CCCM CLUSTER

CCCM guidance on preparedness and response planning, Iraq

Informal Sites

30 April 2020 v.1.1

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This document contains technical inputs from, and has been reviewed by the Health, WASH, Protection (including GBV and Child Protection Sub-Clusters), and Shelter Clusters, and Cash 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
Preventative measures	Suspected case on site	Confirmed case on site	Multiple confirmed cases on site

1. CCCM key activities at informal site level

In informal settlements, CCCM and other humanitarian actors should support the preparedness and response activities of local authorities and Department of Health (DoH), responsible for leading public health interventions. The first step in planning CCCM COVID-19 interventions is to understand the planning and intentions of authorities, with CCCM (and other humanitarian) activities then being designed to complement these and avoid duplication. Activities should be appropriately coordinated with local authorities during design and implementation.

Phase 1 – Preventive measures

- Develop informal site-level humanitarian preparedness & response plan
  - The CCCM actor should ensure the development of a **plan for each informal site, or collection of informal sites** covering appropriate humanitarian preparedness activities (preventive measures) and response, that can be undertaken in the site to **complement and support local authority and DoH activities and responsibilities** and ensure any necessary continuity of humanitarian service provision
  - Appropriate humanitarian and CCCM COVID-19 activities will vary depending on the engagement and activities of local authorities and DoH in the site and surrounding area.
  - Planned activities must be developed at local level in coordination with local authorities and with the engagement of the community representatives/leaders. Ensure collaboration with other relevant partners present or operating in the site, if any, mainly; Health, WASH, Shelter, Protection actors.
  - Plans and activities should follow this guidance for CCCM partners, technical guidance from the Health and WASH Clusters, and WHO/Ministry of Health national guidance. 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 informal site population to identify high-risk groups as per WHO guidance:
        - Elderly persons, people with immune-suppressing illnesses or taking immunosuppressants, people with chronic illnesses e.g. hypertension, diabetes, heart disease, cancer, chronic lung disease, renal 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.
    - Ensure constant monitoring on service availability and informal site residents' access to them.
- Staff protection
    - Ensure all CCCM staff, partner organization staff, and community members/leaders engaged in the COVID-19 response 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-quarantine and not come to work in the site for 14 days after the potential exposure[1]
    - Follow organizational & Directorate of Health guidelines on wearing PPE
- Access analysis:
    - Understand potential access constraints to the informal site for key COVID-19 preparedness and response activities, with WASH, Health, Protection partners
    - Report any potential access constraints affecting service delivery to OCHA sub-office, 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 at the site due to either potential COVID-19 exposure or humanitarian access issues. Informal site-based staff should be trained on key responsibilities, including self-protection.
    - Monitor delivery of key services against Iraq standards as per usual informal site-level process (e.g. WASH service access, food distribution, NFI & Hygiene distributions etc.). Report any concerns to CCCM and relevant Clusters.
    - Establish remote management monitoring protocol, if necessary. Ensure reporting on regular basis from informal site staff or community representatives of: water and soap availability in the site; overcrowded areas; service & protection referrals made; health service presence; suspected COVID case referral; rumor circulation; any protection concerns. Ensure dissemination of IIC contacts and COVID-19 hotline numbers to ensure feedback mechanism access and ease of referrals of suspected cases.
- Community participation & engagement
    - **Success of preparedness and response relies on community understanding and compliance.**
    - Ensure engagement of community representatives in mass messaging and any response planning process, to help with community buy-in. E.g. request input from community leaders and other key groups (e.g. women, youth, elderly people, persons with disabilities etc.).
    - Capacity building on COVID-19 prevention and messaging of community representatives is highly encouraged, as a preparedness measure in case of activation of remote implementation and monitoring.
- Ensure wide dissemination among community of key points of humanitarian preparedness activities (e.g. mass messaging, distribution plans, and any community self-quarantine measures in place) & what to do if cases are suspected and/or confirmed. Informal site-based staff/volunteers, if any, should be able to help explain to the community, as well as disseminating awareness messaging.
- Mass information dissemination:

