Joint Evaluation of the Risk Communication and Community Engagement (RCCE) Collective Service

Evaluation Report

A COLLABORATIVE PARTNERSHIP BETWEEN IFRC, UNICEF AND WHO

World Health Organization

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IFRC Strategic Planning Department
UNICEF Evaluation Office
WHO Evaluation Office

November 2023

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Preface

The Risk Communication and Community Engagement (RCCE) Collective Service is a multi-agency collaborative partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO). With the support of the Global Outbreak Alert and Response Network (GOARN) and the Bill and Melinda Gates Foundation, the Collective Service was established in June 2020 in response to the COVID-19 pandemic. It aimed to transform how the public health and the humanitarian sectors coordinate, implement, monitor and resource collaborative approaches to community-led responses for public health emergencies.

Since its inception, the Collective Service has received support from donors, national governments, and many civil society actors. Through its three major platforms – namely, RCCE coordination, Data for Action, and on-demand capacity and surge support – the Collective Service has responded to the needs for health interventions caused by epidemic and natural disasters in Africa, the Middle East, Asia, the Americas, and Europe.

The joint evaluation was conducted collaboratively by the evaluation offices of IFRC, UNICEF and WHO, which marked the first such joint evaluation undertaken by the three agencies. The evaluation concludes that the decision by IFRC-UNICEF-WHO to launch a global, inter-agency, and coordinated effort on RCCE was appropriate, necessary and timely. The Service made many positive contributions to RCCE coordination, technical guidance, and information management. The findings from the evaluation make a significant contribution to the much-needed knowledge base on what has worked (e.g. in collective service products, capacity-building, and inter-agency coordination) and what more needs to be done to accelerate further the progress in combating global health emergencies (e.g. in preparedness and readiness).

This evaluation report is published at a time when the Collective Service is at a crossroads. A clear majority of the key informants of the evaluation believe that the Collective Service should continue beyond 2023 and remain a feature of health emergency readiness and response in the future, although there is no consensus on its future scope. The evaluation report outlines strategic options and recommends actions aimed at developing a future vision and model for the Collective Service and shaping key elements such as its services, membership and fundraising approach accordingly. We are confident that the IFRC-UNICEF-WHO Collective Service Steering Committee will use the evidence generated by the evaluation and its recommendations to determine the future shape of the Collective Service.

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This evaluation was jointly managed by the IFRC Strategic Planning Department, the UNICEF Evaluation Office, and the WHO Evaluation Office. A Management Team was formed, consisting of Simon Bettighofer (UNICEF), Miki Tsukamoto (IFRC), and Anand Sivasankara Kurup (WHO). Support was provided by Xin Xin Yang and Sergio Riaga (UNICEF); and oversight by Erica Mattellone (UNICEF).

The evaluation results from valuable contributions and support provided by many institutions and individuals. We first would like to extend our appreciation to the evaluation team for generating a useful report, the insights from which will be valuable in designing the next phase of this multi-agency collaborative partnership. The evaluation team consisted of Simon Lawry-White (Team Leader), Magdalena Isaurralde (Social Sciences Specialist) and Juan A. Seclen (Public Health Specialist).

Special thanks go to the evaluation reference group composed of representatives from IFRC, UNICEF, WHO and the Collective Service and members of its Steering Committee, as well as external experts in risk communication and community engagement and public health, who provided technical input and insightful guidance to the evaluation process: Kathryn Bertram (Johns Hopkins), Hazel De Wet (UNICEF), Veronique Durroux (OCHA), Nedret Emiroglu (WHO), Sophie Everest (IFRC), Viviane Fluck (IFRC), Charles Antoine Hofmann (UNICEF), Rachel James (Collective Service), Petra Khoury (IFRC), Rocio Lopez Inigo (Internews), Oliver Lough (ODI), Thomas Moran (WHO), Naureen Naqvi (UNICEF), Eva Niederberger (Anthrologica), Muhammad Shafique (Collective Service), and Carlos Van der Laat (IOM).

The following colleagues served as focal points for coordinating matters during the evaluation: Diane Le Corvec (Collective Service), Alexandra Sicotte-Levesque and Ombretta Baggio (IFRC), Humberto Jaime and Maria Isabel Gamez Salazar (UNICEF) and João Rangel de Almeida (WHO). Their commitment has been instrumental in the successful completion of this evaluation. We also thank the UNICEF Uganda Country Office for supporting the evaluation fieldwork.

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Acronyms and abbreviations

4Ws	who does what, where and when
AAP	accountability to affected populations
ALNAP	Active Learning Network for Accountability and Learning
CDAC	Communicating with Disaster Affected Communities Network
CE	community engagement
CEA	community engagement and accountability
CFM	community feedback mechanism
CS	Collective Service
D4A	Data for Action
ESA	East and Southern Africa
EVD	Ebola virus disease
GOARN	Global Outbreak Alert and Response Network
HEPR	Health Emergency and Preparedness Response
IASC	Inter-Agency Standing Committee
IFRC	International Federation of the Red Cross Red Crescent National Societies
INGO	international non-governmental organization
IOM	International Organization for Migration
LOA	Letter of Agreement
M&E	monitoring and evaluation
MENA	Middle East and North Africa
MOU	Memorandum of Understanding
NGO	non-governmental organization
OCHA	[United Nations] Office for the Coordination of Humanitarian Affairs
ODI	Overseas Development Institute Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PHE	public health emergency
RCCE	risk communication and community engagement
RCRC	Red Cross and Red Crescent
SBC	social and behaviour change
SVD	Sudan virus disease
TOC	theory of change
TOR	Terms of Reference
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children’s Fund
WCA	West and Central Africa
WHO	World Health Organization

Glossary

To facilitate the reading of the evaluation report, this glossary sets out some of the key concepts related to community participation, social and behavioural change, risk communication with communities during public health crises, and other emergency situations. As the report explains, these are all of relevance to the past and future of the Collective Service.

Accountability to affected people (AAP)

"Accountability to affected populations" refers to the responsibility of organizations, agencies, or individuals involved in humanitarian or development work to use power responsibly: to take account of, give account to, and be held to account by the people they seek to assist.[1] This concept recognizes the rights and agency of the affected populations and emphasizes their active participation in decision-making processes that impact their lives.

UNICEF guidance on AAP specifies: "It's about putting the needs and interests of the people and communities organizations serve at the centre of decision-making, and ensuring the most appropriate and relevant outcomes for them, while preserving their rights and dignity and increasing their resilience to face situations of vulnerability and crisis. In practice, this means that people – including children and adolescents – have a say in decisions that affect their lives, receive the information they need to make informed decisions, have access to safe and responsive mechanisms to provide feedback or to complain, and have equitable access to assistance in proportion to their needs, priorities and preferences."[2]

Community engagement and accountability (CEA)

Community engagement and accountability (CEA) can be defined as a way of working that respects all community members as equal partners and whose diverse needs, priorities and preferences guide the work of humanitarian and development practitioners. CEA is achieved "by integrating meaningful community participation, open and honest communication, and mechanisms to listen to and act on feedback, within our programmes and operations".[3]

CEA is based on scientific evidence and the practice of participatory approaches. In fact, it is recognized that when communities take an active role in the design and management of programmes and operations, the outcomes are more effective, sustainable and of a higher quality.[4]

Risk communication and community engagement (RCCE)

The concept of risk communication and community engagement (RCCE) has recently emerged in the context of health and epidemic response.[5] RCCE refers to the processes and approaches to systematically engage and communicate with people and communities to encourage and enable them to promote healthy behaviours and prevent the spread of infectious diseases during public health events.[6]

RCCE is a systematic and planned process – it is a series of activities or interventions that target individuals, social groups and networks, at a household and community level. It addresses the way information is transmitted, perceived, understood and applied. However, it's not enough to only provide information to people and expect behaviour change; some people will not be able to act due to barriers to accessing essential services and this is why community engagement is a critical component. RCCE is equally important to manage and respond to social and economic consequences of risk mitigation measures and support people's well-being.[7]

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[1] IASC (undated). Strengthening Accountability to Affected People (IASC website).
[2] UNICEF (2020). Accountability to Affected Populations Handbook, p. viii.
[3] Ibid., p.11.
[4] Ibid.
[5] International Federation of Red Cross and Red Crescent Societies [IFRC] and the International Committee of the Red Cross (2021). A Red Cross Red Crescent Guide to Community Engagement and Accountability, p. 13.
[6] IFRC (2020). Risk Communication and Community Engagement. Guidance Note for the National Society & IFRC Response Teams, p. 1.
[7] IFRC (2023). Community Engagement and Accountability (IFRC website).

Following the International Federation of the Red Cross and Red Crescent National Societies (IFRC) definition, RCCE includes:

- Sharing timely, accurate information about the epidemic through the most trusted channels, to support people to adopt practices that reduce the spread of infection and to reduce fear, stigma, and panic by addressing rumours and misinformation.
- Establishing systematic community feedback mechanisms to understand the beliefs, fears, rumours, questions, and suggestions circulating in communities about the disease and use this feedback to inform the response.
- Identifying and supporting community-led solutions to prevent the spread of infection and bring the outbreak under control, as it will be the actions of community members that will end – or sustain – an outbreak.[8]

Social and behaviour change (SBC)

Social and behaviour change (SBC) aims to empower individuals and communities, and lower structural barriers that hinder people from adopting positive practices and societies from becoming more equitable, inclusive, cohesive and peaceful. Drawing on various disciplines (from sociology and psychology, to communication and behavioural economics), SBC encompasses any set of strategies and interventions that influence drivers of change and support local action towards better societies. It helps development practitioners and policymakers design more effective programmes for reducing poverty and inequity. And it blends scientific knowledge with community insights, most importantly, to expand people's control over the decisions that affect their lives.[9]

[8] IFRC (2021). A Red Cross Red Crescent Guide to Community Engagement and Accountability, p. 118.

[9] UNICEF (undated). Social and Behaviour Change: Helping families access the decisions that affect their lives (UNICEF website).

Executive Summary

Context and background to the evaluation

The Risk Communication and Community Engagement (RCCE) Collective Service (hereinafter also referred to as 'the Service'), established in June 2020 during the COVID-19 pandemic, is a multi-agency collaborative partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), with the support of the Global Outbreak Alert and Response Network (GOARN). The goal of the Service was "to transform how the public health and the humanitarian sectors coordinate, implement, monitor, and resource collaborative approaches to community-led responses for public health emergencies".[10]

In December 2020 the Service agreed four objectives:

1) Be community-led, facilitating community-led responses to COVID-19;
2) Be data-driven, basing COVID-19 responses on evidence;
3) Reinforce capacity and local solutions to control the pandemic and mitigate its impacts; and
4) Be collaborative, strengthening coordination at global, regional and national levels.[11]

The Service grew out of discussions between individuals from the core partners who had experience of responding to previous epidemics, such as Zika, the Ebola virus disease outbreaks in West Africa in the 2010s and the Democratic Republic of the Congo in 2018 and 2020, and were determined to avoid past shortcomings regarding the lack of effective RCCE. The Service aims to enhance the quality and scale of RCCE approaches to COVID-19 and beyond, improving collaboration and coordination on RCCE among key partners at all levels responding to the pandemic, including technical advice and support to data collection and analysis. The initial focus of the Service was on coordination more than service provision. A grant from the Bill and Melinda Gates Foundation supported the establishment of the structure and capacity of the Collective Service at global and regional levels, with a pilot phase to run from 1 June 2020 to 31 May 2021.

The structure of the Service was established as a global hub (a Secretariat, agency focal points and a steering group), and two regional hubs in East and Southern Africa and West and Central Africa, with technical coordination and support taking place with other regions such as the Middle East and North Africa, and Asia Pacific. Under the global coordination, regular coordination calls were supported by GOARN, various subgroups developed for thematic areas, with the wide participation of UN agencies, NGOs, academics and the media. The Service operated under the constraints imposed by the pandemic, including: the necessity of remote working; lack of face-to-face contact between members of the Service and its clients; and inability to provide support and training on site.

The Service was established with a theory of change (TOC) and an accompanying logical framework. A joint IFRC-UNICEF-WHO strategy for RCCE was adopted in support of the delivery of the COVID-19 Global Response Strategy agreed in March 2020, before the Collective Service was formed. A second strategy, the Interim Global RCCE Strategy, was developed for the period from December 2020 to May 2021. Subsequently, the Service was organized around three strategic areas: *Be Collaborative, Be Data-driven,* and *Be Community-led.*

The services offered by the Collective Service in support of RCCE include:

- Coordination at global and regional level
- Provision of socio-behavioural evidence on which to base RCCE strategies, and to inform response decision-making and community response
- In-country and remote RCCE advisory and technical support, access to a broad set of RCCE guidance and tools, and training devised collectively by the core partners with the participation of many other organizations.

[10] Collective Service (2023). The Collective Service for a Community-led Response: What is the Collective Service? (Collective Service website).
[11] IFRC, UNICEF, WHO (2020). COVID-19 Global Risk Communication and Community Engagement Strategy, pp. 13–16.

Conduct of the evaluation

This evaluation of the Collective Service was carried out under the joint management of IFRC, UNICEF and WHO and implemented by an evaluation team of external experts between January and August 2023, with the final report completed in November 2023 after presentation and validation of findings.

The purpose of the evaluation was to assess the Collective Service's contribution to the overarching goal of RCCE systems-strengthening in the public health and humanitarian responses to the COVID-19 pandemic, and to make proposals and recommendations for the Service partners' decision makers regarding the future strategy, vision and coordination model based on evidence of RCCE good practices and lessons learned from Collective Service implementation and beyond. The evaluation sought to provide answers to a number of questions about the relevance and coherence of the Collective Service, the extent to which planned outcomes have been achieved, the efficiency and effectiveness of coordination and collaboration, how far the Service supported effective decision-making in RCCE and to what extent the Service's internal systems have fostered accountability, learning and improved performance.

The primary intended users of the evaluation are the director-level IFRC-UNICEF-WHO Collective Service Steering Committee, which will use the evidence generated by the evaluation and its recommendations for the future, to help determine the future shape of the Service.

The evaluation methodology included data collection via document review; 88 key informant interviews with staff and consultants from the core organizations and external partners (51 female, 37 male); an online survey for stakeholders involved in the work of the Collective Service at headquarters, regional and country levels, which received 98 responses; as well as four case studies of the progress of collective RCCE at country and regional level, one of which was informed by a country visit to Uganda. Data sources were analysed and triangulated, leading to the distillation of findings, conclusions and recommendations.

Key findings

Relevance

- **Leadership**. The decision by IFRC-UNICEF-WHO to launch a global, inter-agency and coordinated effort on RCCE was appropriate, necessary and timely. The bringing together of actors to coordination RCCE on this scale was unprecedented. Many partners saw the relevance of the global coordination forum and took part with commitment in the several global-level technical subgroups established under the Service. As the pandemic receded, the Service remained relevant by adapting its tools to support RCCE for cholera and Ebola virus disease outbreaks, and latterly for drought and flood responses in Africa.
- **Theory of change**. The Collective Service theory of change provided a sound and well-articulated basis for implementation of the Service. This now needs revision to include logic steps for ensuring that partners and governments are engaged, which was one of the principal gaps in the Service early on. The theory of change should also be updated to encompass a systems approach to capacity-strengthening, rather than focusing just on capacity-building and training, if the Service intends to have a lasting impact on RCCE development capacity.
- **Branding**. There was no intent to create a separate identity and branding for the Collective Service but, lacking wholehearted support from within its own parent organizations, the project found itself having to assert its brand to ensure its survival. The name 'Collective Service' was confusing for some stakeholders since it carries no clear meaning and reinforces the perception of a service identity, distinct from the core partners.
- **Future demand**. As far as relevance can be judged by potential future demand, 87 per cent of survey respondents considered it 'Very likely' or 'Somewhat likely' that they would need the support of the Collective Service in a future health emergency.

Contribution to planned outcomes

The Service made a series of positive contributions in the technical areas of RCCE coordination, technical guidance, and information management.

- **Collective Service Products**. The Service developed RCCE approaches, methods and tools using up-to-date evidence and made them broadly accessible to actors in the sector. The evaluation received positive feedback concerning the technical quality of the products of the Service, while feedback on their utility was mixed. Some products were widely adapted and applied. Interviews revealed a lack of knowledge of the products and, by implication, the underutilization of some. More guidance was generated than could be absorbed effectively by regional and country teams.
- **RCCE Inter-agency Coordination**. The global videoconferences organized by the Collective Service with GOARN support were well attended and proved both relevant and effective during the first year of the pandemic. In some regions, and most evidently in East and Southern Africa, the Service has supported the strengthening of existing RCCE coordination processes with dedicated capacity, the creation of dedicated subgroups, research, and information services, and training in support of country-level and regional RCCE. The support provided by the Service in West and Central Africa was limited in its effectiveness primarily because it was only active for one year. In the Middle East and North Africa, a dedicated inter-agency coordinator supported RCCE capacity development without dedicated funding or support staff. The Service was also in contact with Asia Pacific to share technical resources, and included all regions in global RCCE coordination discussions, webinars and conference calls.
- **Collective Helpdesk**. The Helpdesk, supported by UNICEF, offers remote assistance for technical queries to core partner staff and other RCCE practitioners. From its inception to the time of this evaluation, the Helpdesk generated 224 queries, which can be considered a limited demand. The Helpdesk was launched in 2022 when COVID-19 was no longer at its peak. The platform was not widely advertised or utilized, and despite the provision of FAQs explaining its purpose and function, the Helpdesk has had limited take-up from IFRC and WHO. The Helpdesk is now also supporting an initiative on inclusion and accountability to affected people, hosted by the Active Learning Network for Accountability and Performance (ALNAP).
- **Capacity-Building**. The training provided by the Service on coordination, RCCE, social science, community feedback, and information management, amongst other topics, reached thousands of participants, many from the regional and country offices of the core partners, but also from governments and other partners. Summary statistics on participation were not available. Initially, most effort was focused on building internal RCCE capacity through remote webinars, with limited reach at the national level. As the pandemic receded and duty travel became possible, the Collective Service hub in East and Southern Africa in particular, was able to focus more on in-country, in-person capacity development for governments and local partners. No analysis of the effectiveness of the training could be found.
- **Preparedness**. Systematic capacity development of health systems to prepare for future RCCE has featured little in the work of the Service. No long-term systems development planning has taken place with development partners. Preparedness and readiness have featured little in the work of the Service so far, while East and Southern Africa has been building preparedness/readiness into its country support.
- **Equity**. The Collective Service generated guidelines and tools to help ensure attention to vulnerable groups during the pandemic, including youth, children, women, migrants and refugees, and research was undertaken on barriers to vaccine access. However, attention to equity has been uneven, especially regarding disability, while gender and age (children, youth, elderly) received somewhat more attention.[12]
- **Expectations**. Some of the objectives set for the Collective Service were unrealistic due to limited availability of funds, staffing, short funding cycles, and the emergency nature of the response.

[12] The East and Southern Africa hub has focused on strengthening preparedness and readiness within an equity perspective.

Most interviews and survey respondents were positive about the contribution of the Collective Service both in terms of the coordination and technical work already completed and its potential relevance for future public health emergencies and, potentially, for other types of emergencies. Regional and country-based survey respondents rated the support of the Service highly, with HQ-based respondents giving lower ratings. Amongst the core partners, IFRC staff rated the Service most highly, followed by UNICEF, while WHO rated the Service more moderately. A clear majority of informants consider that the Collective Service should continue beyond 2023, though without consensus about its future scope.

Efficiency and effectiveness

- **Start-up**. The proposal for the Bill and Melinda Gates Foundation, which led to the formal launch of the Service, was developed quickly and with little consultation due to the demanding emergency phase of the COVID-19 pandemic and short time frame imposed by the donor. This led to resistance to the Service from regional offices.
- **Regional structures**. The top-down imposition of the regional Service structure was seen to duplicate and complicate the regional RCCE coordination that had already been set up. There was very little communication within the partners or externally about the Service to explain it. The regional engagement with the Service improved over time, especially in East and Southern Africa, where the core partners acted to better define the role of the dedicated Secretariat team, coordinate the work of the core partners and the regional RCCE coordination group. However, the same support was not leveraged in West and Central Africa and the Service stopped operating after one year. In East and Southern Africa, the Service enjoyed greater continuity, as it shifted its attention to responding to the Ebola virus disease, cholera and other disease outbreaks and emergencies and with demand from governments increasing.
- **Focus**. For some time, the future focus of the Service has been debated among the core partners. In East and Southern Africa, the Service extended its services beyond COVID-19 to other public health emergencies and, to a small extent, other emergencies such as drought that have an impact on health. A broader and unresolved debate relates to how far the Service changes direction to focus on accountability to affected people, currently a priority area of action for humanitarian organizations and the subject of an Inter-Agency Standing Committee Task Force, and to what extent it should act as a function within the newly agreed Health Emergency and Preparedness and Response agenda, led by WHO.
- **Partnership**. IFRC, UNICEF and WHO generally collaborated well over RCCE at country and HQ levels, with some challenges experienced at regional level. The partners understand and have generally respected their different mandates and comparative advantages. Instances of competitive behaviours between the core partners were noted, leading to some erosion of trust and frustration for third parties, who want 'the giants to play well'.
- **Governance**. The Service has been governed by a director-level Steering Committee. Despite recent efforts to clarify future direction, the Committee has been relatively ineffective in tackling difficult coordinating issues between the core partners, especially since the pandemic started to recede. This is not helped by the minimalist nature of the Letter of Agreement, which, by design, provided for no accountability between the partners. The results of this evaluation are anticipated to provide the Committee with an assessment on which they can base future decision-making.
- **Funding**. The ability of the Service to deliver on its outcomes was constrained by a competitive fundraising environment during the COVID-19 response. With COVID-19 funding drying up and many donors revising their strategic priorities toward a climate change agenda, funding remains a challenge. To avoid competition with core partners' traditional donors, the Service has limited its fundraising to non-traditional partners. Even so, it was successful in raising a total of US$6.1 million, the majority from the Bill and Melinda Gates Foundation, supplemented by the WHO-managed Solidarity Fund and the Rockefeller Foundation, and a further US$8.0 million from the core partners, which will have been disbursed by the fourth quarter of 2024.
- **Commitment**. Strong commitment by Collective Service staff members and organization focal points, sometimes in the face of opposition and disinterest from regional colleagues, has enabled the Service

to overcome some of the challenges it confronted. The work of the Service has not been well recognized or supported by the senior management of the core partners.

