 COVID-19, Risk Communication Technical Working Group, Cox’s Bazar, March 2020