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

  - 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.
  - Information campaigns & mass communication should use other methods e.g. door-to-door
  - See ***Mass Messaging & Communicating with Communities section***, below
- All large gatherings should be stopped at the site
  - Coordinate with the municipality/district/mayoral officials, community representatives, including mukhtars and religious leaders to stop large gatherings within the site.
  - Distributions should shift to e.g. phased attendance or door-to-door distribution. **At least 1 meter (3 feet) distance between people must be maintained at all times.**
  - Modalities of activities, whether lifesaving or COVID-19 related, requiring group attendance should change as much as possible
  - *Example **distribution guidance** is available in the Cluster Google Drive*[2]
- New arrivals quarantine
  - Local authority / DoH guidance should be followed on self-quarantine advice for new arrivals or individuals returning to the site, based on the current governorate-level advice and protocols
  - If appropriate to the site, and the role of CCCM within the site / COVID-19 response:
    - Inform/Create awareness within the site residents about the possibility that individuals directly moving into the site could risk transmission of COVID-19
    - Support the community on the creation of community protocols for 14-day self-quarantine for individuals are re-entering or newly arriving to the site from outside the immediate area (i.e. they are moving from outside to the community), in collaboration with local authorities, community representatives, and key partners (Health, WASH, Shelter/NFI, Protection, Food).
    - Self-quarantine involves individuals remaining within their shelter, away from other family members, and not enter communal areas e.g. markets and communal WASH facilities
    - CCCM, and Protection partners, if available, should aim to monitor any community self-quarantine protocols to ensure safety of individuals and that no discriminatory practices or policies are applied against any specific groups or individuals. If programming allows, MHPSS support by phone could be offered to individuals undertaking self-quarantine.
  - Messaging
    - Informal sites where a community self-quarantine protocol is in place should be encouraged to communicate clear information about the reasons, duration, and process of the request for self-quarantine of new arrivals or re-entrants to the site, as well as the agreed community protocols on this must be communicated to the individuals and family members.
    - Be aware that self-quarantine may risk creating stigma towards the new individuals. It should be emphasized that quarantine is merely a precautionary health measure and does not result from any wrongdoing or any other social issue.
    - CCCM mass messaging in the site can support this, encouraging individuals to take responsibility for self-quarantine as well as other safe practices. As for mass awareness campaigns, messaging should be coordinated with local authorities and WASH, Health, CCCM, and Protection actors to ensure consistency of message and no duplication
    - Ensure to emphasise the process for health referrals in case any individuals do show flu-like symptoms
  - The recommendations for new arrival self-quarantine are made in order to ensure individuals moving into the informal site reduce risk of transmission to other community members, following Health Cluster and national and international guidance on COVID-19.

Scenario 2 – suspected COVID-19 case onsite

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

[2] Link here: https://tinyurl.com/CCCMIraqCOVID-19

- 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

In addition to Phase 1 measures:

- In line with Government of Iraq protocols, individuals who might have COVID-19 should be referred to health providers, for confirmation of symptoms, laboratory investigation, and onwards referral. A call should be made to the health provider before travel to the clinic to ensure the individual is received properly and to limit risk of onward transmission. If onward referral is not made, then the protocol advised by the health provider should be followed. If a health provider is not available for referral, inform the Ministry of Health hotlines: 123 for Federal Iraq and 122 for KRI.
- If the family members and close contacts of the individual who might have COVID-19 are not quarantined by the health authorities:
  - They should be requested to self-quarantine to the maximum extent possible in their existing houses/shelters until the case is confirmed positive or negative, if test available, or not showing any flu-like symptoms in the following 14 days. (Role of CCCM in communicating this may vary depending on the site, and engagement of local authorities)
  - WASH facilities should not be shared with neighbouring families, if possible. Cleaning of facilities as advised by the WASH Cluster should be followed.
  - If there is any case of child / children need to be quarantined on their own, contact child protection focal person at district level.
  - If the case is confirmed positive, people that have been in contact with the him/her, relatives and friends, should stay in self-quarantine for 14 days.
- Re-inform all informal site residents to stop gathering, and the importance of physical distancing and good hygiene habits.
- All 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, such as household level distribution.
- Follow Health partner / Directorate of Health guidance on case surveillance
- 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. Humanitarian actors and community representatives should keep information about the affected individuals and families confidential.
- Request Protection partner, if available, to follow up with concerned families on possible Mental Health and Psychosocial Support (MHPSS) e.g. through remote support over the phone if required by health protocols
- Residents of informal sites are likely to be reliant on informal mechanisms of income, in turn likely to be disrupted during COVID-19 restrictions. Promote the continuity of cash-based intervention activities to sustain the access to basic services (e.g. Health) and food and non-food items, following the guidance of the Cash WG and other relevant clusters: Food Security, Emergency livelihoods, WASH and Shelter. See the WHO and WFP "*Guidance note on the role of Cash and Voucher Assistance to reduce financial barriers in the response to the COVID-19 pandemic, in countries targeted by the Global Humanitarian Response Plan for COVID-19"*[3] and the CaLP *"CVA in COVID-19 contexts: guidance from the CaLP network"*[4]