- **Skills and competencies**. The importance of coordination as a competency was highlighted by key informants, while it was suggested that soft skills were needed in addition to experience of specialisms related to RCCE. Reportedly, this combination is not readily available, while the social science skills on which the Service relies are also said to be in short supply and great demand in the core partners, in the open market, and in countries of operation. The Service will need a team of deployable, skilled personnel to provide in-country support to RCCE, especially if the Secretariat itself is further reduced in size and dedicated regional resources are no longer part of the Service's model.

Data for Action

- **Approach**. The Data for Action approach, introduced after the first year of the Service, was conceptually strong, bringing together social science research, information management, and monitoring and evaluation that collated, analysed and displayed data from multiple sources. This combination has shown significant potential for analysing beliefs, attitudes and behaviours related to infectious disease outbreaks and for presenting data and evidence in ways that decision-makers can access to improve risk communication, community engagement and programme design.
- **Information management and social sciences**. One of the major successes of the integrated work between information management and social sciences concerns the data portal. This constitutes a unique effort to consolidate quantitative and qualitative data and analyses. The social science, information management and monitoring and evaluation teams delivered training to the regional offices in East and Southern Africa, West and Central Africa, Middle East and North Africa, and Asia Pacific regions and webinars on the use of tools for data analysis, community engagement and RCCE monitoring. The Service has demonstrated innovative use of quantitative and qualitative evidence and digital health approaches to inform RCCE in target regions and countries. Many interviews included positive feedback about the Service website and the data analysis (data deep dives on specific topics) behind the website graphical presentations, including the 'dashboards' and the social-behavioural indicators for RCCE. The Community Feedback Mechanism Tracker has helped to show the state of community feedback mechanisms led by the core partners in a variety of disease outbreaks.
- **Informing RCCE**. The bringing together of risk communication, social science research and community feedback proved to be innovative and relevant in providing data and analysis of the status of the public health emergency outbreaks, the social attitudes towards them, and adaptations for risk messaging and community engagement approaches in regional forums and in a few countries where the Collective Service engaged more fully. At country level, the Service has helped to demonstrate how community feedback can be pooled, coded and collectively analysed to inform regular and timely decisions on risk communication and community engagement.

Accountability and learning

- **Performance monitoring**. Key performance indicators for the Collective Service were devised at the outset and a results framework was developed. In practice, monitoring has tended to focus on activity and output. In the results framework, the links between processes, achievements in monitoring and evaluation, and the global results framework were not easy to trace. In general, monitoring reports are heavy on qualitative description and brief in terms of advances towards pre-determined milestones and targets. In East and Southern Africa, regional tools for tracking activities and summarizing outputs have been devised.
- **Learning exchange**. From the beginning, the Service has enabled the exchange of experience on RCCE at HQ and between regions. The website includes a substantial set of RCCE case studies and lessons learned. The Service has consistently reflected on its work and made adjustments over time to stay relevant to the evolving operating context and to improve performance.

Conclusions

The original vision for the Collective Service was based on the core partners' understanding that they needed to work together on risk communication and community engagement to deliver quality and effective RCCE, strengthen coordination at global, regional and national levels, empower communities to respond to COVID-19, to improve risk communication and reduce the spread of COVID-19. Their vision has proven correct. The widespread investment in RCCE by governments in responding to the pandemic meant that risk communication and community engagement became, at least in some cases, more responsive to the beliefs, attitudes and behaviours of communities. There was a consensus amongst key informants that RCCE will remain a feature of health emergency readiness and response in future.

The achievements of the Collective Service give much to build on for future development. Equally, the experience of the past three years provides those responsible for the future of the Service with the opportunity to address the weaknesses and challenges that have reduced its relevance, coherence and effectiveness, including: objectives set for the Service that did not match the scale of the resources available; limited communication about the purpose of the Service within and beyond the core partners; lack of integration of the Service into the mainstream work of the core partners; an inadequate formal agreement on which to base the partnership; unresolved issues within the partnership left unaddressed for a long period; limited collection of data on the performance of the Service; and restrictions on where it could raise funds.

The emergency that arose out of the pandemic provided a driving force for coordination and cooperation. After two years of operations, participation in global RCCE coordination reduced as the pandemic emergency receded and, later, the war in Ukraine meant that the pandemic response received even less attention. Funding for the COVID-19 response and epidemics in general started to fall off across the agencies. By early mid-2022 and since then, individual agency agendas have asserted themselves strongly and the Collective Service has been drifting. The future strategy, vision, and structure of the Collective Service is now in need of definition.

Lessons learned

Lessons from the evaluation include:

- Lack of consultation and use of a top-down approach at the outset of a multi-party initiative can lead to long-term misunderstanding and lack of cooperation.
- A small group of committed individuals can launch an inter-agency initiative even in adverse circumstances, but the core capacities of organizations cannot be mobilized without detailed planning and endorsement from the very top.
- Harnessing the comparative advantages of large institutions can bring significant dividends when the impulse to collaborate overcomes the competitive forces that might otherwise block collaboration.
- Good personal relationships and trust made collaboration work. Poor relationships and misunderstanding hindered it.
- Quality consists not in the volume or comprehensiveness of technical documentation but in the ability to apply it at field level and its relevance as judged by field practitioners.
- The boundaries between the coordination systems for public heath emergencies led by WHO and for humanitarian response, led by the IASC, need active management to ensure efficient coordination between them.
- Any services that support the extension of coordinated national initiatives can only be productive when there is sufficient demand, in this case the interest and willingness of governments.

The future of the Collective Service

The core partners agree that the Collective Service should continue, but for the past two years have not been able to agree on its future remit or scope. This report discusses the issues behind these disagreements and proposes that the Service should support risk communication and community engagement functions in health-related emergencies, whether in stable or humanitarian operating environments. The report then describes three options for the future level of ambition of the Service in terms of scale and reach:

Option 1: Change the Collective Service model to implement proactive development of national partners' RCCE preparedness and implementation capacity;

Option 2: Maintain and/or expand the current regional Collective Service model; or

Option 3: Continue regional RCCE coordination without additional support based on the Collective Service model.

Recommendations

The evaluation provides a total of 12 recommendations which build on the findings, conclusions and lessons learned, and the discussion on the remit and level of ambition of the future Collective Service. The recommendations are ranked in order of priority and are aimed at enabling a sustainable and effective future for the Collective Service, based on a renewed consensus and agreement between the core partners. The recommendations as listed below include only the title statement for each recommendation, while the full text of the recommendations is provided in Section 7.

1. Agree a joint policy statement on the need to coordinate RCCE;
2. Base the future of the Collective Service on demonstrated success criteria;
3. Develop a new vision and model for the Collective Service, and endorse and communicate the result;
4. Base the Collective Service offering on assessed demand for RCCE support;
5. Expand the membership of the Collective Service;
6. Develop inter-agency funding proposals for the Collective Service;
7. Link, rather than merge, the work of the Collective Service and the IASC;
8. Determine whether a pooled fund would be beneficial for the Collective Service;
9. Implement a Collective Service standby mechanism;
10. Revise the Collective Service theory of change;
11. Consider changing the name of the Collective Service; and
12. Extend the current Collective Service to allow time for a new agreement.

To support the decision-making of the Collective Service Steering Committee, the evaluation also includes a Decision Table based on the strategic options and recommendations provided.

1 Introduction

The Risk Communication and Community Engagement (RCCE) Collective Service (CS, also referred to as 'the Service'), established in 2020, is a multi-agency collaborative partnership between the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), with the support of the Global Outbreak Alert and Response Network (GOARN),[13] and key stakeholders from the public health, humanitarian and development sectors. This partnership was created to enhance coordination and increase the scale and quality of localized community engagement approaches in a rapidly evolving crisis: the COVID-19 pandemic. (The organizations forming the partnership are referred to collectively as the 'core partners', or 'core organizations' throughout the report.)

In mid-2022, a formative outcome-oriented evaluation was proposed by the core organizations to assess the Collective Service's achievements and to inform a strategic vision for the Service moving forward. The evaluation was jointly managed by IFRC, UNICEF and WHO. The intention from the outset has been that findings and recommendations from the evaluation will be used by the Collective Service Steering Committee and Secretariat to shape the future of the CS. The evaluation Terms of Reference (TOR) are included as Annex L.

This report is structured as follows: Section 2 summarizes the launch, evolution and scope of the CS work. Section 3 details the purpose of the evaluation, its objectives, scope and methodology, including the five main questions that the evaluation has sought to answer. Section 4 includes the main evaluative assessment of the Collective Service. Section 5 includes conclusions and lessons learned. Section 6 looks to the future, setting out issues and strategic options for the consideration of the Collective Service, followed by Section 7 presenting the evaluation recommendations.

2 Overview of the Collective Service

2.1 The growing importance of risk communication and community engagement

RCCE as a pillar in health emergencies came to prominence because of the perceived failures in the international response to Ebola virus disease (EVD) in West Africa in 2014 and again in 2018–19, and against the Zika outbreak in Latin America (2015/2016).[14,15,16] Reportedly, RCCE coordination was implemented in many countries in response to the COVID-19 pandemic, typically led by the Ministry of Health. According to interviews, the scale and duration of the pandemic helped to mainstream the concept of RCCE and increase its relevance as a key pillar of a comprehensive and effective response. The pandemic led to the wider adoption of RCCE, moving it 'front and centre' as part of the PHE mechanisms, a trend seen as unlikely to reverse.

In the absence of a vaccine, RCCE became one of the primary lines of defence against COVID-19. RCCE provides a means to promote behaviour change in the affected population, taking account of the complexity of human behaviour and using socio-behavioural data to identify ways to reduce risks by understanding people's changing perceptions and attitudes.[17] As noted by a 2022 inter-agency evaluation of the COVID-19 humanitarian response: "Two-way communication with communities was key to allowing authorities and organizations to listen to and immediately address specific concerns so that the advice they provided could be relevant, trusted and acted upon. Rumour tracking was used in several contexts to closely monitor misinformation and report back to relevant actors so that COVID-19 messaging materials and methodologies could be adapted accordingly."[18]

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[13] In this report, GOARN, IFRC, UNICEF and WHO are referred to collectively as the 'Collective Service partners'.

[14] Pan American Health Organization/PAHO (2016). Zika Virus Infection: step by step guide on RCCE.

[15] WHO (2016). Risk Communication in the context of Zika Virus.

[16] According to the Red Cross Red Crescent CEA guidelines: "Lessons from humanitarian and health crises, including the COVID-19 pandemic and the West Africa and DRC Ebola outbreaks, have taught us that constructive and meaningful engagement with local communities and trusted leaders is essential for disease prevention measures to be adapted, accepted, well understood and successful. Impractical or enforced response measures and a lack of dialogue with communities instead leads to frustration, resistance, and non-compliance, which adds to the spread of infection.", p. 122.

[17] IFRC, UNICEF, WHO (2020). COVID-19 Global Risk Communication and Community Engagement Strategy, p. 8.

[18] IAHE (2022). Inter-Agency Humanitarian Evaluation of the COVID-19 Humanitarian Response, p. 53, paragraph 144.

2.2 Purpose and rationale for the Collective Service

The inter-agency coordination of the Collective Service for the COVID-19 response was established under the partnership of IFRC, UNICEF, WHO and GOARN. Its objective was to improve collaboration on RCCE among key partners at all levels, support data collection and analysis, and strengthen coordination at global, regional, and national levels. The initial rationale was for improved coordination more than for service provision. RCCE co-ordination was conceived as "collectivizing services and resources", meaning that the products created by any of the three core partners would be owned by all. At its establishment, the Service sought to:

- Formalize and recognize the partnership with a clear mandate, providing strategic direction for risk communications/community engagement as an integral part of the response
- Bring together ongoing initiatives with the public health, biomedical, humanitarian and development sectors and avoid duplication, possible competition and confusion
- Engage with the broader community of civil society organizations and service providers
- Address capacity gaps to ensure demand-driven solutions for operational needs.[19]

2.3 Launch of the Collective Service

The CS was born from discussions at HQ level between individuals in the core partners who had had previous experience in responding to EVD outbreaks in the Democratic Republic of the Congo in 2018–20 and West Africa in 2014–16. Their determination that past mistakes regarding risk communication and community engagement should not be repeated, including the need to avoid an uncoordinated response, led to informal collaboration around the emerging threat of COVID-19 between IFRC, UNICEF and WHO at both technical and management levels. In contrast to the initial simple and relatively informal coordination model first envisaged, the funding proposal submitted to the Gates Foundation, and the grant received in June 2020, brought in a more formal arrangement, including a Steering Committee.

The concept for the RCCE Collective Service was presented to the IASC Principals in April 2020 by IFRC and UNICEF.[20, 21] A subsequent consultation led to the development of a Briefing Pack,[22] which included a set of Q&A designed to explain the Collective Service and allay concerns from the humanitarian clusters and organizations. The same document stated that the IASC Principals had endorsed the Collective Service at their April 2020 meeting.[23.] At the same meeting, the Principals requested an update on the progress of the Collective Service which, reportedly, they have not yet received.

2.4 Bill & Melinda Gates Foundation Grant and the Letter of Agreement

The first grant from the Gates Foundation supported the establishment of the structure and capacity of the Collective Service at global and regional levels, as reflected in the Letter of Agreement (LOA) between IFRC, UNICEF and WHO. Since it was not possible to find a way for the partnership to receive the grant as a single body, separate grant agreements were made for each of the three recipient organizations.[24] The Gates Foundation grant was used to recruit the global and regional coordinators, technical leads for RCCE, information management (IM) and social science, and subsequently for consultancies, short-term support in M&E, and for fundraising.

[19] IFRC, UNICEF and WHO (2020). Letter of Agreement for the Establishment of a Collective Service for Risk Communication and Community Engagement for COVID-19 (internal document).

[20] IFRC and UNICEF "outlined a proposal for a global collective service for communication and community engagement to meet the growing demand from partners at country, regional and global levels to provide robust coordination and technical support", with the result that, "The RCCE proposal to be further consulted at the IASC RG2 [Results Group 2] on Accountability and Inclusion prior to discussion at the EDG [Emergency Directors Group], to determine how to operationalize it and build upon existing structures." (IASC Principals minutes, April 2020). Results Group 2 ended and has continued as IASC Task Force 2 on Accountability to Affected People, with a two-year term.

[21] As co-chairs of the then IASC Results Group 2 (RG2) on Accountability and Inclusion.

[22] IASC, Results Group 2 (2020). COVID-19 Risk Communications and Community Engagement (RCCE) and the Humanitarian System: Briefing Pack.

[23] In the background paper for the IASC Principals session, it was suggested that "six months after its establishment, lessons from the COVID-19 collective service will be shared with IASC Principals with the view to establishing a permanent system-wide capacity to support communication, community engagement and accountability in a more coordinated and predictable manner."

[24] Gates Foundation, IFRC, WHO, and United States Fund for UNICEF (with UNICEF as sub-grantee). The letter is dated 23 September 2023, which is well after the commencement of the CS.

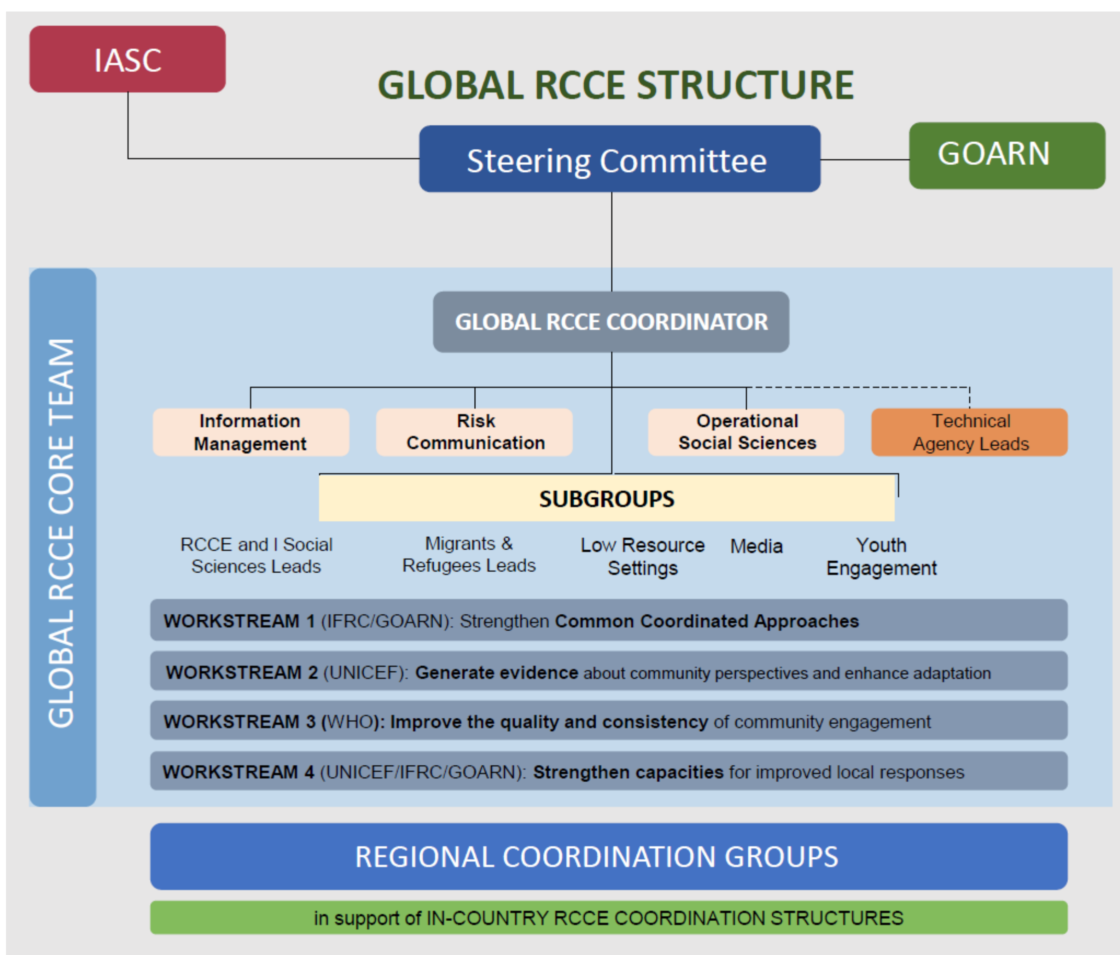
The LOA was signed on 23 September 2020, after the grants were agreed. It established a Collective Service for Risk Communication and Community Engagement for COVID-19, and potentially future epidemic and humanitarian responses, with a pilot phase from 1 June 2020 to 31 May 2021.

- **Purpose**. The LOA stated the purpose of the Service as: "to ensure that the complementary strengths of all partners are supported and leveraged to deliver the greatest impact, and to bring together a wide range of organizations involved in RCCE policy, practice and research to provide practical support to those delivering on the ground".[25]
- **Goal**. The overarching goal was "that people-centred and community-led approaches are championed widely, resulting in increased trust and social cohesion, and ultimately a reduction in the negative impacts of COVID-19",[26] moving from the directive, one-way communication, towards the community engagement and participatory approaches that have been proven to help control and eliminate outbreaks in the past.[27]. The CS was intended to bring together a wide range of organizations involved in RCCE policy, practice and research to provide practical support to those delivering on the ground.[28]

Strategic areas. The LOA specified four strategic areas for the Collective Service:

1) Strengthen common and coordinated RCCE approaches;
2) Generate data about community perspectives;
3) Improve the quality and consistency of community engagement approaches; and
4) Strengthen the capacity of national governments, institutions and organizations and reinforce local solutions.

Figure 1 – RCCE Collective Service structure



Source: Collective Service (2021). RCCE Global Structure 2021 (internal document).

[25] Collective Service (2021). A Collective Service for Risk Communication and Community Engagement, p. 2.
[26] IFRC, UNICEF, WHO (2020). COVID-19 Global Risk Communication and Community Engagement Strategy, p. 4.
[27] Ibid.
[28] Collective Service (2021). A Collective Service for Risk Communication and Community Engagement, p.2.

Structure. The structure of the RCCE Collective Service is shown in Figure 1 and described below.

- **Global hub.** The agreement covered the formation of a global hub in Geneva, including a Global Coordinator and an Information Management Officer hired by IFRC, a Social Science Research Coordinator hired by UNICEF, and two Risk Communication Officers hired by WHO. Additionally, each organization designated at least one Technical Focal Point to represent the complete scope of their regional RCCE programming for COVID-19. A Steering Group was established, with the potential for expansion to include a broader range of partners. (The team immediately around the Collective Service Global Coordinator was referred to in interviews as 'the Secretariat'. The term does not appear in Figure 2 but is common parlance and has been used throughout the report.)
- **Regional hubs in Africa.** The LOA specifies the establishment of two CS regional hubs covering the greater African region. The East and Southern Africa hub was to comprise a Regional Coordinator and an Information Management Officer, both of whom were employed by IFRC, as well as a social science research position and one surge staff member, both of whom were to be hired by UNICEF. For West and Central Africa, UNICEF was responsible for hiring a Regional Coordinator, one social science researcher, and one surge staff, and an Information Management Officer was to be hired by IFRC. No posts or associated budget were designated for WHO in the regions.
- **Collective Service subgroups.** The CS established subgroups in various thematic areas. These groups are said to have been very active in coordination and information-sharing for the first 12 months of the Service, co-led by partners and involving many other organizations including: United Nations agencies, the Global Health Cluster, non-governmental organizations (NGOs), academics, community engagement specialists and media organizations, which also took on chairing roles in the subgroups.

  The subgroups included:

  - Community engagement in low resource settings
  - Capacity strengthening
  - Operational social sciences
  - Youth engagement (YES!)
  - RCCE and media
  - Monitoring and evaluation for RCCE
  - Contact tracing
  - Migrants, refugee and other vulnerable groups
  - Action by Churches Together (ACT) Alliance demand creation group/community-led response.

Other national working groups included EVD (Guinea and Uganda), and regional, for example, social listening in the MENA region and the Feedback Subgroup in WCA. Some subgroups developed guidance and associated tools and resources, which are listed in Annex F. The Collective Service also engaged in the vaccine confidence task team, co-led by UNICEF and WHO and with IFRC, and supported the development of global guidance on managing demand within a changing landscape as well as the roll-out of the Global Event on COVID-19 vaccine demand in June 2022.

2.5 Collective Service theory, strategy and objectives

The Collective Service was established with a theory of change (TOC), included as Annex D, and an accompanying logical framework. The model assumes that if evidence and resources are used and strategies implemented, such as coordination and alignment, innovation and improved science, community partnership and capacity-building, then the quality and consistency of RCCE approaches will be improved. This improvement will be achieved through more consistent, systematic and predictable support to partners at the global and regional levels involved in the public health, humanitarian and development responses to the COVID-19 pandemic and beyond.

The TOC follows five logic steps:

Step 1. **If evidence and resources are used,** such as: (1) multiple channels of evidence base; (2) human resources and plans to scale up coordination, social science and community engagement capacity; (3) building up strategic partnerships; and (4) expanding the donor base and developing an investment case.

Step 2. **And certain strategies are implemented**, such as: (1) coordination and alignment between global and regional staff; (2) promoting innovation and improved data collection, handling and visualization; (3) amplification and community partnership through the engagement of existing networks; (4) capacity-building in RCCE.

Step 3. **Then the following outputs will take place:** (1) existence of joint strategies and workplans, improved synergies, inclusive and predictable services, etc.; (2) real-time social sciences analysis strengthened, effective management of information, etc.; (3) responsive leadership, improved decision-making, etc.; and (4) improved quality of participatory RCCE though guidance, minimum standards, tools, etc.

Step 4. **And consequently, the following outcomes will be achieved:** (1) strengthened common coordinated approaches; (2) improved quality and shift of focus; (3) enhanced adaptation and amplification of strategies with a better use of evidence for decision-making; and (4) strengthened capacities for improved local response. Moreover, the quality and the consistency of RCCE approaches will also be improved at the country level.

Step 5. **This, in turn, will have an impact on** the population, where people and communities will be informed of the existing risks, will believe in the recommended measures, will take protective actions, and will influence the response. They will also participate in and own preventive and response measures to enhance their knowledge and motivation to act. All these steps will create an environment that is conducive to appropriate health practices. In conclusion, people-centred and community-led approaches will be widely promoted, resulting in increased trust and social cohesion, and ultimately a reduction in the negative impacts of crises.

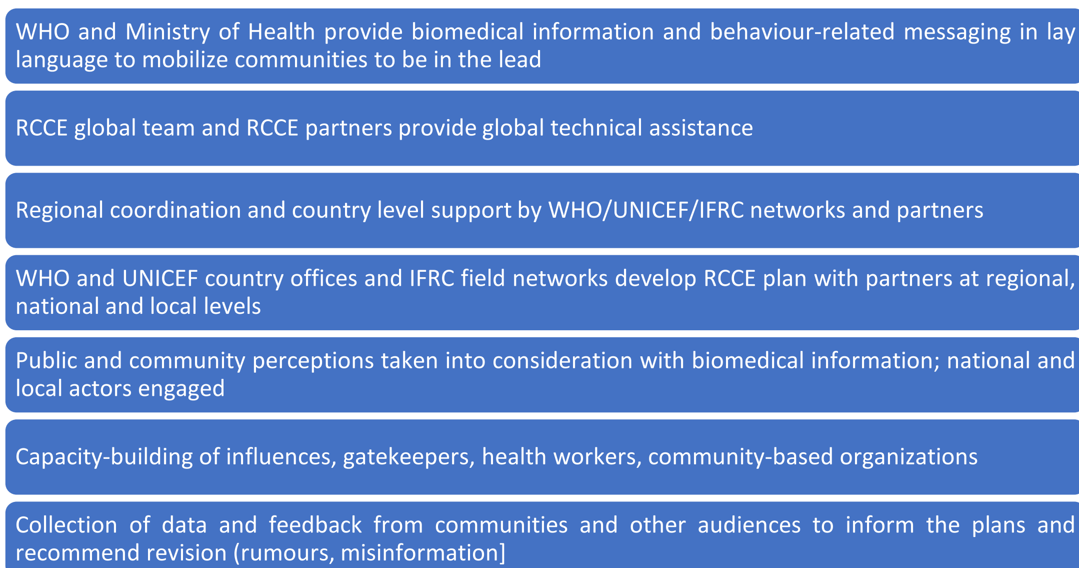
The TOC assumes that the quality and consistency of RCCE approaches is improved at country level through:

1. Active and effective coordination mechanisms;
2. Evidence-based national RCCE plans;
3. Enhanced institutional accountability in decision-making; and
4. Strengthened local capacity to improve local response.

RCCE strategy. The first joint IFRC-UNICEF-WHO strategy for RCCE was the COVID-19 Global Response strategy developed in March 2020, before the Collective Service was formed.[29] Figure 2 below captures information flow mechanisms outlined in this first strategy.[30]

[29] IFRC, UNICEF and WHO (2020). COVID-19 Global Response: Risk Communication and Community Engagement (RCCE) Strategy. All Partners.
[30] Ibid., p. 6.

Figure 2. Information flow mechanisms for joint RCCE efforts



A simpler presentation of the strategy was included in the Interim Global RCCE Strategy of December 2020–May 2021 (Figure 3).[31] This second strategy was a product of the Collective Service, and, reportedly, revised the first strategy based on knowledge gained since the start of the pandemic.[32] The Interim Strategy established four objectives or strategic pillars for the delivery of RCCE by governments, NGOs, etc.[33]

Figure 3. Strategic objectives of the RCCE Collective Service

The first CS workplan 2021–22 broke down the four objectives into 'services', including: (i) accelerating collaborative efforts with and among partners, donors and experts working in RCCE; (ii) strengthening evidence for decision-making in policy and programming; (iii) promoting the quality and consistency of RCCE; and (iv) strengthening knowledge management and capacity-building efforts.[34] The formulation of the CS services and objectives has evolved since then.

[31] IFRC, UNICEF, WHO (2020), COVID-19 Global Risk Communication and Community Engagement Strategy.

[32] On page 6 of the document it is stated that: "The first COVID-19 global risk communication and community engagement (RCCE) strategy was published in March 2020. Since then, our knowledge about the disease has greatly increased, as has our understanding of how people are affected by and are responding to it. This new RCCE strategy reflects these changes in context and knowledge. The strategy reflects the experiences and views of a range of partners working on RCCE. It builds on and revises the first RCCE global strategy and is supported by existing RCCE guidance materials."

[33] IFRC, UNICEF and WHO (2020). COVID-19 Global Risk Communication and Community Engagement Strategy, pp. 12–16.

[34] Collective Service (2021-22). RCCE Collective Service Workplan 2021–22 (internal document), pp. 4–5.

The CS 2023 workplan was reorganized with specific key results for three strategic areas:[35]

1. Be collaborative: The key result in this area is that operational coordination on risk communication and community engagement is effective, predictable and replicable to prepare, respond and build resilience to future crises. To do so, certain activities will be carried out:

- Development of a structured coordination mechanism to activate the RCCE pillar with a Collective Service approach when it is needed
- Development of a Collective Helpdesk in coordination and services in three languages
- Development of standard operating procedures that will be part of the partnership framework/Memorandum of Understanding (MOU) and serve as the established mechanism for RCCE coordination ensuring a predictable and sustainable coordination
- Expand the scope to other PHE and humanitarian responses as well as the base and diversity of partners of the Collective Service
- Strengthening of partnerships and networks (e.g. youth and women-oriented stakeholders), as well as inter-agency working groups.

2. Be data-driven: The key result in this area is to achieve a shared minimal capacity to collecting, organizing, analysing and sharing data for community engagement for response coordination. To do so, the following activities will be carried out:

- Development/sharing/disseminating of standardized tools and procedures for data analysis and monitoring of activities (e.g. revised M&E indicator guidance adapted also to EVD, revised Data for Action Handbook, etc.)
- Definition of minimal commitments for collective data-sharing agreed across partners
- Adapt and disseminate multi-language RCCE information packages and collect feedback to support immunization demand and accountability systems levering the UNICEF-led digital engagement platforms such as the Internet of Good Things and U-Report
- Mainstreaming of RCCE data and social science capacity to multi-disciplinary group of actors.

3. Be community-led: The key result in this area is to strengthen existing community engagement and regional and country-level capacity for readiness and response. Activities foreseen are:

- Technical assistance to countries/regions due to the need to start prioritizing countries for dedicated support (vs responding globally)
- Remote technical assistance and demand tracking for decision making through the CS Helpdesk
- Development of a collective definition for “community readiness” at country level in advance of the next emergency response.

2.6 Performance indicators

In line with the theory of change, the Collective Service Secretariat adopted a set of key performance indicators against which to track its progress. These indicators are broken down into major families of outcomes and outputs:

- **Outcome 1:** Strengthened collaborative RCCE approaches to increase quality, harmonisation, optimisation, and integration of RCCE.
- **Outcome 2:** Availability of evidence to systematically inform policy and programming and improve effectiveness and efficiency.
- **Outcome 3:** Improved quality and consistency of risk communication and community engagement approaches.
- **Outcome 4:** Reinforced national capacities for improved local solutions.

A logical framework was agreed with the Gates Foundation in January 2021 and has been adapted over time. The framework includes a description of intended results (outcomes and outputs), activities, lead agencies, status of implementation and a timeline, and covers the period Q1 2021 to Q4 2022. The framework comprises

[35] The 2023 workplan does not explicitly include the third strategic objective ‘Reinforce Capacity and Local Solutions’ presented in Figure 5 above since capacity-strengthening was taken to be an enabler and is a component of each of those three areas. It should be noted that this workplan was a draft prepared by the CS coordinator and the Secretariat but was never subsequently agreed or committed to in terms of human and budgetary resources.

4 outcomes and 24 output indicators (see Annex E).[36] The August 2022 version of the framework sought to clarify the difference between monitoring the work of the CS, namely indicators focused on processes, versus those tracking the effectiveness of its work, which has been reported via case studies and reports on the status of activities. At regional level, the results framework contains detailed information of activities and the status of implementation ("achieved", "ongoing" and "overdue"), based seemingly on a subjective own assessment rather than other measures. The CS tracks and reports on queries received from the country, regional and global levels and analyses trends. Support is provided to the adoption of results frameworks to specific interventions, the use of new and existing data collection tools, and routine monitoring design and implementation.

2.7 Evolution of the Collective Service

The organization of the CS and its services evolved as the nature of the pandemic changed, but was also affected by tensions over funding, and divergent positions in the core partners on the type of emergency to be supported. In its first phase (June 2020 to October 2021) support functions at global and regional levels were established along with the Secretariat, supervised by the Steering Committee. In this phase, the duties of the Secretariat were established, encompassing global coordination, supported by GOARN, and information management and the social sciences component were put into place, (the latter with support from Anthrologica, a consultancy firm). Coordination between the global and the two African subregions was set up. In the regions, it proved challenging to structure the teams and recruit consultants to support the CS, with recruitment delays in both UNICEF and IFRC. The CS reached its peak in terms of capacity at the end of the first year of work, with well-established coordination between the Secretariat and the regions, as well as areas of work, and expertise in each of the components.

As vaccination campaigns progressed, the basis of the Collective Service came under review and its mandate was adjusted as interest in COVID-19 started to decrease and funding started to decline. A new global coordinator was designated in October 2021. Without the prospect of additional funding, resolving questions over the content and scope of collective services became a pressing task. It was deemed essential to establish an alternative funding model to continue support for the CS because, by the end of 2021, resources for COVID-19 were scarce and almost non-existent by early 2022. The CS needed a new post-COVID-19 perspective, as priorities shifted to other issues. A strategic discussion was initiated in January 2022 and culminated in June 2022 with the approval of a high-level strategy by the Steering Committee.

In various interviews it was reported that the discussion at this stage was hampered by disconnects between the agencies' agendas and priorities. On one side, UNICEF and IFRC, which work in both PHE and humanitarian crises, wanted the CS to become the start of coordinated community engagement between PHE and humanitarian crises, sectors which typically don't work together. For WHO and GOARN the primary focus remained how to establish a sustainable model for RCCE in PHE, testing its usefulness in crises such as cholera or EVD before extending to humanitarian crises. Up to this point, the CS had focused on COVID-19. The Secretariat began to respond favourably to requests for technical assistance in various non-PHE crises, such as the Ukrainian refugee response, the drought in the Horn of Africa and the floods in South Africa. The scope of the Collective Service was broadened to support PHE responses to other disease outbreaks, in addition to COVID-19, in particular to cholera, EVD, and mpox.[37] Since then, the Secretariat has responded to requests for support to other humanitarian crises, without limits set on which types of crisis were in or beyond the scope of the CS.

2.8 Data for Action

On the basis of its learning in its first phase, the Collective Service developed a "Data for Action" (D4A) approach, which is a practical approach to data that aims to maximize the impact of its collection, analysis, tracking and dissemination on data. This approach is the result of the close collaboration between the social science, information management, and monitoring and evaluation teams, which led to the integration of the different technical teams and a collaborative approach to the development of collective goods. Further details of this component and recommendations for the next phase of the CS can be found in the Case Studies report of this evaluation (see Case Study 3).

[36] One of the challenges of monitoring performance is that most indicators are "narrative" and not easily measurable. They refer, for example, to the establishment of support to national RCCEs, or support to regional research structures. The real impact of these activities is therefore difficult to track.
[37] The evaluation uses mpox as the term preferred by WHO to monkeypox, though several key informants referred to monkeypox.

In 2022, the CS released the RCCE "Data Handbook", that outlines the processes involved in the use of data for RCCE for COVID-19 and provides links to useful resources. The Handbook introduced the concept of D4A, which brings together three complementary areas of work: (i) social science; (ii) information management; and (iii) monitoring and evaluation.

Social science

The social science component is based on four pillars:

1. **Delivering capacity-building and training** to support partners in applying social science evidence in health emergencies, including data collection, analysis and operationalization of socio-behavioural information.
2. **Data mapping and structuring** to identify evidence gaps and to generate socio-behavioural trends and support the visualization of socio-behavioural variables through a dashboard. From the resources available on the website, it is possible to identify a diverse range of case studies pertaining to COVID-19, EVD, cholera, mpox, and natural disasters such as earthquakes or cyclones. The case studies document RCCE practices in various emergencies, with the aim of identifying best practices.
3. **Providing direct support to country-level teams** to formulate research questions, develop research protocols, data analysis and quality assurance of research outputs.
4. **Adapt, develop and contextualize common tools, approaches and standards** to support partners to conduct operational social science research and learn from communities about their views, perceptions, capacities, practices and behaviours.

Information management

The Collective Service includes an information management (IM) service that supports RCCE activities through improving data collection and collation, creating data management standards, data analysis, and supporting the effective dissemination of information. The IM team is responsible for providing technical guidance, design and implementation support, and training to strengthen existing information systems or develop responsive solutions for RCCE partners at regional or country level. The team relies on both in-house technical assistance from global and regional teams, and on-call technical assistance from service providers or IM stand-by partnerships. The IM component has four objectives:

- Data compilation to support evidence generation on community engagement for PHE
- Data management to implement, store, organize and maintain large and complex datasets
- Identify robust and innovative methods and tools for interpreting data through explanatory or predictive analysis
- Design generic information management tools based on in-country experience to accelerate and scale-up IM for community engagement.

IM has contributed to the development of important CS databases, including:

- **Social Behaviour Dashboard on Public Health Emergencies:** It is reported to be a first-of-its-kind repository of social and behavioural data on COVID-19, covering 198 countries and consisting of over 250,000 data points from 411 different data sources. The dashboard is an open access website developed by the Collective Service and is intended to facilitate the monitoring of social behaviour changes during public health emergencies, currently pertaining to diseases such as COVID-19, EVD, cholera, and mpox. In addition to the dashboard, a social data tracker displays social behavioural data on COVID-19 from multiple research projects conducted in the field or at the global level by partners and academic communities.

- The **Community Feedback Mechanism (CFM) Tracker** monitors community feedback mechanisms led by the CS partners to support RCCE response on public health emergencies, especially COVID-19, with a community feedback dashboard specifically for COVID-19 in East and South Africa, that shows the main trends in community feedback reported by agencies responding to the disease across the subregion since July 2020.

Monitoring and evaluation

The Collective Service has established a mechanism to provide in-depth RCCE monitoring and evaluation technical assistance for CS partners. The range of M&E activities includes support to:

- Development/adaption of intervention targeted theories of change
- Adoption/operationalization of results frameworks to intervention-specific frameworks
- Design/review of data collection tools and the overall data collection and routine monitoring design
- Data collection and routine monitoring implementation
- Descriptive and exploratory data analysis, including inferential questions, where possible
- Use of data for decision-making through the provision of evidence-based programmatic insights.

Collective Service Training Package

As part of D4A, the Service developed a combined training package for RCCE coordination, social science and community feedback in seven modules, aimed at implementation staff communicating, working and engaging with communities in humanitarian and health emergency contexts. According to regional actors interviewed, the training modules were delivered in both ESA and WCA regions. In WCA, the sessions were held in English and French in February and March 2022 with 700 individuals invited to participate, either directly on the regional platform or through the three agencies, as well as some national task forces, as arranged by UNICEF offices in the Gambia and Cameroon, in particular. (The number of active participants is unclear.)

Overview of tools for Data for Action

Under D4A, the Service developed a series of tools and guidelines to support RCCE technical work in the field. Most of these tools were developed by the technical working groups, who collaborated to design or adapt existing RCCE resources. Table 1 provides a description of the various tools compiled or designed by the CS.

Table 1. Overview of tools supporting Data for Action

Information Management
Social Behaviour Dashboard: Open access website with four main objectives: i) Gathering existing and validated social and behavioural data; ii) Exploring social and behavioural trends across 6 dimensions and 35 indicators; iii) Tracking socio-behavioural changes over time and by country; and iv) Showing indicators disaggregated by gender, age and specific population groups, if data is available (e.g. migrants, health workers).
Social Data Tracker: Dashboard that measures and tracks key social behavioural data on COVID-19 from multiple research projects conducted in the field or at the global level by partners and academic communities.
Wiki for Community-led Response: Open-source online platform that provides a list of key tools to support risk communication and community engagement for specific responses. The toolboxes relate to coordination, social science, monitoring and evaluation, and information management.
RCCE-CS Newsletter: Biweekly newsletter provides updates on RCCE experiences, events and relevant studies from the whole world.
Community Feedback Tracker: The Community Feedback Mechanism (CFM) Tracker monitors community feedback mechanisms led by the Collective Service's Partners to support RCCE response in public health emergencies and more specifically for COVID-19.
Social Science
COVID-19 Behaviour Change Framework: Main objectives: i) Monitor changes in human behaviour and help to identify trends and opportunities; ii) Help the prioritization of response activities and inform decision-making amongst all partners; iii) Accelerate and support transparency and information, knowledge, perceptions, sharing; iv) Support preparedness and response planning; and v) Generate evidence for policy or strategy revision, operational reviews and lessons learned.
Social Science Research Training Pack: The training is divided into seven different modules with the objectives of teaching how to design tailored operational research, analyse existing research, and reinforce the use of evidence.

Monitoring & Evaluation

RCCE Indicator Guidance for COVID-19: The indicator guidance can be used to monitor progress in implementing activities and to evaluate the RCCE response to COVID-19. The indicator guidance has been written primarily for national RCCE. However, it is hoped that it will provide a useful reference point for the development of indicator frameworks for RCCE responses to other disease outbreaks.