Scenario 3 – confirmed COVID-19 case onsite

As Scenario 2 measures, plus:

- If individuals who have confirmed COVID-19 are not hospitalized or requested to stay in a government facility[5], the advice of DoH or the health provider should be followed. This might include requesting the individual to self-isolate in their house/shelter for at least 7 days and 3 days without fever, whichever is longer (the virus contagion period). (Role of CCCM in communicating this may vary depending on the site, and engagement of local authorities)

[3] "Guidance note on the role of Cash and Voucher Assistance to reduce financial barriers in the response to the COVID-19 pandemic, in countries targeted by the Global Humanitarian Response Plan for COVID-19" Link here: https://www.who.int/health-cluster/about/work/task-teams/cash/en/

[4] CVA in COVID-19 contexts: guidance from the CaLP network": Link here: https://www.calpnetwork.org/themes/cva-and-covid-19-resources-guidance-events-and-questions/

[5] For more information, see: "COVID-19 Outbreak Preparedness and Response Operations in IDP Camps" prepared by the Health and Shelter Clusters. Document here: **https://tinyurl.com/CCCMIraqCOVID-19**

- If family members and close contacts of the individual are not already undertaking quarantine in government facilities, they should be requested to self-quarantine inside their house/shelters for 14 days (the virus incubation period), and use separate WASH facilities to neighbours if possible. If not possible, adequate sanitization of WASH facilities after every use should be advised. If there is any case of child / children need to be quarantined on their own, contact child protection focal person at district level. (Role of CCCM in communicating this may vary depending on the site, and engagement of local authorities)
- CCCM to encourage community members to support those undertaking self-isolation or quarantine, ensuring sufficient access to food and basic items without them having to access shops (delivery of items should ensure to respect 1 meter social distancing, or preferably items being dropped in front of their shelter and collected by the person once the delivery has been completed).
- Coordinate with WASH partner for disinfection protocol / cleaning kit distribution to households and surrounding households/possible contacts
- Coordinate with MHPSS actors to continue ongoing PSS for individuals living in the site to minimize anxiety and stigma.
- Conduct mass messaging to reach all informal site population on COVID-19 awareness & prevention measures. Door to door 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 prioritized. Messaging should complement and support that conducted by DoH / local authorities.
- Monitor for rumours and stigma against affected families and address through community engagement in coordination with Health, WASH, Protection.

Scenario 4 – multiple cases and rapid spread in the informal site

As Scenario 3 measures, plus:

- Recommend movement of humanitarian staff into and within the informal site to be limited to delivery of essential, lifesaving services only
- Closely monitor delivery of essential services (including water supply, access of residents to health facilities outside the informal site), activating contingency plans if necessary, and keeping inform the population on approved Health and Protection referral pathways.
- 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 informal site.
- Request movement of residents within the informal site to be kept to a minimum
- If referral of all cases to medical facilities is not possible, support community efforts to isolate people that might have 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 communicable disease surveillance system, as well as the regular surveillance run by the MoH.

To support information sharing within the humanitarian community, 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.