Data Handbook in RCCE: The purpose of the Handbook is to provide an outline description of the processes involved in the use of data for RCCE for COVID-19, and to provide links to useful resources. This handbook can be used to understand the role of social science, M&E, and information management in supporting RCCE programming.

Collective Helpdesk

The Collective Helpdesk, launched in February 2022, is a technical service available for any user from the regional or country levels. The Helpdesk responds to queries and requests for technical advice with a view to giving access to CS technical expertise, resources, data and knowledge bases. The Helpdesk aims to provide rapid, remote technical assistance by finding relevant resources and connecting individuals to regional or global RCCE experts for advice on design, implementation and monitoring of projects. UNICEF leads the Collective Helpdesk on behalf of the CS, providing a dedicated coordinator. By June 2023, 244 requests had been made to the Collective Helpdesk. Demand peaked in early 2022 and again at the end of 2022.

2.9 Working with media

Under the Collective Service, the Media Working Group set out to strengthen the understanding amongst RCCE partners of the role of media and communication in pandemic response and infodemic management. The CS centralized the media guidance from WHO. It also highlighted the importance of the media in addressing stigma through partnerships with BBC Media and Internews via webinars on the role of the media in addressing stigma related to COVID-19. With Internews, the CS organized media dialogues for journalists and other media professionals under the task force. The CS collaborated with the WHO-led Africa Infodemic Response Alliance, which issued periodic reports on infodemic trends. In both WCA and ESA, webinars were held with journalists to inform them about the risks and protective behaviours linked to participatory community engagement and community-level work, and the Corona West Africa website platform disseminated guidelines to the media on fighting disinformation and prejudice.

2.10 Collective Service funding and budgets

As the initiative progressed, in addition to grant funding, the partner agencies planned and allocated financial and technical resources for the operation of the CS annually. The Collective Service funding peaked at US$4.2 million in 2022, including grants and core partner allocations. Table 2 below summarizes the financial resources received from donors to the CS from 2020 to 2023. The Gates Foundation provided four separate grants between 2020 and 2023, an initial US$2.2million, followed by US$1.2 million in 2021, US$853,605[38] in 2022 and a final US$300,000 in 2023. At the start, there were also discussions of a possible US$2 million from the Welcome Trust, which did not materialize.

Discussion of options for setting up a fund or bank account for the CS were not fruitful, and it was agreed that three separate grant agreements should be drawn up, one for each participating organization, an arrangement the donor would not normally have accepted. There was one narrative proposal and, since the beginning, narrative reports have been combined into one, with separate financial reports accompanying. The second grant came with requirements to improve strategic planning and governance.

In late 2022, the CS obtained a grant from the Rockefeller Foundation for US$500,000 to support regional coordination and response for RCCE services and activities for COVID-19 and additional public health emergencies in Malawi, Uganda, and Zambia. In part, this grant was intended to help define the way forward for

[38] US$500,000 in cash grant and US$353,605 in-kind support, to develop a tracking framework to systematically collect evidence and data on the impact of Collective Service activities.

the CS RCCE approach in the post-pandemic era and was made contingent on match funding, which was obtained from the Rockefeller Foundation. A further and final US$300,000 was received from the Gates Foundation in 2023, with a final completion deadline of end 2024.[39]

The initial funding from the Gates Foundation accelerated the collaboration between the core partners based on the structure and activities specified in the grant agreement. Having a single donor gave the donor significant influence over the Service. Initially, the Gates Foundation wanted to specify the countries in Africa that were to receive support for RCCE from the grant, but the core organizations pushed back against the pre-specification of countries, arguing that the selection could not be determined without first understanding needs on the ground.

The Solidarity Fund managed by WHO donated US$1.35 million to the CS. The funds were used until 2022 largely to fund the development of RCCE tools and services. In 2020–2022, all three agencies allocated internal financial and human resources to maintain the CS operations (Table 3). Apart from contributions to core cost, IFRC, UNICEF and WHO have all funded research studies, training, or travel costs for short-term deployments from budgets other than the CS.[40] All three organizations have contributed to the core budget but, in the absence of clarity about the future of the CS, they have been reluctant to commit further funds or to agree to multi-year work plans.

Table 2. Donor funding to the Collective Service (US$)

Donor	2020	2021	2022	2023
Bill & Melinda Gates Foundation	2,200,000	1,222,585	853,605	300,000
The Rockefeller Foundation	-	-	500,000	
Solidarity Fund	-	1,350,000	-	
Total (in US$)	**2,200,000**	**2,550,000**	**1,000,000**	**300,000**

Table 3. Core partners' financial allocations to the Collective Service (US$)

Partner	2020	2021	2022
IFRC	903,000	925,125	837,935
UNICEF	907,200	825,200	1,411,070
WHO (*)	395,280	822,260	350,000
GOARN	-	-	240,000
Total (in US$)	**2,205,480**	**2,572,585**	**3,183,669**

(*) This excludes funds provided to hire a Risk Communication Lead.
For 2020 and 2021, figures do not include in-kind contributions of technical lead staff time.

[39] This funding is specifically to support ESA surge support to build the capacity of government and partners at national and subnational levels to provide coordinated RCCE services through strengthened IM and community feedback mechanisms, operational social science support, and shared data intelligence and analysis.
[40] Other investments in systems have included the informatics platform, website, the Helpdesk, and the purchase of licenses, data capture, synthesis and visualization.

3 Evaluation Features

3.1 Purpose, objectives and scope

The purpose of the evaluation was to assess the Collective Service's contribution to the overarching goal of RCCE systems-strengthening in the public health and humanitarian responses to the COVID-19 pandemic, and to make proposals for the CS partners' decision-makers regarding the future strategy, vision and coordination model based on evidence of RCCE good practices and lessons learned from CS implementation and beyond. The specific objectives of the evaluation were to assess:

- **Quality of the design and approach:** including theory of change, logical framework, intervention logic, alignment with international practices in providing coordination and support services, and the comparative advantage of the Service positioning and its role in the COVID-19 response.
- **Achievement of outcomes:** determining what has been achieved under the four CS strategic areas, namely: strengthened collaborative RCCE approaches; availability of evidence to inform policy and programming and improve effectiveness and efficiency; improved quality and consistency of risk communication and community engagement approaches; and reinforced national capacity for improved local solutions.
- **Resourcing:** assessment of the extent to which the human and financial resources were adequate to the planned outputs and outcomes of the CS.
- **Coordination and collaboration:** assessing the quality of coordination and management of the CS at the global, regional and country levels, comparing regions where inter-agency teams have been put in place with areas lacking this coordination; in the selection and management of partnerships to advance the overarching goal and objectives of the CS in RCCE, during the COVID-19 and other public health emergencies (PHE); and in the structures, governance and decision-making and their impact at implementation level.
- **Added value of Data for Action:** investigating the quality and overall coherence of the Data for Action (D4A) approach used by the CS (indicators, baselines, data accuracy, timeliness and management), and how evidence and knowledge have been used to improve decision-making and the approach to RCCE taken by the Service.
- **Adequacy of internal monitoring and evaluation, and knowledge management systems:** quality and coherence of internal Collective Service M&E and knowledge management systems, including the utility and application of lessons learned and good practices to implementation.

Scope. The evaluation focused on the period 2020–2022. The subject scope of the evaluation is collective responses to public health and humanitarian emergencies, in particular as supported by the CS. The evaluation also considers whether the Service has contributed to the development of national (government and non-government) capacities and preparedness for RCCE. The evaluation has focused on the CS core partners but has also gathered the perspectives of other stakeholders. Four case studies provide a more in-depth analysis of RCCE in selected locations and areas of work by the CS. The agency-specific work of IFRC, UNICEF and WHO on RCCE for COVID-19 outside their joint coordinated work on RCCE is not discussed, except where it overlaps with that of the CS. Questions over the future of RCCE surge capacity have not been addressed, as these are the subject of an ongoing consultancy commissioned by UNICEF.

3.2 Evaluation questions

The evaluation questions (EQs) set out in the original TOR were reviewed and revised during the inception phase to reduce overlaps across the sub-questions and to ensure that they responded to the key issues identified by evaluation stakeholders during the inception phase. The revised EQs addressed by the evaluation are:

- **EQ1:** To what extent is the Collective Service design and service offering relevant, clear, and coherent for its users at HQ, regional and country level?
- **EQ2:** To what extent have the planned outcomes of the Collective Service been achieved, and by what means?

- **EQ3:** How efficient and effective has the coordination and collaboration of the Service proven in delivering on the objectives of the Service?
- **EQ4:** To what extent has the Data for Action approach been effective in informing RCCE decision-making?
- **EQ5:** To what extent have the Service's internal data, M&E and knowledge management systems fostered accountability, learning and improved performance?

During the inception phase, an evaluation matrix was compiled, showing how each data collection method would contribute to answering each of the evaluation sub-questions. This matrix is included as Annex A.

3.3 Evaluation timing and phases

The evaluation was conducted between January and August 2023, in four phases: inception phase, January to March, plus three implementation phases from April to August: Phase 1, in which initial interviews and document review, plus an online survey, were used to make a preliminary assessment to inform the Collective Service Steering Committee retreat in April 2023. Phase 2, including further document review, data analysis, and testing of the evaluation findings and proposals in one or more workshops. Phase 3 included preparation of the draft final report, validation workshops, with the main findings, conclusions, recommendations, and lessons learned presented to the Reference Group. The segmentation into three implementation phases was intended to support the future planning processes of the Service, with the initial evaluation results presented to a retreat of the Steering Committee held in early April 2023. The final report of the evaluation was completed in November 2023 after a comprehensive review and validation process with key stakeholders.

3.4 Joint management of the evaluation

The evaluation was originally commissioned by UNICEF. During an evaluation inception visit to Geneva in January 2023, all core Collective Service partners agreed that the evaluation should be jointly managed. The TOR were duly amended, and an Evaluation Management Team was formed, comprising members of the IFRC, UNICEF and WHO evaluation functions. UNICEF offered to continue as the sole funder of the evaluation and a member of the UNICEF Evaluation Office was designated the evaluation manager responsible for day-to-day management of the evaluation and liaison with the team. Evaluation focal points from each organization were designated to ensure access to relevant documents and data and to propose and liaise with potential key informants (for further details on the management and governance arrangements see Annex H).

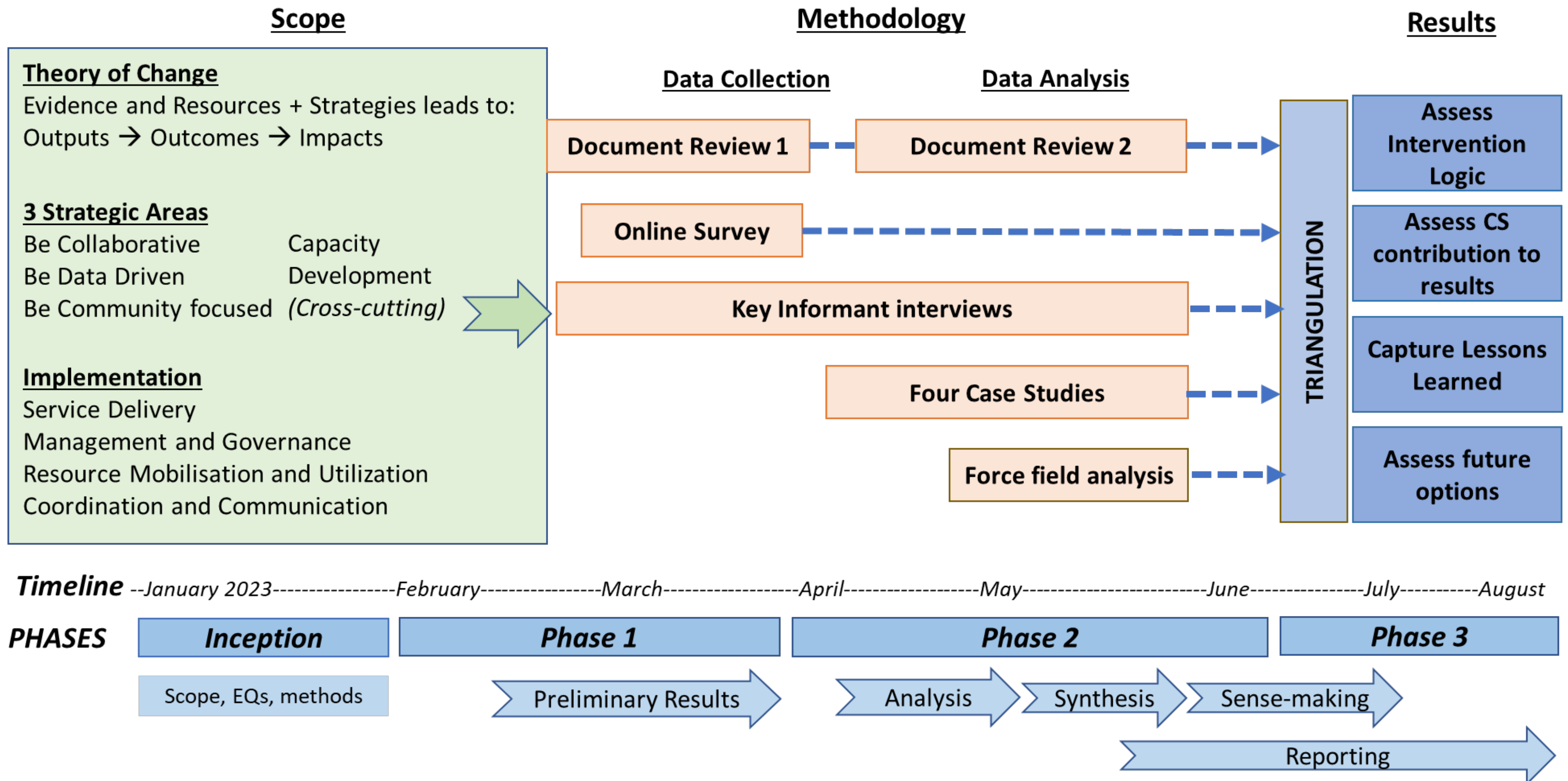
3.5 Use of the evaluation

The principal users of the evaluation are the Steering Committee of the Collective Service. The evaluation seeks to contribute to the optimisation, remodelling, and/or expansion of this inter-agency RCCE initiative by providing the Committee with the evidence of the contribution, progress and shortcomings of the Service so far and includes detailed discussion of future options to inform its deliberations and decisions over the future of the Service. Additionally, the report provides learning material for managers and technicians interested in the role of RCCE in responding to the COVID-19 pandemic and other PHEs.

3.6 Approach

The evaluation has adopted a mixed methods approach, as summarised in Figure 1 below. From the outset, it was agreed that the evaluation would focus on the contribution of the Collective Service. In doing so, it has drawn on the CS theory of change and strategies to establish the intended contribution to the stated desired outcomes. As the CS exists to support others to achieve results in RCCE, and because there was no systematic way of gathering information on its own performance, the evaluation has necessarily relied more on the views of key informants than quantitative data. Therefore, efforts were made to ensure that feedback was balanced across a range of stakeholders at country, regional and HQ levels, and from external informants. The evaluation took a participative approach to data validation (see 3.7 below). The sources of feedback were broadened further by the use of an online survey. Further details on the principles, quality standards and guidance frameworks followed by the evaluation are provided in Annex H. The evaluation phases, timeline, data gathering methods and analysis strategy for the evaluation are captured in Figure 4 below.

Figure 4. Evaluation phases and methods



3.7 Methodology

Document review. The evaluation has benefited from access to a wide range of documentation pertaining to the Collective Service and to RCCE more generally, including: CS agreements, definitions, strategies, guidelines, plans, budgets and donor reports; strategies and guidelines from the CS and the core organizations related to RCCE and related specialisms; IFRC, UNICEF and WHO position/vision statements on the future of the CS; the Overseas Development Institute (ODI)/Humanitarian Policy Group RCCE Collective Service Rapid Learning Review (ODI rapid review), 2021; guidance and models on RCCE from other organizations; agency and inter-agency evaluations related to the COVID-19 pandemic; region- and country-specific RCCE materials shared with the evaluation team by key informants; and case studies posted on the CS website. A full bibliography is included as Annex B.

Online survey. An anonymous online survey was issued in English and French and disseminated by the CS Secretariat, GOARN, and by the IFRC, UNICEF and WHO evaluation focal points to a range of stakeholders involved in the work of the Collective Service at the global, regional and country levels.[41] A total of 98 responses were received, including 46 from UNICEF, 24 from IFRC, 14 from WHO, and 14 from other organizations. The proportion of respondents from country, regional and global (HQ) levels were 50, 30, and 20 per cent respectively, meaning that the majority of respondents were outside HQ, as intended, to gather data from countries and regions that might not otherwise be engaged in the evaluation. A summary survey report is available in Annex J.

Key informant interviews. 88 key informant interviews were conducted (51 female interviewees, 37 male), including those from the visit to Uganda, the majority with staff and consultants from the core organizations at global, regional and country levels, plus donors, and external partners, the majority of which were involved at some stage in the work of the CS. Working from contact lists provided by the Secretariat, interviewees were sampled purposively to ensure a range of interviews across organizations and levels and including a range of participants from organizations other than the core partners, in particular those involved in CS subgroups. A full list of interviews is included as Annex C, accompanied by a sample interview protocol.

Case studies. To provide further depth of understanding and analysis of the progress of collective RCCE at country and regional level, the evaluation undertook four case studies to examine the design, implementation and, where possible, results of the CS coordination and support to RCCE at regional and country levels in response to the COVID-19 pandemic and other PHEs. The studies covered: East and Southern Africa; West and Central Africa; a 'counterfactual' group of three regions, the Middle East, Latin America and Asia Pacific, where RCCE was not supported by the Collective Service, or to a limited extent; and Data for Action.

Country and regional visits. During the inception phase, it was agreed that a field work element would be important, and that the evaluation management team would request country visits where there had been a high level of interaction with the Collective Service from either global or regional levels, ideally to three countries and one or more regional offices. However, there were several constraints to the team making such visits.[42] Eventually, only one country visit was made, to Uganda, with logistical support for the planning and organization of the visit provided by UNICEF. Lessons from this visit are incorporated into the case study on the CS in East and Southern Africa.

Data sources and validation. Quantitative data was drawn from the online survey, budgets, and numerical indicators from Collective Service reports and the web site. Qualitative data was drawn from interview notes and transcriptions, documentary evidence and the document review and free text comments in the online survey. Data analysis was based on collation of data sources, in particular the documentation, interview notes and recordings, the four case studies, and the online survey, with data extracted and assembled under the five evaluation questions, then analysed and triangulated before extracting and drafting the findings recorded

[41] Including management, technical groups, and a broader set of organizations which have participated in online forums and as Helpdesk customers.

[42] In attempting to select locations to be visited, several challenges were encountered, including countries and regions where, variously: one or more agency had recently evaluated their COVID-19 response; those deemed too busy to receive a visit because of ongoing emergency; those with an operating environment considered too insecure; and in one case, resistance to the evaluation based on it being seen as a means of promoting the Collective Service. In another location, given that all RCCE coordination was conducted remotely, face-to-face interviews were considered inappropriate.

in Section 4. Further synthesis led to the force field analysis, summary assessment and lessons learned set out in Section 5. Preliminary assessments were tested through regular interaction with the evaluation management team, including weekly progress reviews, online discussions with key technical staff and evaluation focal points from each core organization. Where the evaluation team was uncertain of their analysis, this was tested through the stakeholder consultation workshops. Two 90-minute workshops with 10 and 12 key informants respectively from HQ, regional and country levels were conducted, exploring selected themes emerging from the evaluation. Three Reference Group meetings were held at the preliminary, emerging and draft report stages, and their feedback was used in finalising interim products. The group's written comments were addressed in the preparation of the final evaluation report. Further discussions were held with the evaluation focal points in the final stages of report preparation.

Variations. The inception report version of Figure 4 included a 'good practice review', which was intended to test whether the resources generated by the Collective Service were in line with good practice in the sector. This was not carried out because: (i) the organizations concerned themselves play a normative role and set the standards for other actors in the sector; and (ii) the technical quality of the documents and tools, which was generally considered to be high, did not emerge as a limiting factor in the CS achieving results. The level of the utilization of these products did, however, prove more germane to the evaluation.

Evaluation principles. The evaluation was conducted in line with the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation, the UNEG Ethical Guidelines for Evaluation, and the UNEG Guidance on Human Rights and Gender Equality in Evaluation. All interactions with stakeholders were based on the principle of informed consent and confidentiality. The views and statements of individual key informants to the evaluation are anonymized and quotes from interviews or from survey responses are unattributed. Data was stored on a dedicated UNICEF SharePoint to which only the evaluation team and designated members of the IFRC, UNICEF and WHO evaluation offices had access. For more detail, see Annex H.

Limitations. Table 4 below sets out the limitations experienced by the evaluation.

Table 4. Limitations of the evaluation

Limitation	Description
Country and regional visits	As noted above, only one country took place and no regional office visits. The lack of direct interaction with actors at national and local levels greatly limited data gathering and made it difficult for the evaluation team to gain a detailed understanding of country level implementation of RCCE coordination as implemented in different contexts. The team increased the number of regional and country remote interviews to compensate for the lack of visits. However, the depth of information gathered from the interviews, interactions and observations in Uganda highlighted what could not be gained from remote interviews.
Interview requests	Several requests for interviews received no response or could not be scheduled in time, especially for those outside the core partners. Despite several requests, it was not possible to interview any RCCE adviser from WHO AFRO or its West Africa hub.
Documentation	Important documentary sources became available to the evaluation team only at the last stages of the evaluation and the team has tried to reflect them in the analysis.

Risks. The risks to the evaluation as set out in the Inception Report, and how they were mitigated, are set out in Annex K.

4 Findings

The evaluation findings are organized under the five evaluation questions introduced above and listed in the evaluation matrix in Annex A.

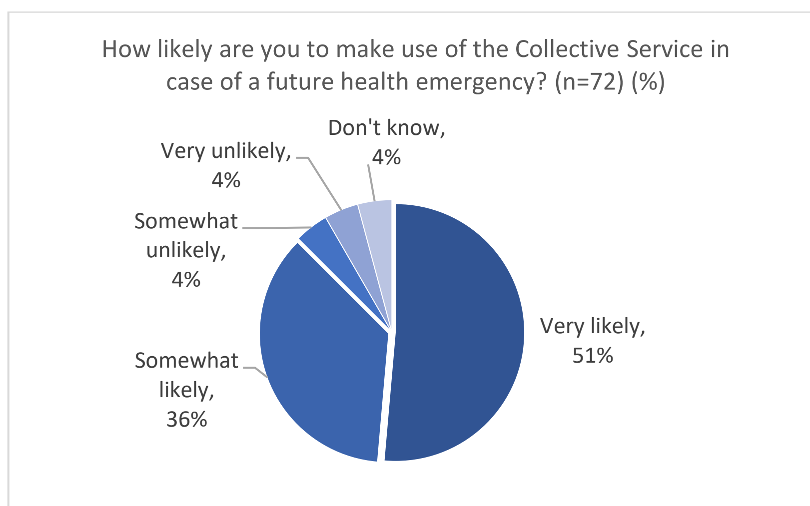
4.1 To what extent is the Collective Service design and service offering relevant, clear, and coherent for its users at HQ, regional and country level?

The decision by IFRC, UNICEF and WHO to launch a global, inter-agency and coordinated effort on RCCE was appropriate, necessary and timely. The Service brought actors together to work on RCCE on an unprecedented scale. The theory of change proved sound, with some gaps, and the RCCE guidance and tools generated were high quality. Some were well used, several others were not. The CS combination of social science research and community feedback proved to be innovative in informing country-level RCCE. The great majority of informants to the evaluation considered that the Service would continue to be relevant to future health emergencies.

Relevance. The decision by IFRC, UNICEF and WHO to launch a coordinated effort on RCCE was appropriate and timely. The global videoconferences supported by GOARN proved both relevant and effective during the first year of the pandemic as a forum for information-sharing and learning, and were well attended by a wide range of RCCE actors. The bringing together of actors to coordinate RCCE on this scale was unprecedented. The guidance materials developed by the Service, including by its subgroups, were based on good practice and were consistent with individual core partner guidance. Bringing together risk communication, social science research and community feedback proved to be innovative and relevant in providing analysis of the state of the PHE outbreaks, the social attitudes towards them, and adaptations for risk messaging in regional forums and in a few countries where the CS engaged more fully. As the pandemic receded, the Service remained relevant by adapting its tools to support RCCE for cholera and EVD outbreaks (also briefly mpox and the Marburg virus disease), and latterly for drought and flood responses.

One test of relevance is to understand the value of the Service and the likely future demand for its support as perceived by stakeholders' experience (Figure 5). Survey respondents rated their own organizations' performance in RCCE highly but when asked in which parts of RCCE their organization was least successful, the most frequently cited function was RCCE coordination, followed by capacity-building. Some interviewees were convinced that something like the Collective Service would be needed again for any future pandemic and that closing it now would mean having to recreate it later. A total of 87 per cent of survey respondents considered it 'Very likely' or 'Somewhat likely' (respectively 51 per cent plus 36 per cent; Figure 5) that they would need the support of the Collective Service in a future health emergency (67 per cent for WHO respondents).

Figure 5. Likelihood of future use of the Collective Service



Theory of change. Within the confines of the five logic steps, the theory of change (TOC) and the logical framework (see Annex D) provided a sound basis for the development of guidance by the Service. The inter-agency RCCE guidance (called Interim Strategy) was based on the TOC and is consistent with it. However, there are gaps in the logic chain. *Step 1* 'If we use evidence and resources' assumes that the pre-conditions for the use of evidence are met, which was only partially true in the case of the Service because, as explained below, beyond the global level, the use of global guidance was constrained by the resistance of regional offices to the Service. While *Step 2* on strategies includes **'**Capacity-building in RCCE', and *Step 4* on outcomes includes 'Strengthened capacities for improved local response', the CS has had no underlying strategy for capacity development, beyond training courses.

Quality and utilization. The evaluation received positive feedback concerning the quality of the RCCE products of the Collective Service. The Interim Strategy of December 2020 is seen as a core document.[43] Several subgroups under the main RCCE coordination group, with memberships going well beyond the core partners, produced their own guidance on specific themes (listed in Annex F). To ensure consistency and to support cross-partner working, core partners made sure that CS and agency-specific guidance were consistent. The CS and its working groups created guidelines, negotiating content that all parties could support.[44] The CS products carried the logos of the three core organizations, which made them authoritative and influential, according to key informants. The RCCE guidelines adopted by the Service were derived from documents produced by the three core partners, which are themselves regarded as good practice sources for how to respond to health emergencies. The CS website also includes documents from other partners that are authoritative in their own domains (e.g. Johns Hopkins University, Office for the Coordination of Humanitarian Affairs/OCHA, International Organization for Migration/IOM, United Nations High Commissioner for Refugees/UNHCR).

The evaluation has not been able to systematically collect information on the usage of the various guidance documents and cannot therefore form clear conclusions about their added value. The Interim Strategy and the guidance it included were well developed. A second set of interim guidance was prepared but it was never formally approved or published. Feedback on the utility of products was mixed. Positive feedback emerged from the online survey, where RCCE online resources were rated more highly than any other category of CS services. Asked about the most significant contributions of the CS, resources and knowledge sharing were the most mentioned in the survey, along with "country and regional support in RCCE practices" and "evidence gathering". One respondent referred to "materials that enabled adaptability for national context" and country and regional respondents pointed out the utility of the technical guidance for "setting up innovative and timely mechanisms for coordination and data visualization including RCCE dashboards". About one third of survey respondents expressed appreciation for the standardized data provided in the data dashboards; "extremely useful during the first year of the response", according to one.

Some interview feedback pointed to more guidance having been generated by the CS and its subgroups than could effectively be absorbed by regional and country teams, even if their technical quality was considered high. Interviews at regional and national levels revealed familiarity with only a few products (the interim strategy, the dashboards, and the Question Bank being referenced most often) leaving open the question of how well utilized other tools were. This might point to the need for fewer, shorter documents developed, based on country-level demand and in local versions and local languages. Shortage of a translation budget was reported as an issue by the Secretariat.

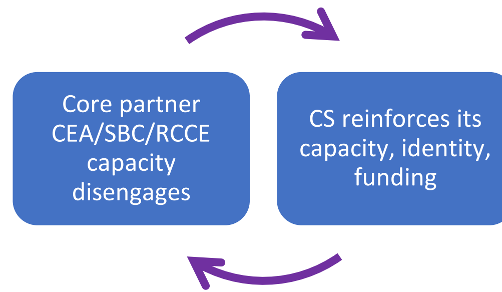
Branding. There was no intention to create a separate identity and branding for the Collective Service. However, the Service was marginalised by some technical CEA/SBC/RCCE staff in its sponsor organizations, especially at regional level, while others remained ignorant of it, thus leaving only a small group of supporters in each core partner, who sought to gain engagement from colleagues for the work of the Service at regional and country level. To attract funding, the Secretariat promoted the CS as a distinct service, with the brand asserting itself on the website, in the newsletter and in donor reports. As the ODI rapid review stated, the CS

[43] A second version of this guidance was prepared but its approval was delayed for so long it was regarded as longer relevant to the evolving nature of the pandemic and was never released. There were challenges over the clearance of this key publication. WHO clearance processes are lengthy, causing frustration for other partners. However, guidelines issued without the WHO endorsement and carrying the WHO logo are not seen as credible by health partners.

[44] Later, agency-specific guidance was brought into line with that of the CS and new agency specific guidance was delayed pending the agreement on CS documents. UNICEF stopped issuing new guidance on SBC for the pandemic once parallel CS documents were approved.

as a pilot had limited resources and was pressured for quick wins on the ground. The Service has been caught in a negative feedback loop which led it to generate a distinct profile to survive, as illustrated in Figure 6.

Figure 6. Separation of the Collective Service from core partner capacity

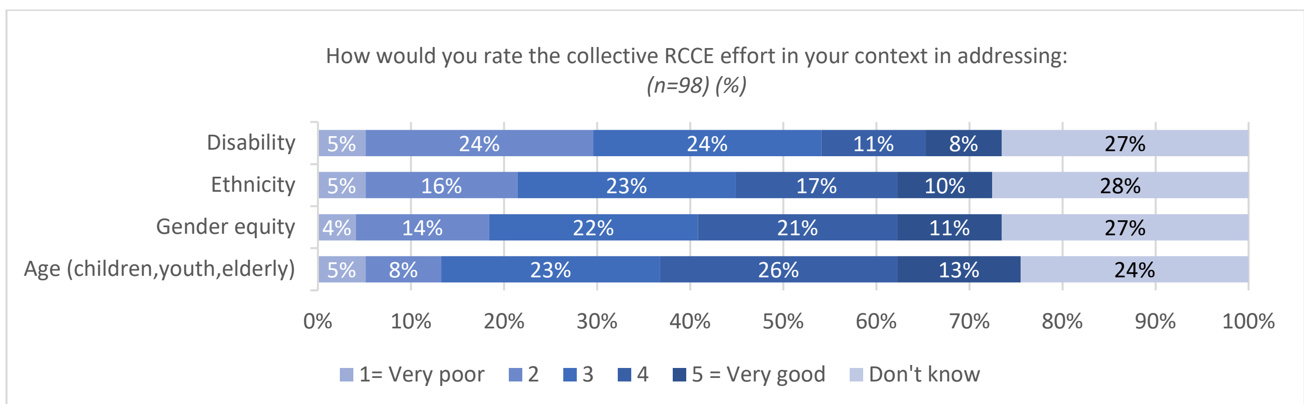


The name 'Collective Service' has been problematic because (i) its meaning is unclear to those not directly involved with the Service – any inter-agency service could use the name, and(ii) it has added to the idea of the Service being distinct from the core partners.[45]

Equity. The attention by the Collective Service to gender, equity, inclusion and diversity has been variable and limited. Whether the Service has added value over and above the equity approaches adopted by the core partners is not easy to determine. CS subgroups generated guidance materials targeting the needs of vulnerable groups. It is not clear how much these were applied. IFRC, UNICEF, and WHO issued factsheets on 'Young People and COVID-19', and 'Children and COVID-19' for use by the media (but not under the Collective Service).

According to the Collective Service's own reporting, it has endeavoured to ensure communities are at the heart of equitable, accountable and predictable response mechanisms as informed, prepared and empowered actors.[46] A number of guidelines and tools were prepared, including the Youth Subgroup's 'Operational Guidance on Youth Engagement and Leadership', and 'Practical Tips on Engaging Adolescents and Youth in the COVID-19 Response'.[47] The CS guidelines[48] developed for religious leaders included supporting vulnerable groups, preventing violence against children and women, and children and youth participation.[49]

Figure 7. Ratings of collective RCCE effort



[45] In Uganda, there were indications of a lack of understanding of the name 'Collective Service'. Key informants and meeting participants referred to 'collect services' or 'collective services'. There was also a sense that their participation in a collective activity related to RCCE made them part of the Collective Service.
[46] Collective Service (2023). Final Grant Report Prepared for the Bill & Melinda Gates Foundation. June 2020–September 2022 (internal document).
[47] Collective Service (undated). Our Subgroups (website).
[48] Faith and Positive Change for Children/FPCC (undated), Six Global Guidelines for Religious Leaders (website).
[49] Collective Service (2023). Final Grant Report Prepared for the Bill & Melinda Gates Foundation. June 2020–September 2022 (internal document).

Several documents were produced regarding improved take-up and access to vaccines for vulnerable groups. [50, 51] In spite of these efforts, the impression gained from interviews was that equity received only patchy attention. Survey respondents gave moderate to low ratings for the attention to areas of equity, as shown in Figure 7, with a high level of 'Don't knows', itself a sign that equity themes may not have been prominent in RCCE implementation. Excluding 'Don't Knows', the lowest rating was for attention to disability, with only 19 per cent of respondents rating the CS support as 'Good' or 'Very good', with Gender and Age (children, youth elderly) rated somewhat better, with 32 per cent and 39 per cent of respondents recording CS support as 'Good' or 'Very good', respectively.

4.2 To what extent have the planned outcomes of the Collective Service been achieved, and by what means?

Regional and country-based participants in the evaluation rated the support provided by the Service highly, with somewhat lower scores from those based at HQ. The Service was considered to have performed well in basing its support on the latest evidence and good practice and in improving the coordination of RCCE at global level and in some regions and countries. The CS has invested in training and systems improvement, with community feedback the topic most in demand. The Service invested heavily at global, regional and country levels in improving data collection and analysis to support improved decision-making for RCCE in public health and other emergencies. Capacity development does not yet have a well-developed approach and preparedness and readiness for RCCE have featured little in the work of the Service. The CS has not been established on a financially sustainable basis. With some exceptions, IFRC, UNICEF and WHO have collaborated well on RCCE, bringing their respective comparative advantages to bear.

The TOR for the evaluation asked for the assessment of 'preliminary outcomes'. With the agreement of the management team, the evaluation has focused its analysis at the level of the Collective Services contribution**.**

Regarding the four strategic areas defined for the Service:

- **Be community-led**. The CS has invested in training and systems improvement for community feedback, which was then the support most in demand. Red Cross Red Crescent National Societies were a lynchpin of community engagement for PHE response, including RCCE, and UNICEF helped local partners and local structures in support of RCCE.
- **Be data-driven**. The CS has invested heavily at all global, regional and country levels in improving data collection and analysis to support improved decision-making about RCCE for the pandemic and other emergencies. Data dashboards collated multiple sources of data to provide regional and country situation analysis. Important support was provided to the analysis of community feedback data across sources and to improve the quality of data. (See also section 4.4 and the Data for Action case study.)
- **Reinforce capacity and local solutions**. IFRC, UNICEF and WHO have all used their resources to strengthen local response capacity. Online training modules on RCCE have attracted a large audience (according to interviews, around a hundred people per module for the training on social sciences, emergency coordination and community feedback). In-person training to countries was limited until mid-2022, with remote training dominant before then and seen as less effective. Some training was simplified and adapted to target specific in-country issues. Capacity reinforcement has often been effective in contrast to capacity development, for which there is not yet an effective approach.
- **Be collaborative**. IFRC, UNICEF and WHO have worked well together on RCCE in several regions and country situations, with and without CS support (a complete mapping is beyond the remit of the evaluation). IFRC has no presence in two thirds of the countries in Africa, while WHO has presence but limited capacity to support RCCE, which is delegated to UNICEF. There have been some tensions between the core partners at all levels over direction, leadership and resources.

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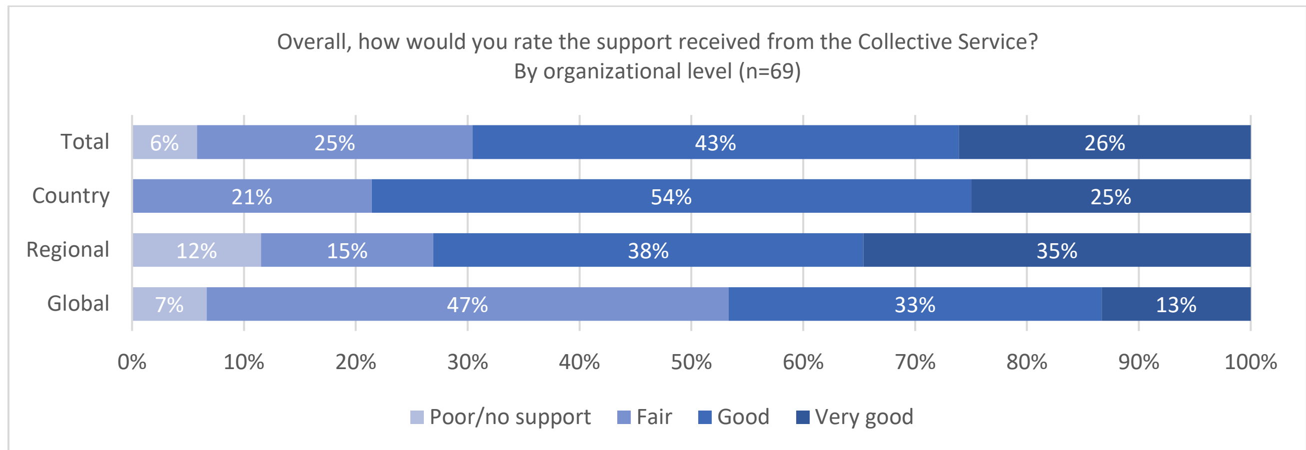
[50] Including on migrant inclusion in COVID-19 vaccination campaigns, drawn up by the Subgroup on Migrants, Refugees and Other Vulnerable Groups: IOM (2022). Migrant Inclusion in COVID-19 Vaccination Campaigns. In March 2022, the CS published a UNICEF report on the lack of equity in access to vaccinations. In ESA, D4A provided research evidence said to have changed the narrative from one of vaccine hesitancy towards one focused on barriers to access. Country-specific examples where the CS paid attention to equity included: a synthesis of community feedback that identified 'Access to Health Services by Pregnant Women and Other Vulnerable Groups' (Uganda, May 2023), while in Zimbabwe feedback on COVID-19 vaccines highlighted the need to adapt immunization services to enable priority groups to access vaccines.

[51] Collective Service (2023). Final Grant Report Prepared for the Bill & Melinda Gates Foundation. June 2020–September 2022 (internal document).

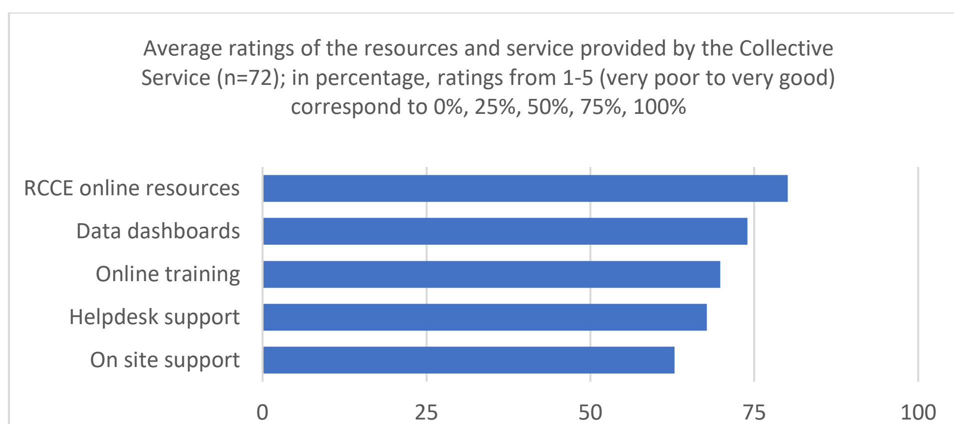
Satisfaction levels. CS user ratings are employed here as a proxy measure of relevance of the Service and the progress it is perceived to have made. Survey respondents were asked for a single rating of the support they received from the Service. The Service was rated 'Good' or 'Very Good' by 70 per cent and 73 per cent respectively by region and country-based respondents, showing a relatively high level of satisfaction, while global/HQ participants gave a lower average rating (43 per cent) for the same measures (see Figure 8). Broken down by organization, the equivalent percentages for IFRC, UNICEF and WHO were 86, 63 and 53 per cent, respectively.

Figure 8. Ratings of support received from the Collective Service



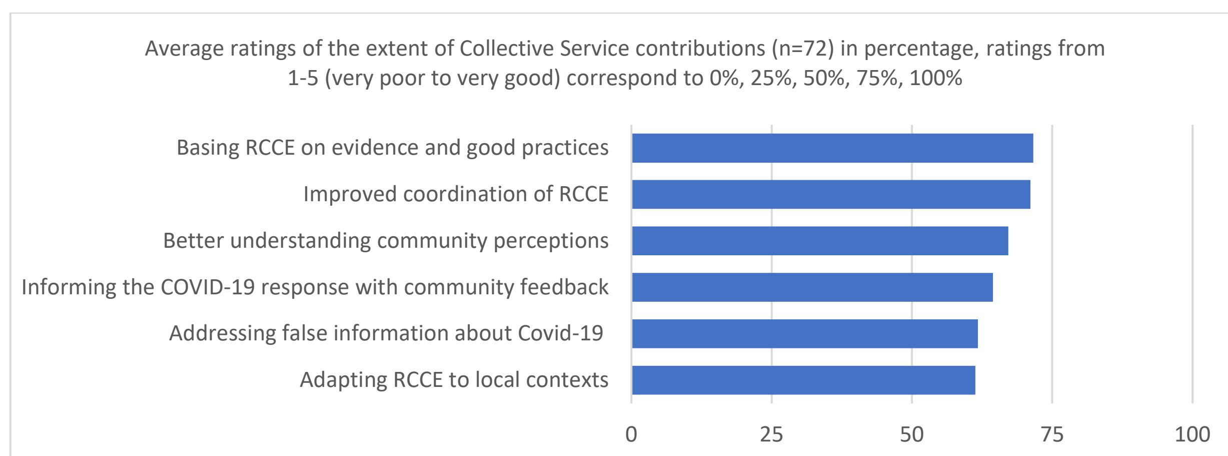
Delineated by types of product and services, survey respondents provided the following ratings, here calculated as a single percentage rating (see Figure 9). Online resources are rated highly at 80 per cent, and Helpdesk and on-site support more moderately at 60 per cent plus.