2. Multi-sectoral informal site-level preparedness & response planning

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

The list of activities should be discussed and agreed with partners in the informal site, if a specific partner is available; if not, CCCM Cluster can oversee the soft component of life-saving ones. 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
Informal site-level preparedness & response humanitarian plan in place *including access / remote management plan* (complementing local authority / DoH plans & activities)	
Regular coordination with key humanitarian & government actors continues	
Regular coordination with the community representatives	
High-risk groups identified (based on age and pre-existing medical conditions factors)	
Access to area-based services is monitored	
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	
Large gatherings are stopped & alternative distribution modalities are in place	
New arrivals quarantine information campaigns are underway and protocol with the community is established, if appropriate to the site	
Suspected cases & follow-up reported to the CCCM Cluster	

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 informal site 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

Where informal sites are supported by a humanitarian health partner through a static or mobile clinic, the below activities need to be conducted.

Activity[6]	Detail	Status / Notes
Inform all partners of what to do if a case is suspected	Provide COVID-19 hotline numbers to the informal site management and health partners providing services in informal sites	
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 when PHCs are provided at the PHCCs or by MMTs	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:	Strict infection prevention procedures and improve natural ventilation to all rooms	

[6] PHCs: Primary health care services. PHCCs: Primary health care centers. MMTs: Mobile medical teams

https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125	* Only if the static PHCC is managed by a Health actor.	
On-the-job training of health workers at PHC level	Training of health workers providing services in the Primary Health Care centers/mobile clinics in IDP informal sites 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 informal sites	

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 informal site 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.	
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

Note: *CP focal point will be identified at district level not at the site level please see the referral pathway for informal sites*

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)	
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: *Living in overcrowded or inadequate shelters can lead to an increase in some forms of GBV. For example, early or forced marriage may be used as a measure to address economic hardship. Domestic violence incidents may increase due to the stress related to economic hardship and overcrowded shelters with extended family living together. Moreover, site layout can increase the risk of rape or sexual harassment when sanitation facilities are not separated by sex, lighten at night or not built in secure locations. The distance between the shelters may also increase GBV due to stress related to lack of privacy. GBV risks may heighten further during the COVID-19 situation, 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 informal site 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.	
Conduct Safety Audit SA assessments, if feasible, to assess the GBV risk factors present in the informal sites and coordinate with the relevant sectors to improve safety and minimize the identified GBV risks in the sites.	
Disseminate joint GBV and MHPSS messages to raise awareness using the possible modality to prevent GBV, how to cope with the emerging stress in positive ways, and how and where to seek for support if needed.	
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	
Coordinate with the local authorities and actors to address food gaps	

Shelter/NFI

Activity	Detail	Status / Notes
Improve Inadequate Shelter condition	If needed, provision of SOKs or plastic sheeting to reinforce the shelter or build separations within UAB. Provision of cash for rent for people at risk of eviction	
HHs NFI kits distributions	If needed, provision of essential items to avoid vulnerable HHs exchanging them.	

MPCA

Activity	Detail	Status / Notes
MPCA to eligible IDPs and returnees residing outside camps based on the SEVAT	800USD upfront payment to eligible HHs living outside camps to cover basic needs including food, rent, WASH, Health, transportation, communications.	

3. Mass messaging & Communicating with Communities

Informal site CwC

- ONLY the approved WHO/Ministry of Health messages should be used
- CCCM should ensure that messaging campaigns complement and support those undertaken by the local authorities,
- CCCM should ensure that humanitarian informal site-level messaging is coordinated between any Health, WASH, and Protection partners to ensure one effort. This might include joint 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 informal site 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 campaigns 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/1PB90ELMHOaQmDYRY8rcUvtNIOOeA78sU**

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[7]. 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:
  - Door-to-door by humanitarian teams, if considered safe;
  - Messaging through mukhtars, sector leaders, & informal site 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 informal site)
  - Mobile vehicles with loudspeaker
- 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 informal site communities by word of mouth, and through social media. This may lead to inaccurate information being circulated.

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

- 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 informal site level

Listening to and being able to address questions and rumours/misinformation will increase success of the information campaign. A straightforward method of collecting and addressing questions and rumours is through Outreach Workers/Community Mobilisers and community leaders.

Informal site-based staff and volunteers can be requested to:

- Write down the questions and rumours they hear or receive on a regular basis
- Monitor informal site 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 in the site through loudspeaker/megaphone.

Key Principles of Risk Communication[8]:

- **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.

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