Figure 9. Ratings of resources and services provided by the Collective Service



The survey included a general question about the contribution made by the Collective Service to various outcomes (see Figure 10). These ratings are useful in understanding which areas are considered to have been better supported than others. 'RCCE that is based on evidence and good practice' (74 per cent) and 'Improved coordination of RCCE' (73 per cent) were seen to have made the greatest contribution, while 'Adapting to local context' and 'Addressing false information about COVID-19' were rated lower (62 per cent and 61 per cent). The majority of those responding to the online survey say they would use the CS again, which points to a positive perception of its contribution. Amongst the arsenal of RCCE approaches, methods and tools developed, some are seen to have contributed to strengthening RCCE capabilities and practices across all regions and in some countries. The take-up of some tools was limited and there was insufficient translation budget to make them available in all UN languages. Some local translations were undertaken.

Figure 10. Ratings of extent of Collective Service contributions



Social sciences. The application of social science has been a prominent component of the Collective Service. The CS promoted the creation of a Social and Behavioural Framework comprising five key dimensions to monitor social data during the progression of the pandemic, which proved fundamental in identifying key indicators for monitoring behavioural change during the different stages of its development. From this framework, the Question Bank was derived,[52] which was mentioned severally during the evaluation as an important and widely referenced and used tool in ESA, WCA, and MENA. The framework provided the basis for the collection and compilation of social indicator data and was later extended for use in other public health emergencies beyond COVID-19. The social science focal points in ESA and WCA regularly provided technical assistance for the review of protocols and reports of knowledge, attitudes and practices studies conducted by countries.[53] In ESA, guidelines, methods and tools have been adapted for regional and country use. This enabled the collection of socio-behavioural data in multiple locations.

In the case studies, examples of longer-term support provided to some priority countries were identified. In the Central African Republic (CAR), there was efficient collaboration on RCCE, based on inter-agency cooperation that long predated COVID-19, while Malawi was also highlighted by both the regional hubs in Africa as having made a major contribution through social sciences (see Table 5). The comparison is of interest because CAR had no engagement with the Service, while Malawi was fully supported to respond to an acute crisis.

Table 5. Examples of the application of social science to RCCE

In the Central African Republic (CAR), as part of the analysis of the socioeconomic impact of COVID-19 on migrant and displaced populations, the UNICEF country office worked closely with the national RCCE mechanism and Ground Truth Solutions, which undertook a series of surveys. The Collective Service team supported the research process by co-constructing the survey questionnaires, discussing community specificities and using data from community feedback to assess local opinions. Working closely with CAR was greatly facilitated by the dialogue between the SBC regional office and UNICEF staff in CAR.	The CS support to Malawi began with technical assistance to the 4Ws (who does what, where, and when) during the COVID-19 pandemic. The outbreak of cholera in 2022 offered the opportunity to continue collaboration with the national task forces. The CS supported the community feedback mechanisms and trained 400 volunteers and 8 health workers in 4 districts on SBC, RCCE, community-based surveillance and community feedback data collection and utilization. Community Feedback Committees were established. As the cholera outbreak intensified in 2022, an operational synthesis of social and behavioural evidence was conducted and social science support missions were conducted in 2023, with rapid qualitative assessments.

[52] The questions were translated into four languages thanks to the support of Translators Without Borders.
[53] This support was most often activated through UNICEF country offices, and in some cases overlapped with regular assistance by the SBC functions in UNICEF regional offices.

Challenges experienced in the implementation of social sciences included:

- **Broadening focus to more emergencies**. As the CS broadened its scope in response to demand from country offices to support different types of emergencies beyond COVID-19,[54] the social science capacity to meet demand was exceeded. Requests for support became ad hoc, without limits on the range of possible queries having been agreed. There is, as yet, no standardized process for requests for support other than for public health emergencies.
- **Narrow analysis**. The CS has added value to the understanding of community practices, knowledge and perceptions, and this has been used to provide data that can be used to improve risk communications and programme design. However, the analysis has tended not to incorporate other variables such as surveillance and epidemiological data, and health-care supply, to provide the more comprehensive analysis that would be needed to build health systems and ensure preparedness for RCCE.

Partner mandates and comparative advantage. In general, the roles and contributions of IFRC, UNICEF, and WHO are understood and recognised by each other. In most situations, the three organizations appear to have collaborated well over RCCE under the pressures brought on by the pandemic and over a sustained period. None felt on secure ground in responding alone to the pandemic, which improved cooperation and lowered competition. Cooperation at country level between the parties was often productive, and often based on good working relationships established before the pandemic. The organizations are familiar with each other's mandates and, in general, understand what they can expect from each other. Feedback gathered for the evaluation on coordinated RCCE indicates that:

- **IFRC**. The Red Cross and Red Crescent Movement has a direct connection to and presence in communities via its National Societies. Communities can be accessed and supported directly through National Society branch structures and their many thousands of volunteers. The volunteer networks are considered by all parties to provide 'value' engagement at community level. The IFRC has a decades-long engagement in the strengthening of National Societies, including in community engagement and accountability. The IFRC is not present in all countries as it operates a country cluster approach where it oversees two or three countries from one office, which limits its ability to engage in some countries. In its absence, the National Societies represent the Red Cross and Red Crescent Movement, however their capacity, reach and effectiveness can vary greatly between countries.
- **UNICEF** is perceived to have strong capacity in SBC, and to have broad presence and capacity in many countries, especially those affected by emergencies. WHO staff interviewed were clear that "RCCE has been assigned to UNICEF" and UNICEF staff were clear that governments expect UNICEF to provide country-level RCCE coordination, therefore inter-agency RCCE is dependent on UNICEF for its coordination in many countries. UNICEF has been increasing its SBC capacity in recent years, but this does not mean that all SBC staff have the high level of skill required to support RCCE coordination effectively in every high-risk country, unless they are prepared for that role. UNICEF often has subnational presence through its implementing partners. The organization is seen to be well funded compared with other core partners and to have the capacity to apply its funding flexibly. In several instances, it has used its resources to fill short-term gaps in CS capacity and to hire consultants. It enjoys an advantage in being able to raise funds from the private sector, which WHO cannot.
- **WHO** is acknowledged as having lead responsibility for setting standards in PHE and structure of PHE response and to have the lead responsibility for supporting governments during PHE. Governments naturally turn to WHO to fulfil these roles. WHO often has a co-lead role with government over the PHE response, with UNICEF in a co-lead role for RCCE as one of the response pillars. WHO engaged heavily with journalists as part of its efforts to improve communication and address false information circulating about COVID-19 as part of its work on infodemics. WHO often has limited capacity for RCCE in-country, though it has provided RCCE surge capacity in support of epidemic response (including EVD and cholera). The Gates Foundation grant for the CS included no funding for WHO in the regions,[55] which was said to have affected its participation: "Without specific funding for the CS, you are left

[54] At HQ level, the Service has dropped the label of RCCE, and the website is now simply titled 'Collective Service'. The website now covers, for example, drought and earthquake response without consensus amongst key informants that this is appropriate. In ESA, the Collective Service still retains RCCE in its title.

[55] WHO does receive funding in Africa via a parallel initiative called the Africa Infodemic Response Alliance (AIRA).

out"; "Governments judge you based on what you bring to the table." In Africa, WHO AFRO appears not to have been well informed about the CS and did not appoint a focal person for the Collective Service, making it hard for the CS coordinators in ESA and WCA to ascertain who they should deal with in AFRO.[56] According to the other partners, it would be helpful for WHO country offices to strengthen their understanding of inter-agency coordination, in particular the concept of neutral coordination.

- **GOARN**. Feedback from key informants was unanimous that GOARN successfully coordinated global videoconferences on RCCE that were open to all, initially weekly and subsequently biweekly, and which drew together a very wide range of stakeholders. Participation peaked at over 100 and was typically 60 plus during the first year. A survey of participants in 2020 showed high levels of satisfaction with these calls. According to the ODI rapid review, the platform cut across silos of humanitarian and public health work and brought together both practitioner, technical and academic perspectives, providing a shared space that did not exist elsewhere.[55] The global coordination calls are regarded to have been most valuable in their first 9 to 12 months, after which interest and participation declined. Some informants found the discussions became too internal, without sufficient focus on RCCE implementation at country level and, as the discussions broadened beyond RCCE for the pandemic, others found them less salient. The start of the war in Ukraine in February 2022 took the 'oxygen' from the global calls. While GOARN performed well in the coordination of global RCCE calls, it was used very little as a deployment mechanism for short-term RCCE support. Some key informants regarded this as a missed opportunity but there were several obstacles to GOARN as a deployment mechanism.[57]

Role designation. The June 2020 Letter of Agreement did not clearly assign roles to the partners within the Service. However, the earlier April 2020 IFRC, UNICEF and WHO COVID-19 Global Response Strategy did provide some broad, if imprecise, guidance: "WHO provides the key biomedical technical information, guidance and messaging to partners for further use", while, "UNICEF, IFRC and civil society partners globally and locally amplify and contextualize this key knowledge and roll-out processes and approaches to systematically engage and communicate with people and communities to encourage and enable them to foster healthy behaviours and help prevent the spread of the disease." It was not possible to locate a clearer definition of roles, though reportedly, recently the Steering Committee has discussed the possibility of a clearer delegation of responsibilities within the partnership.

Non-collaborative behaviours. In interviews, instances of intentional non-collaborative behaviours between the core partners were raised including:

- Blocking (restricting access of one party to meetings or contacts)
- Talking down (criticizing to third parties)
- Overclaiming (representing a collective effort as the product of one party)
- Excluding (having responsibility for collective reporting but reporting only one organization's results as the total results of all).

These incidents tended to lead to erosion of trust and confusion for other parties. Some third parties expressed their frustration in being caught up in such conflicts, especially between UNICEF and WHO, and wanted to see that "the giants play well".

Relative contributions. UNICEF made the greatest contribution to core resources for the Service, followed by IFRC and WHO (see Table 3 in section 2.10). Both UNICEF and IFRC were able to deploy CS staff in the regions thanks to grants from the Gates Foundation. Within Africa, UNICEF contributed to RCCE coordination in many countries, and IFRC where it is present. The Red Cross and Red Crescent Movement as a whole was a major contributor to RCCE at the grassroots level via its National Societies. WHO played its greatest role in support to government coordination of national response to the pandemic overall and to RCCE at global level, and less in the implementation of RCCE at country level.

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[56] Despite several attempts, it was not possible to interview anyone from WHO AFRO for this evaluation.

[57] GOARN deployed technical staff to Kenya, Malawi and Uganda to temporarily support country teams in dealing with other outbreaks such as EVD and cholera, via WHO and UNICEF, not the CS. Several months were taken up in trying to agree a mechanism by which GOARN could deploy via the Collective Service, which was not possible in part because the Service has no legal identity.

Differences of mandate and ways of working. IFRC, UNICEF and WHO have demonstrated that they can collaborate under the pressure brought by the pandemic. However, at HQ level, competition started to re-emerge as the COVID-19 pandemic emergency faded. Tensions have arisen in the partnership about the future remit and scope of the Service, which have remained unresolved for the past two years (discussed in detail in Section 6). For some key informants, the apparent disconnection between PHE implementation and humanitarian structures continues to be a frustration.

The multiple terminologies and acronyms employed by the core partners (RCCE, Infodemics, CEA, SBC, AAP) have affected staff understanding of the goals of the Collective Service and have led to some confusion. The conceptual clarity regarding the scope of the work of the CS has been challenged by organizations having to juggle the range of terms used within the partnership.[58] This has been less of a concern at country level, where RCCE was adopted as the label for coordination because it was used by governments as part of the public health response mechanism for COVID-19 and all parties supported the pillar.[59] The IFRC and UNICEF staff and work on CEA and SBC, respectively, were reoriented to support RCCE coordination for the duration of the pandemic and reverted back when the emergency passed.

Goals and objectives. The resources available to the Collective Service were adequate for regional RCCE coordination in two Africa regions and for service delivery to a limited number of countries, with positive results as discussed elsewhere in the report. The resources were not adequate for its higher-level goals regarding systems' improvements and preparedness for future public health emergencies, which would have required a more general mobilization of the core organizations' emergency and development capacities to achieve a common goal, which did not happen. Funding for the Service was short-term, never for more than one year at a time. The CS has only been able to make limited progress on its wider ambition of establishing a body with global reach that cuts across the disciplines of public health, humanitarian and development work, because the core organizations have not done the work required to reach agreement on how the larger goal could be achieved. The Service was not able to scale up its work to regions beyond Africa, as originally planned, in part because of limited funding, and because of lack of corporate support in general and doubts about the role and value of CS regional structures, in particular.

Sustainability. Further evaluation at a later stage will be needed to assess the sustainability of the results of the Service. The global goods created by the Service (guidance documents, training courses, database systems) should remain useful in the medium term, provided they continue to be well housed and maintained. The development of a system of national to local structures for RCCE in Uganda may well have a lasting effect. There is evidence that, once established, they leave an 'imprint', meaning they can be revived in future, as with the RCCE systems built for the pandemic that were revived to respond to the EVD crisis in Uganda and cholera elsewhere in ESA. Countries that have built robust RCCE systems without CS support, including Central African Republic and the Democratic Republic of the Congo have done so over an extended period and outside periods of crisis more than during. As to the sustainability of the Service itself, it has not had a sustainable financial footing since its inception. The core partners invested internal resources to ensure the CS continued into years 2 and 3 but short-term, stop-start funding has not proven a sound basis for the sustainability of the CS. The question of a longer-term funding model has not been addressed.

Capacity development. Most effort on capacity in the first half of the project period appears to have been on building internal RCCE capacity, with some partner and government participation. Capacity-building had limited reach at the national level initially. Regions later focused more on capacity development for governments, inter-agency coordination mechanisms and Red Cross and Red Crescent National Societies. The training provided by core partners and the CS has been varied and overall has reached many participants.[60] In the past

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[58] Including: Infodemics (WHO); Community Engagement and Accountability (CEA, used by IFRC); Communication and Community Engagement (used by Communicating with Disaster-Affected Communities/CDAC (IFRC, UNICEF and WHO are all members of CDAC, see: www.cdacnetwork.org/); Social Behaviour Change (SBC, used by UNICEF); and Accountability to Affected People (AAP, used by IASC and in the humanitarian sector more widely).

[59] Similarly, the Overseas Development Institute, Humanitarian Policy Group RCCE Collective Service Rapid Learning Review (2021) found that "Supposedly different approaches often end up looking very similar in practice on the ground, and do not appear to form major barriers to collaboration between actors at national or subnational level."

[60] A partial summary of training activity comes from the Final Grant Report Prepared for the Bill & Melinda Gates Foundation June 2020–September 2022. Data available includes: 1,300 infodemic managers trained in 142 countries (p. 18); in WCA, 729 members of 14 country-level working group members trained on RCCE (p. 20); in ESA, country trainings in Eritrea, Eswatini, Malawi and Zimbabwe (p. 20). Social Science Training and Competency

year, ESA has increased its training at country level, especially on community feedback systems. It was not possible to locate either a comprehensive record of the training provided or any systematic assessment of its effectiveness.[61]

Systematic capacity development of health systems to prepare RCCE for future emergencies appears to have featured little in the work of the CS. No long-term systems development planning has taken place with development partners. The partners have yet to apply a model for assessing capacity that leads to the planning of sustainable capacity development of national and local institutions.[62,63] This is beyond the capacity of the current Service. As noted above, the TOC assumes that institutions can absorb and retain knowledge and become effective in RCCE through training courses but the CS has made no such assessment and the body of literature on capacity development does not support this assumption.

Resource mobilization. The ability of the Service to deliver on its outcomes was directly related to the level of financial resources available. As some staff in the core organizations regarded the CS as competition for, or duplication of, their organization's RCCE-related functions, the Secretariat reports that it was told by the resource mobilization functions of the core partners to seek funds from non-traditional channels only, e.g. foundations, and to avoid other sources from which the organizations had already requested funds for similar activities. This was a significant challenge for the CS and for the Secretariat both then and now, and left the CS in a financially vulnerable position.

In 2021, the Secretariat developed a Resource Mobilization Strategy with short-term and long-term strategies for fundraising and mapping of potential donors. The Secretariat advocated with several potential donors and secured further funds from the Gates Foundation and new funds from the Rockefeller Foundation. The CS was successful in raising and sustaining funding over a three-year period, albeit at a modest level compared with the potential need. In ESA, services have been sustained through funding for EVD and cholera outbreak responses, while partners at all levels have found it hard to maintain momentum as pandemic funding has reduced and other priorities have taken attention, especially the war in Ukraine. The Secretariat advocated for a mixed approach to financing of the CS, incorporating a minimum commitment from the three organizations and ad hoc funding sought by the Secretariat. All three agencies then invested internal resources to support the Service, demonstrating their commitment. Interviews indicated that without this commitment, further funding from the two foundations would probably not have been forthcoming and the CS might then have ended.

Human resources

- **Commitment.** Strong commitment by CS staff members and organization focal points, sometimes in the face of disinterest and, on occasion, opposition from within the core organizations themselves, has enabled the Service to continue. This has come at a price in burnout of some staff. There has been staff turnover at all levels from the membership of the Steering Committee to the adviser, coordinator and technical roles at regional level. There have been three global coordinators so far, meaning that each coordinator has been in post on average for only one year.[64] There was also turnover in regional coordinators in both WCA and ESA. Some contracts have already ended and those still in role face uncertainty until decisions are made about the future.

Framework: 5 countries in ESA (2021–2022); Trainer of Trainers remote session (IFRC); 80 practitioners were trained regarding the application of social science evidence in health emergencies followed by cascade trainings (no statistics); 1,950 people have taken IFRC's COVID-19 community feedback toolkit and e-learning on RCCE (p. 21); WHO convened 80 webinars on the WHO Information Network for Epidemics, "in close coordination with the CS, making available 449 expert panellists to more than 56,000 participants, from 149 countries and territories, with representation from as many as 935 organizations" (p. 21). An April 2023 update to the Rockefeller Foundation reports orientation of health workers on an integrated community package with 640 people from 12 districts trained by WHO, and 72 health workers and 16 partners trained on CFM.

[61] READY is a project based at Johns Hopkins University and funded by USAID. It was initiated in late 2018 and will close in March 2024. It assembled a comprehensive package of RCCE capacity-building resources, mostly training courses (undated).

[62] For longer-term preparedness, the Collective Service could make further use of the document 'Accompanying READY Capacity Assessment for Conducting SBC/RCCE in Large-Scale Emergencies', which takes a comprehensive approach to assessing all the institutional aspects required for RCCE to be placed on a sustainable foundation, covering human resources, finance, surge operations, technical SBC capacity, coordination, SBC strategy and implementation, mobile technology and social media, and monitoring and evaluation.

[63] CDAC has an established coordinator training package for communication and community engagement coordinators and also has a capacity assessment tool.

[64] The first global coordinator was replaced so that a 'neutral' coordinator could be employed instead, which may point to a lack of trust in a core partner being able to assign a staff member to act impartially on behalf of all.

- **Skills required.** The importance of coordination as a skill was highlighted by key informants, soft skills over and above any technical specialism. It requires the ability to understand the perspectives and needs of multiple parties and to arrive at compromise solutions, while remaining positive, impartial and focused on finding practical solutions. Some in the core partners have found it hard to accept that an inter-agency coordinator can operate without putting the interests of their own organization first. The coordinators at global and regional levels played a neutral role, except where this was undermined by the coordinators being assigned agency-specific tasks by their supervisors. The CS has depended on skills in social science and information management. Reportedly, finding skilled social scientists is a particular challenge. "It is hard to get consultants; there aren't enough, and we repeatedly use the same organizations" (i.e. consultancy companies).
- **RCCE surge capacity.** One of the concerns of the Steering Committee is that there should be surge capacity for the overlapping disciplines of RCCE, AAP, CEA, and SBC. The GOARN network did not prove effective as a source of short-term deployments of RCCE experts.[65] Hiring consultants was seen as a preferable and simpler solution. The evaluation heard that Norwegian Capacity (NORCAP) of the Norwegian Refugee Council has RCCE advisers on its rosters and that REDR Australia has begun to deploy CEA advisers on surge assignments. Under a USAID-funded project on AAP, with IFRC, OCHA and UNICEF, a 'roadmap'[66] was agreed two years ago for the development of greater capacity in community engagement and accountability to address the "lack of known high-quality, senior inter-agency coordination capacity, able to predictably support collective approaches to community engagement and accountability". The document specifies profiles for a senior adviser/coordinator, and information manager and a senior social scientist, all of which would also be relevant to the CS.[67] Reportedly, the roadmap has not advanced significantly since 2022 and to enable its implementation UNICEF has commissioned a further consultancy, which has developed a concept paper for inter-agency standing capacity in AAP, including for community engagement. Such a capacity would be very helpful in supporting key elements of the work of the Service.

4.3 How efficient and effective has the coordination and collaboration of the Service proven in delivering on the objectives of the Service?

The Service has successfully supported RCCE coordination globally, with the support of GOARN. In ESA, the Service has operated continuously, allowing it to develop and become effective over time. In WCA, the effectiveness of the Service was constrained by being active for only one year. Training on RCCE, social science, community feedback, and information management reached thousands, but no analysis of its effectiveness was found. Governance of the Service has not always been effective and the Steering Committee has yet to resolve difficult issues between the partners on future direction (the evaluation is intended to provide evidence to support its decision-making). For the period June 2020 to March 2024, the Service succeeded in raising US$6.1 million from two foundations, which were enthusiastic about the progress made by the Service. A further US$8.0 million was contributed by the core partners, which proved important in ensuring that the donors felt able to make repeat contributions.

Launch of the Service. The way that the Service was launched has had a lasting impact on its efficiency and effectiveness. Initial discussions of how to coordinate RCCE before the formal launch of the Collective Service were driven by committed counterparts at HQ in IFRC, UNICEF and WHO and GOARN, up to director level. The funding proposal for the Gates Foundation was developed very quickly ('overnight', according to some) with hurried consultations within core organization HQs, and no consultation with regional offices. The legacy of

[65] The evaluation has gathered some evidence as to why GOARN was not used as a deployment mechanism for short-term country-level technical support. Some key informants regarded this as a missed opportunity but a number of factors contributed. Several months were taken up in trying to agree how GOARN could deploy personnel via the Collective Service which, having no status as an official entity, could not be a recipient. As GOARN is essentially a mechanism for experts to be deployed from member institutions via WHO, there were complications in agreeing TORs for the deployments managed by IFRC or UNICEF because they would have reporting lines to the agency to which they were deployed and to WHO. There was no particular reputational advantage to UNICEF or IFRC of an expert deployed by WHO, especially with the budget for each assignment accruing to WHO. Some GOARN candidates were seen as not sufficiently experienced in RCCE. RCCE is not a core skillset offered by GOARN and it would need time and investment to build a larger pool. GOARN deployments are for four to five weeks, which may not be adequate.

[66] Collective Community Engagement and Accountability: A roadmap for technical support, May 2022, commissioned by UNICEF, on behalf of OCHA, and the partners of the Collective Service, with funding from USAID Bureau of Humanitarian Assistance.

[67] The Roadmap states that "The CDAC Network, UNHCR, IOM, WHO and the Collective Service for RCCE have focused on elements of inter-agency capacity development within different emergency contexts. A joint planning process should therefore be facilitated to identify activities covered by current workplans and identify potential capacity and resource needs to support priority activities not currently covered."

this rushed beginning is still felt in some resistance to and lack of understanding of the Collective Service. The funding proposal sent from HQ level in July 2020 took no account of the RCCE coordination initiatives already in place in ESA and WCA. Three years later, UNICEF HQ and WHO do not want to see the continuation of CS structures at regional level, even though the evidence shows that, where well integrated with regional RCCE networks, they can add value.[68] WHO informants pointed to the lack of information provided by WHO at the global level about the Service to the regions as a constraint. One consequence of the rapid start-up was that it bypassed the need for the core partners to establish corporate commitment to the Collective Service and specific arrangements for oversight. It is widely considered that lack of corporate commitment from the core partners was and remains an important constraint.

There was, understandably, a need for the new Collective Service to act fast, faced with the pandemic crisis. However, the core partners did not communicate adequately within their organizations about the purpose and mode of operation of the CS when the project was launched. In December 2020, a letter was drafted by the IFRC, UNICEF and WHO directors to be sent to all their regional offices (at deputy regional director level). The letter was never sent due to objections from one organization. There was no general communication within the core organizations or to partners to explain the CS either then or at any time since. The lack of, and errors in, communication about the CS seem to have exacerbated tensions between partners. Poor communication from HQ regarding the CS was noted in the online survey: “It was not clear at regional or country level the support or benefit of the Collective Service”; there was a lack of “explaining its role and responsibilities to the countries and regions”; and “The model is not clear and there is a constant ‘identity crisis’ linked to different views amongst partners.”

Regional implementation of the Service. The establishment of two subregional structures in Africa was an important element of the CS implementation and a contentious one. Given the strong level of interest stakeholders expressed in how the CS progressed in the two subregions, and why they differed in their evolution, a detailed discussion is included here.

East and Southern Africa (ESA). The RCCE Technical Working Group for ESA was established in March 2020, i.e. before the Collective Service. It remains active today, with 40 plus participants, now under the leadership of the CS regional coordinator. It is the only pillar from the WHO-endorsed pandemic coordination platform established by the Regional Health Partners Forum that remains active. The lifting of travel restrictions in 2022 proved important in allowing in-person, on-site support to be provided by the CS team for one to four weeks at a time. The CS team consider this to have been more effective than the earlier remote support. As IFRC had less restrictive travel policies than the UN, IFRC staff were able to travel when UNICEF staff could not. In June 2021, IFRC and UNICEF agreed to exchange coordination and surge support roles, with the coordination role shifting from IFRC to UNICEF and vice versa for the surge support role. WHO has played an active role in regional RCCE coordination in ESA and co-chairs the Community Feedback subgroup.

With HQ endorsement, the Service in ESA broadened its support for PHEs beyond COVID-19, to support EVD (and SVD in Uganda), to cholera in Malawi and Mozambique, and Marburg virus disease in Tanzania. After a challenging start, there is evidence that CS has added value to regional RCCE coordination and to RCCE in specific countries in ESA, especially to community feedback systems, through training and especially in supporting the categorization and consolidation of community feedback data across actors at country level, with quality assurance providing more reliable data sets. In ESA, the most important contributions at country level seem to have come after the COVID-19 emergency. Feedback from the two donors concerned is very positive on the services provided in ESA, which is why they have each provided more than one tranche of funding.

The CS in ESA has had a dedicated coordinator post since the beginning, allowing an understanding of the role of the CS to develop, and demand for services at the country level to grow over time. The dedicated regional surge and information management support capacity provided by IFRC has provided specific, time-limited inputs to coordinated RCCE at country level that are seen by the country-based partners, including the Ministries of Health, to have added value. Reportedly, there is increased demand for support to social science, community feedback, and information management in ESA, including for other types of emergencies, for example,

[68] Some informants from the Asian Pacific region made similar observations, to avoid duplication of effort, and avoid any disruption to existing regional RCCE networks.

drought. Ten governments are reported to be seeking support currently, which may exceed the team's capacity to deliver. As it stands, the funding for the three CS posts will expire at the end of 2023, which risks leaving significant demand unmet.

The fact that the Service appeared to have a separate identity was initially viewed negatively by colleagues in the region. Yet recently the CS has been using its own logo partly for reasons of fundraising, but also because if it is considered to be a semi-independent actor, it may be viewed as impartial, enabling it to navigate inter-agency politics and thus facilitate a collective arrangement for RCCE, as is reported to have happened in Mozambique.

West and Central Africa (WCA). The CS support structure in WCA was integrated into the RCCE Regional Group, which predated the CS, having been launched in February 2020. The regional group was chaired by UNICEF and co-led by WHO. As in ESA, the regional coordination group was a broad platform with other UN agencies and large INGOs.[69] The recruitment of CS consultants was relatively quick, and once support was launched to the RCCE forums at the regional level, support was stepped up.[70] The team provided regular technical assistance in social sciences (review of protocols, reports, methodology) and coordination (review of RCCE national strategies and plans for vaccine deployment). A community feedback subgroup was led by the Information Management Consultant hired by IFRC, providing regular analysis on community feedback data collected by regional partners, trends and actionable recommendations. During the first six months, the RCCE Regional Group, with support from the Collective Service, assisted the media through training and sharing materials on the pre-existing Corona West Africa website.[71] The initial funding for four staff was for six months only.[72]

Those involved in the CS in WCA consider that its first year was dynamic and efficient at regional level, with good coordination between ESA and WCA RCCE mechanisms. After the first year, participation in WCA regional coordination decreased and the continuation of the Collective Service in WCA was questioned, particularly by UNICEF, regarding its legitimacy and the sustainability of assistance to countries. The team was refocused on adapting the RCCE training courses to the needs of the countries of the region, including simplification and greater country-level participation. The CS in WCA subsequently lost momentum and funding. The discontinuation of the Service in WCA from July 2021, and resistance to adopting it on a long-term basis, prevented the benefits of a more sustained CS support service from being demonstrated. Regional stakeholders report that the regional RCCE coordination in WCA is being redefined and the biweekly coordination meetings are not currently being held.

In both ESA and WCA, the Service personnel and their managers emphasised to their regional colleagues the benefits of the extra resources and personnel for RCCE that the CS provided, while also downplaying the use of the name 'Collective Service' to avoid perceptions of a competing entity. In ESA, the UNICEF and IFRC SBC/CEA senior advisers decided to make the CS a delivery vehicle for the regional RCCE taskforce set up under the regional Health Partners Group, coordinated by WHO. The advisers were able to delegate the RCCE coordination, which by then had become close to a full-time job for them. Some objections from regional staff continued but the value of the additional CS resources in support of RCCE coordination and technical support was gradually established. The CS fared less well in WCA, perhaps because it faced greater resistance, and it was funded for only one year, without the chance to implement in-country service delivery after COVID-19 travel restrictions were lifted.

Regional RCCE platforms. Several regions established regional RCCE coordination platforms. Coordination varied between ESA, WCA, MENA and AP in the breath of participation and the extent to which they were for information-sharing only or for joint planning of country-level interventions. All these regions had regular coordination meetings, and some provided online training. Latin America seems to be the outlier in not having a regional coordination mechanism. At the county level, many countries introduced an RCCE coordination

[69] IOM, OCHA, UNHCR; Médecins sans Frontières, Médecins du Monde, Oxfam, Save the Children.

[70] Nevertheless, certain obstacles would slow down the renewal of contracts following the six-month initial period. The case study provides an explanation of the various phases of the CS assistance with external and internal resources.

[71] Further information on the materials shared on the Corona West Africa site are presented in the case study.

[72] For the period from March to June 2021, the team was funded by UNICEF. From July to September 2021, the CS coordination was provided by a UNICEF emergency specialist, as there was no dedicated coordinator in place. From Oct 2021 to March 2022, four staff were funded by the CS (two Surge Support, one IM, and one Social Sciences), with a focus on the combined training package on coordination, social sciences and community feedback.

mechanism, with the active support of IFRC, UNICEF and WHO (depending on the country) and in some cases, support from the Service from regional or HQ level. Other regions acted on RCCE for themselves from an early stage in the pandemic and have had only limited support from the CS since, with variations by region.

The evaluation reviewed three regions beyond Africa to see how they had approached regional RCCE coordination and how this compared with the regions supported by the Service to see if this provided learning about the role played by dedicated CS capacity versus little or no external support.

- In the **Middle East and North Africa**, an RCCE Inter-agency Working Group (IAWG) was set up at the same time as the CS, with the inter-agency coordinator (IFRC) based in Lebanon, and WHO and UNICEF counterparts in Cairo and Amman respectively. The IAWG sought to implement the RCCE CS results framework and the workplan, providing methods, tools and services developed at the HQ level, accompanied by online training, webinars and on-demand technical support in addition to regional meetings. Unlike some other regions, WHO was an active participant in this forum. The partners have reportedly agreed to extend the life of the IAWG, with a rotating chair.
- In **Asia Pacific**, an Inter-agency Working Group (IAWG) was formed in early 2020 by IFRC, WHO, and OCHA (reportedly UNICEF did not take part). Regional technical leads received RCCE training from the CS in coordination mechanisms, information management, social science and M&E tools. A regional web portal was developed with OCHA support, with RCCE technical materials adapted to the region, online training courses, and data dashboards hosted on the IAWG website. The regional IAWG is considering expanding its RCCE support to respond to other emergencies, such as natural disasters.
- In **Latin America**, the Pan American Health Organization (PAHO) launched a rapid response to COVID-19 in all its 35 Member States across the region, incorporating RCCE as one of the pillars, with a technical working group in support[73] and primarily focused on health workers at government authorities and the Ministries of Health. UNHCR led an inter-agency effort on RCCE coordinating with its partners, and IFRC's regional CEA team implemented CEA for migrants from the Venezuela crisis response in south and central America. UNICEF regional office activated SBC in support of the pandemic response across the region, focusing on country authorities, health managers and health workers, social media, stakeholders and opinion leaders; UNHCR and IFRC worked primarily for the migrant population and community, local organizations and leaders. While all core partners were active in RCCE or related work, interviewees indicated that there was little or no coordination or lesson-learning exchange between them. The impression gained was that RCCE for the earlier Zika outbreak was better coordinated by the UN than that for COVID-19. The CS Secretariat expressed some frustration that it could not gain traction in the LAC region.

These examples demonstrate that partners spontaneously responded to the need to coordinate their responses to the pandemic. All regions had different coordination arrangements (or none), different levels of participation, and the levels of support they could offer varied. It is reasonable to assume that the support available via a dedicated team in ESA had more capacity to support more regional partners and more countries but equally regions can summon a measure of coordination and support capacity without additional resources. An objective assessment of RCCE support needs is required to know the level of resources each region might need.

Governance. The governance structure for the Collective Service is a Steering Committee composed of a Director/Manager from each of the CS partners. Key informants held differing views about the role and effectiveness of the Steering Committee. At the beginning, it was not clear whether the Committee should be advisory or executive in its function. Initially, the participants regarded the Committee as a place to exchange information and debate RCCE approaches to the pandemic, rather than as a decision-making forum, and without the need for operating procedures.[74] The Committee is seen to have been relatively ineffective in tackling difficult issues between the partners, including by some of its own members. The Committee was not helped

[73] Technical support sessions were conducted in Spanish, English, French and Portuguese.

[74] Possible reasons for this include: there was pressure on the Collective Service to deliver while the pandemic was ongoing; the good working relationships between the parties most involved made formal agreements and definitions unnecessary in the short term; and the core organizations found it hard to resolve their differences over the functioning, purpose and future of the service.

by the minimalist nature of the LOA, which provided for no accountability between the partners and a perceived lack of support from their own senior management.[75] The LOA states explicitly that the agreement implies no form of partnership, even though key informants regularly describe the CS as a partnership.

In later CS workplans, the organizations agreed to undertake specific tasks with deadlines, thereby making commitments to each other and in effect accepting a form of mutual accountability not envisaged in the LOA. In 2022, the Steering Committee agreed TOR for itself, stating that the committee "holds decision-making power".[76] The TOR was self-authorized and was not taken for approval to a higher level in the core organizations, which might have brought greater support from the corporate level and obligated the committee members to ensure greater clarity of purpose and allocation of roles.[77]

The CS has suffered from strategic drift since early 2022. There is no consensus on the future role or structure of the CS. The Steering Committee is looking to the evaluation to provide an evidence base against which future decisions can be made. Several HQ-based key informants stated that, for the Collective Service to have a firmer foundation, a new Memorandum of Understanding and/or Partnership Framework will be required, including the three core organizations (and potentially other organizations). This has already been attempted. In 2022, the Secretariat coordinated the development of a new Commitment Charter and a Partnership Framework, neither of which were finalized or approved.

Synthesising across all data sources, the challenges with the governance of the Service seem to come down to: (i) lack of common vision; related to (ii) lack of consensus because of inter-agency politics and competition; (iii) lack of a concerted process to achieve compromises and reach an agreement on the future, and (iv) committee members being unable to deliver the high-level commitment of all core partners, or unwilling to seek it because of reasons (i) and (ii).

Boundary management: PHEs and the humanitarian architecture.[78] We heard that the public health emergency architecture led by WHO is not well matched to, or understood by, the majority of those working within the IASC-defined humanitarian response architecture,[79] and vice versa. Some actors engage with both systems, including IFRC, UNICEF and WHO (also, for example, Oxfam, Médecins sans Frontières, Save the Children). Key informants expressed concern that there have been disconnects between the PHE and humanitarian staff within the same CS organization and that this has not been helpful in implementing RCCE. WHO, for its part, sees any PHE-humanitarian disconnect as less of a problem. The new Health Emergency Preparedness and Response initiative (HEPR) led by WHO and under consideration by its Member States has potential to create better connections between PHE and humanitarian response (see Section 6).

The key issue seems to stem from the implementation of PHE response not (or not systematically) factoring in aspects of health emergencies that fall outside the International Health Regulations (IHR), including the work of other coordination mechanisms whose actions during pandemics and epidemics can influence health outcomes and the non-health impacts of epidemics, such as economic hardship. Humanitarian coordination systems, for their part, including health, water, sanitation and hygiene (WASH) and education clusters, for example, do not connect to the pillar-based incident management system overseen by WHO. The two systems do not speak unless they are made to, which, reportedly, does not always happen. In principle, IFRC, UNICEF and WHO are well placed to manage the boundaries between the two systems, resolving any miscommunication and tensions that occur either at HQ or in the implementation of the response. The evaluation received feedback that other organizations would be grateful if the differences and tensions between the PHE and humanitarian systems were managed more proactively. A commitment to do so could readily form part of any new MOU agreed between IFRC, UNICEF and WHO as part of any extension of the Collective Service.

[75] The LOA captures the aspiration to establish the CS in a "spirit of collaboration and good partnership" but also asserts that it gives rise to no collective accountability to the donor nor any mutual accountability between the parties.
[76] Collective Service (2022). Risk Communication and Community Engagement Steering Committee: Roles and Responsibilities, p. 2.
[77] The CS has never been formally endorsed by the three Principals of the core organizations or their deputies.
[78] At present public health emergencies architecture is in testing mode with the Health Emergency Preparedness and Response frame.
[79] For more on the humanitarian architecture, see IASC (2011). IASC Architecture; and IASC (2019). IASC Coordination in the field.

4.4 To what extent has the Data for Action approach been effective in informing risk communication and community engagement decision-making?

The Data for Action (D4A) approach, introduced after the first year of the Service, was conceptually strong, bringing together social science research, information management (IM), and monitoring and evaluation (M&E) to collate, analyse, and display data from multiple sources. The Service created data management standards and provided technical guidance, design and implementation support, and training for core and local partners, including government representatives. The social science, IM and M&E teams delivered training to the regional offices in ESA, WCA, MENA and Asia Pacific regions and webinars on the use of tools for data analysis, community engagement and RCCE monitoring. At country level, the Service has helped to demonstrate how community feedback can be pooled, coded and collectively analysed to inform decisions on risk communication and community engagement.

Data provision and presentation. The Service capacity in information management and social science are regarded as having been important throughout the life of the CS so far. After one year, these were reorganized under the label Data for Action (D4A), including M&E.[80] There was significant investment in the CS website, generally regarded as well populated with useful resources (guidelines and tools) and an effective means of sharing high-quality and reliable RCCE information on a user-friendly platform. Many interviews included positive feedback about the website, and the data analysis behind the website graphical presentations.[81]

RCCE CS informatics platform. By the end of 2020, the decision was taken to implement a CS informatics platform. The IM function was reoriented to provide open access to high quality, reliable evidence and data through data collection, data compilation and strategic data analytics, and later, data visualization with dashboards and interactive map and charts for information on the pandemic and other outbreaks, including mpox, cholera and others. The online survey reflected the perception that the tools were useful in providing an up-to-date picture of the pandemic. Data dashboards appear to have been the most popular of the IM tools. The D4A approach has proven relevant but so far lacks a cohesive strategy that creates synergy between the three main D4A components, particularly between social science and M&E. By 2021, during the depth of the pandemic's second and third waves, the platform showed COVID-19 epidemiologic data tracked over time at global, regional and country level.[82] The Community Feedback Mechanism Tracker showed the state of community feedback mechanisms led by the CS partners for a variety of outbreaks worldwide.

Data-driven. The CS strategic objective to "Be data-driven" was well met, in that a major part of the effort of the Service has been in the collection, collation, cleaning and analysis of data at global, regional and country levels. Latterly, in ESA the Service has made targeted technical inputs in training and supporting national actors to strengthen RCCE capacity in communities and make accessible consolidated data, especially on community feedback, for decision-makers. The evaluation was not able to establish a clear link between the data analysis provided by the Service and decision-making by governments. (In Uganda it was possible to observe the link being made in inter-agency discussions.) Some country-based RCCE practitioners mentioned that data from social sciences, dashboards and M&E tools played some role in influencing the execution of RCCE activities. However, it was clear that a data utilization strategy aimed at informing RCCE programming at regional and country levels was lacking.

Access to an arsenal of RCCE tools and information. The CS was able to generate several tools to support and build technical capabilities in social science research, community engagement, and monitoring in RCCE. The tools were hosted on the CS website with free access, and online technical support for their use was also made available. The interviews and online survey showed that this CS-produced resource was very well received and perceived as useful, especially according to respondents based at the country level.

[80] The initial allocation from the Gates Foundation funded the social science component but not monitoring and evaluation. In 2021, it was agreed that the monitoring and evaluation component should become part of a new concept of Data for Action.
[81] To be able to generate analysis, the Service had to ask country offices for data. A few key informants found this to be 'extractive' because the work undertaken to provide the data exceeded the value of services received in return.
[82] Using data from Johns Hopkins University website.

Collective Helpdesk. The Collective Helpdesk enjoyed limited promotion by the Service and has stimulated limited demand (224 queries so far), with most coming from UNICEF (as it is an internal resource).[83] Despite the Helpdesk providing FAQs explaining how it works and what is available, IFRC and WHO have made little use of it, as they are not convinced of the need for it and would rather deal with queries internally. UNICEF regional offices have also remained unenthusiastic about the Helpdesk, although it now has a second role, supporting an ALNAP-hosted initiative on AAP and inclusion.[84]

4.5 To what extent have the Service's internal data, M&E and knowledge management systems fostered accountability, learning and improved performance?

Key performance indicators for the Service were devised at the outset and a results framework was developed. In practice, monitoring has tended to focus on activity and output, with qualitative commentary. In ESA, regional tools for tracking of activities and summarizing outputs have been devised. From the beginning, the Service has enabled the exchange of experience on RCCE at HQ and between regions. The website includes a substantial set of RCCE case studies and lessons learned. The Service has consistently reflected on its work and made adjustments over time to stay relevant to the evolving operating context and to improve performance.

Performance monitoring. Key performance indicators for the Service were devised at the outset (see Annex E) but were not actively used in the early phase because many of them depended on progress being made at country level, while countries were little engaged with the Service, and their collection lacked routine country-based data sources with which to track progress. A results framework has been used to monitor the work of the CS at regional and country level and to sum up results for global reporting, though not using the full set of the key performance indicators initially developed, as some were deemed not appropriate for regional level reporting. These monitoring systems tend to focus on activity and output with qualitative and subjective comment, as the systems do not yet allow more systematic or objective measures. Milestones or final targets are not explicitly defined in the framework. In ESA, the evaluation found regionally devised tools for tracking of activities and summarizing results. The latest round of support from the Gates Foundation is aimed at improving measures of progress. The Secretariat is aware that the CS does not have a structured process for tracking the effectiveness of its own services and work is ongoing to improve this.

Sharing good practices. The CS has promoted and practiced the exchange of information and experience on RCCE from the start, both at HQ and regional levels. The CS website now includes a compendium of RCCE country experiences, lessons learned, guidelines, case studies, and other technical materials available for all users. Data has been gathered from some regions beyond Africa. Some interviewees reported frequent use of the CS RCCE website.[85] The CS has used webinars and global and regional newsletters (ESA) to share experience at HQ and regional level.

RCCE learning. The Service has invested in reflecting on its own performance and adjusting its approach. In 2021 and 2022, the CS conducted progress meetings and retreats to monitor coverage and quality of the CS service delivery with the participation of the HQ and regional representative. This allowed the Service to re-orient some activities and to improve the CS website with further RCCE guidelines, tools, data, and case studies. The global and regional forums supported by the CS were one of the venues for this cross-organization learning. In September 2022, the CS conducted an internal analysis of its work and main contributions for the period 2020–2022. This document summarised what had been achieved, identified CS technical contributions, and potential areas for improvement.

Research and evaluation. In early 2021, the ODI completed a rapid learning review of the CS, with findings and recommendation and identifying issues several of which are still to be addressed (hence the frequent mention of the rapid review in this evaluation). In 2022, the CS requested an external assessment entitled

[83] UNICEF has used the Helpdesk mostly to support the development of country strategies for AAP, in line with its AAP strategy for 2022–2025.
[84] IASC Accountability and Inclusion Resources Portal.
[85] Statistics for the website show an average of 1,200 users per month with steady and continued use from August 2021 to April 2023, the period for which data was made available, peaking at 1,600 in November 2022, showing that interest did not tail off at the end of the pandemic.

‘RCCE Social Data in Decision-making’.[86] UNICEF and IFRC have completed evaluations of their COVID-19 response. UNICEF has commissioned a global evaluation of its work on SBC. WHO has completed an evaluation of its COVID-19 response in the Eastern Mediterranean, and the COVID-19 Global Evaluation Coalition has completed its Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to COVID-19. Most of these exercises were completed, or are to complete, in 2023.

[86] The external consulting firm’s report on the utilization of data by the CS was released in December 2022 but was deemed by UNICEF to be of inadequate quality and has not been acted on.

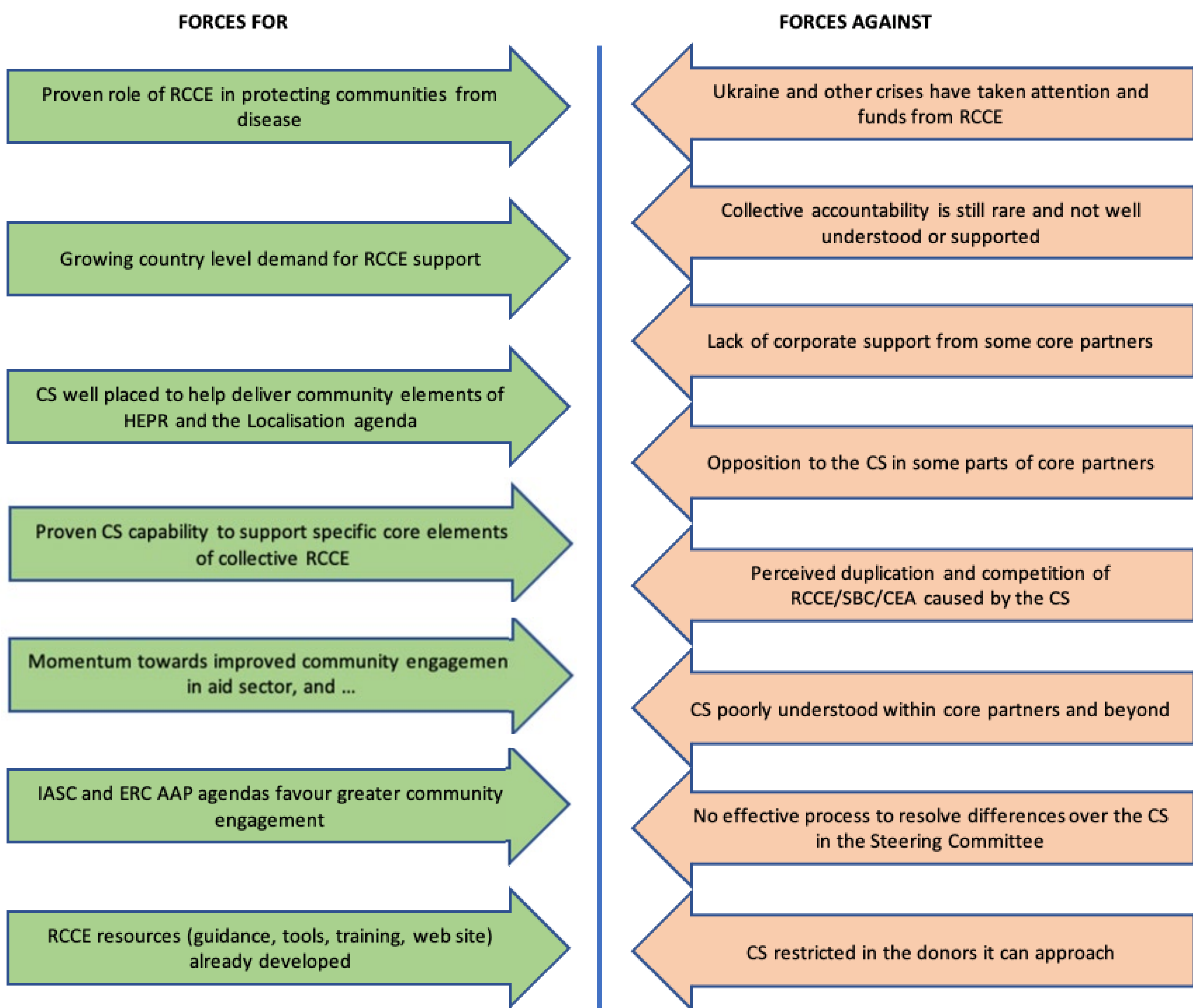
5 Conclusions and Lessons Learned

This section provides the last evaluative element of the report. It is divided into three parts, a force field analysis, a summary assessment, and lessons learned.

5.1 Force field analysis

Drawing on the findings, Figure 11 summarizes the evaluation's analysis of the forces that have been, and are, working for the progress and further development of the Collective Service, and those working against. If the Collective Service is to advance and develop on a more secure basis, the 'forces for' will need to be exploited and the 'forces against' mitigated.

Figure 11. Collective Service force field analysis



5.2 Summary assessment

The original vision for the Collective Service was based on the core partners' understanding that they needed to work together on risk communication and community engagement to empower communities to respond to COVID-19, to improve risk communication and reduce the spread of COVID-19. Their vision has proven correct and multiparty; coordinated RCCE became central to the pandemic response to in many countries. That the Service produced positive results against the backdrop of COVID-19 and the severe limitations it imposed is a significant achievement. In most of the cases reviewed, IFRC, UNICEF and WHO collaborated well over RCCE at country level, though there are capacity gaps, and some non-collaborative behaviours were noted. The partners understand, and have generally respected, their different mandates and comparative advantages.

The Collective Service supported collective and coordinated RCCE on a scale not previously witnessed and implemented in the adverse circumstances of lockdowns and travel restrictions related to the pandemic. The CS was founded by senior staff from the core partners whose enthusiasm and shared commitment led to its launch. The grant funding obtained and subsequent investments by the core organizations enabled global and regional RCCE coordination to be strengthened, with examples of effective service delivery at country level. The 2021 ODI rapid learning review noted that, "The Service has filled important gaps in terms of coordination, technical guidance, and data."[87]. This has continued to be the case even after the pandemic receded.

In response to the pandemic, coordinated RCCE at country and regional levels was initiated by governments and groups of agencies in various regions without the intervention of the Collective Service. The Service has been successfully harnessed to support and lead these regional efforts in ESA, and partially in WCA, with some support to the MENA region. The CS has also demonstrated good use of quantitative and qualitative evidence and digital health approaches to inform RCCE in target regions and countries. That the CS developed RCCE approaches and tools using the most up-to-date evidence and made them broadly accessible to actors in the sector is one of its major contributions.

The project has provided dedicated capacity, with the requisite skills, at regional and HQ levels that has provided coordination, guidance, on-site and remote support, and data analysis, all of which have demonstrated value in situations where there has been a demand. The skills on which the Service depends are reported by the Secretariat to be in short supply and great demand, both in the agencies and the open market, especially social science.

The pandemic drove a new willingness in some countries to adopt collective RCCE. Under the Collective Service, ideas of inter-agency coordination on RCCE that had been considered before the pandemic were implemented and, despite the unique pressures of the COVID-19 pandemic, reached levels of cooperation not seen previously. In a few countries, the CS has demonstrated that collated and collectively analysed community feedback, coupled with the application of social science, can be used to create a combined analysis of social attitudes, beliefs and responses, which can be used to improve the community engagement process and the communication of health risks and protective behaviours, working with print and social media and enlisting key influencers. This is notable because community feedback is normally gathered and implemented on an agency-by-agency basis. So far, there are very few community feedback systems that take multiple sources of data from different organizations and sources and analyse across them to create one consolidated picture. There is potential for the CS experience to be harnessed more widely to inform the evolving practice of other humanitarian and multi-mandate agencies.

A majority of interviews and survey respondents were positive about the Collective Service both in terms of the work already completed and its potential relevance for future public health emergencies, and potentially other types of emergencies. Feedback on the CS from those working at country level was generally more positive than from those based at HQ. Most key informants and two-thirds of survey respondents considered that the Collective Service should continue beyond 2023, though with important differences concerning its future scope. A small minority considered either that the season for the Collective Service ended with the end of the pandemic, or that a service separate from the core capacities of the three main partners was unnecessary.

Set against this overall positive assessment, the CS has had a number of weaknesses and faced various challenges that have reduced its effectiveness, including: very limited communication about the purpose of the Service within and beyond the core partners; lack of integration of the CS into the mainstream work of the core partners; the reluctance of some staff of the core partners to cooperate with the Service; an inadequate formal agreement on which to base the partnership; limited collection of data on the performance of the CS; and restrictions on where it could raise funds. There are indications of limited use of CS guidance and tools (some have been actively and repeatedly used), and underutilization of data generated by the CS for decision-making, again with exceptions.

[87] Lough, O. and Holloway, K. (2021). The Risk Communication and Community Engagement (RCCE) Collective Service: Rapid learning review. Humanitarian Policy Group Report, London: ODI, p.7.

Some of the objectives set for the CS were unrealistic, especially the aspiration for sustained health systems improvement, given the limited availability of funds, short funding cycles, the emergency nature of the response, and the limited engagement of teams within core partners. Preparedness and readiness for RCCE has received only limited attention from the CS.

The emergency that arose out of the pandemic provided a driving force for cooperation. That force has dissipated and as it has done so, the drive for agencies to focus on their individual agendas has asserted itself. The Collective Service is at a crossroads. Since early 2022, the CS has been drifting, despite the Secretariat and some senior managers' efforts to define a future path. The inability of the core partners to agree on the future focus of the CS is putting its future in jeopardy.

As the CS is a collective, inter-agency undertaking, it needs a clear vision, corporate commitment, and a strong partnership agreement behind it. Governments need to be informed and engaged for the Service to be relevant to them.

Looking ahead, to make the Service effective and stable into the future, the core partners will need to agree a renewed vision and to build on it. This will provide the basis for the core partners to make the compromises and new commitments needed to relaunch the Service, assign to it the necessary financial resources to secure its future in the medium term, and to tap into new external funding on a significant scale.

5.3 Lessons learned

Lessons from the evaluation include:

- Lack of consultation and use of a top-down approach at the outset of a multiparty initiative can lead to long-term misunderstanding and lack of cooperation.
- A small group of committed individuals can launch an inter-agency initiative even in adverse circumstances, but the core capacities of organizations cannot be mobilized without detailed planning and endorsement from the very top.
- Harnessing the comparative advantages of large institutions can bring significant dividends when the impulse to collaborate overcomes the competitive forces that might otherwise block collaboration.
- Good personal relationships and trust made collaboration work. Poor relationships and misunderstanding hindered it.
- Quality consists not in the volume or comprehensiveness of technical documentation but in the ability to apply it at field level and its relevance as judged by field practitioners.
- The boundaries between the coordination systems for public heath emergencies led by WHO and for humanitarian response, led by the IASC, need active management to ensure efficient coordination between them.
- Any services that support the extension of coordinated national initiatives can only be productive when there is sufficient demand, in this case the interest and willingness of governments.

6 The Future of the Collective Service

In this section, the report sets out key issues that the Collective Service partners need to resolve together, and options for the future of the Service.

6.1 Core organizations' visions for the future of the Collective Service

According to the IFRC, UNICEF and WHO vision statements for the future of the Service, drafted before the evaluation began, all organizations want to see the Service continue. All partners are concerned about losing the gains achieved by the Collective Service so far and there are also practical concerns about job losses in the Collective Service as contracts expire. There is much in common between the vision papers, and some important differences, which the CS Steering Committee has not yet resolved.

Interviews show that: IFRC is invested and wants to continue to host the Service. UNICEF is committed to rolling out SBC and AAP across the organization, and, in concert with IFRC, is committed to the Collective Service continuing in close coordination with the broader inter-agency humanitarian initiative on community engagement and AAP. WHO also wants the Collective Service to continue with a focus on community protection, which includes but goes beyond RCCE. All these positions are consistent with the organizations' respective mandates.

The vision statements agree on the following:

- The Collective Service should continue (though with differing future visions)
- RCCE empowers communities and makes PHE responses more effective
- The importance of coordinated preparedness, readiness and response (and recovery)
- The need for coordinated community engagement during PHEs
- The need to be better prepared for future PHEs
- Coordination efforts should add value to the response at country level and offer defined services
- The need to avoid confusion caused by overlapping or unclear coordination processes at HQ and country levels
- RCCE should be based on science (medical and social) and on accepted norms and standards
- The need to find ways to provide additional RCCE capacity in (i) coordination; (ii) social science; and (iii) data, information and knowledge management (the WHO paper also specifies capacity in joint strategy development and needs assessment)
- The need for (rapid) RCCE surge capacity
- The need for a broader partnership that incorporates additional partners (noting that none of the vision statements give a rationale for expansion, proposals for organizations to be asked to join, the criteria for their selection, or an optimal size for the partnership)
- Any HQ structures dedicated to coordinated RCCE support should be limited in size.

There are also important differences and lack of clarity, regarding some aspects:

- WHO is more focused on the deficit in government capacity for RCCE than IFRC and UNICEF
- WHO does not want formal coordination RCCE structures at regional or country level (what comprises 'formal' is unstated)
- How any new coordination mechanism would be led, and by whom
- Whether an HQ/global structure based around the new expanded partnership would be (i) accepted, and (ii) financed by all the partners (new and existing)
- Whether responsibility for regional and national coordination should be delegated in advance of a crisis, versus agreeing who coordinates based on who is 'best placed at the time'
- WHO specifies that there should be decision-making independent of the Steering Committee (other papers do not address this point)
- UNICEF and IFRC are both keen, in principle, to progressively align and coordinate with the IASC's AAP agenda and processes with RCCE in humanitarian settings.

An agreement between the core partners on the future shape of the Collective Service depends on decisions to be made concerning two principal and related dimensions:

- **Remit.** The future technical focus of the Collective Service
- **Level of ambition.** How much support, of how many types, and in how many locations and, therefore, the appropriate level of investment.

These two dimensions are now considered in turn.

6.2 Future remit of the Collective Service

WHO wants to keep the focus on RCCE in the health sphere, as now expressed under community protection within the framework for Health Emergency Preparedness and Response (HEPR). The HEPR framework has been agreed by the May 2023 World Health Assembly, though its practical implementation is still under consideration. The HEPR, presents 'five Cs', one of which is community protection including: community engagement; risk communication and infodemic management; population and environmental public health interventions; and multisectoral action for social and economic protection. Community protection as described is broader than RCCE and is said to require multisectoral action and coordination. [88, 89, 90]

The IASC has revisited its 2011 commitments to accountability to affected people (AAP) via the April 2022 IASC Principals statement on AAP, which commits IASC members to "empower affected people, including women, girls and young people, to continuously and effectively shape humanitarian decision-making; to ensure that we are collectively more accountable to the people we serve; collectively promote more meaningful engagement of affected people in every aspect of the humanitarian response, including by strengthening collective feedback mechanisms and enabling timely collective action and course correction based on people's needs and regular feedback, and; to increase participation in, and support of, locally led coordination platforms and local leadership." [91, 92] IFRC, UNICEF and WHO are either members of or standing invitees on the IASC, so the renewed commitment to AAP is relevant to them all. Therefore, finding a harmonized approach that allows the organization to be effective in both RCCE and AAP in humanitarian settings is desirable. Separately, further momentum has been added to AAP by the Emergency Relief Coordinator's Flagship Initiative on AAP, working initially to develop country-level solutions to AAP in four countries, in concert with four Humanitarian Coordinators.[93] This will eventually need to be coordinated with the IASC work on AAP.

The IASC Task Force on AAP, with IFRC as a co-chair, is focused on extending and improving engagement with communities affected by humanitarian crises and accountability to communities. As with all IASC Task Forces, it is an inter-agency policy group and is not operational. Whether RCCE is complementary to AAP and sits alongside it, or whether RCCE is merely a subset of AAP into which it can be subsumed is so far unresolved. Key informants were divided on the subject. The 2020 humanitarian 'Briefing Pack' called directly for the integration of RCCE and AAP in humanitarian response: "The communities will not distinguish between RCCE and accountability to affected people (AAP) and community engagement, neither should we."[94] Some key informants noted that COVID-19 was not the first priority for communities facing hunger or escaping conflict, so a more holistic view of their needs was more appropriate than a purely health focus.[95]

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[88] Including "multisectoral engagement to address anticipated potential negative health, economic and social consequences of response measures", and "maintenance of cross-sectoral decision-making and coordination mechanisms".

[89] The greater emphasis on increased multisectoral action is consistent with a 2021 World Health Assembly (WHA) request to the WHO Director General "to strengthen global, regional and country preparedness and response capabilities and capacities for health emergencies by enhancing engagement of relevant stakeholders at all levels" (WHA 74 resolution).

[90] WHO has also developed The Preparedness and Resilience for Emerging Threats (PRET) initiative, which is an innovative approach to improving disease pandemic preparedness.

[91] IASC (2022), Statement by Principals of the Inter-Agency Standing Committee (IASC) on Accountability to Affected People in Humanitarian Action.

[92] Further, in their meeting of November 2022, the IASC Principals "underscored the need to address the power dynamics and putting in place incentives to ensure that AAP is central to principled humanitarian action", and "agreed that a people-centred approach extends beyond the humanitarian system, presenting challenges common to, and requiring collaboration with, development actors". See IASC (2022), IASC Principals Bi-Annual Meeting. Summary Record and Action Points, pp. 2–3.

[93] The IASC initiative on AAP is being taken forward by the IASC Task Force on AAP. In a few interviews, it was suggested that the Flagship Initiative had 'taken the wind out of the sails' of the Task Force. The two initiatives are not currently coordinated.

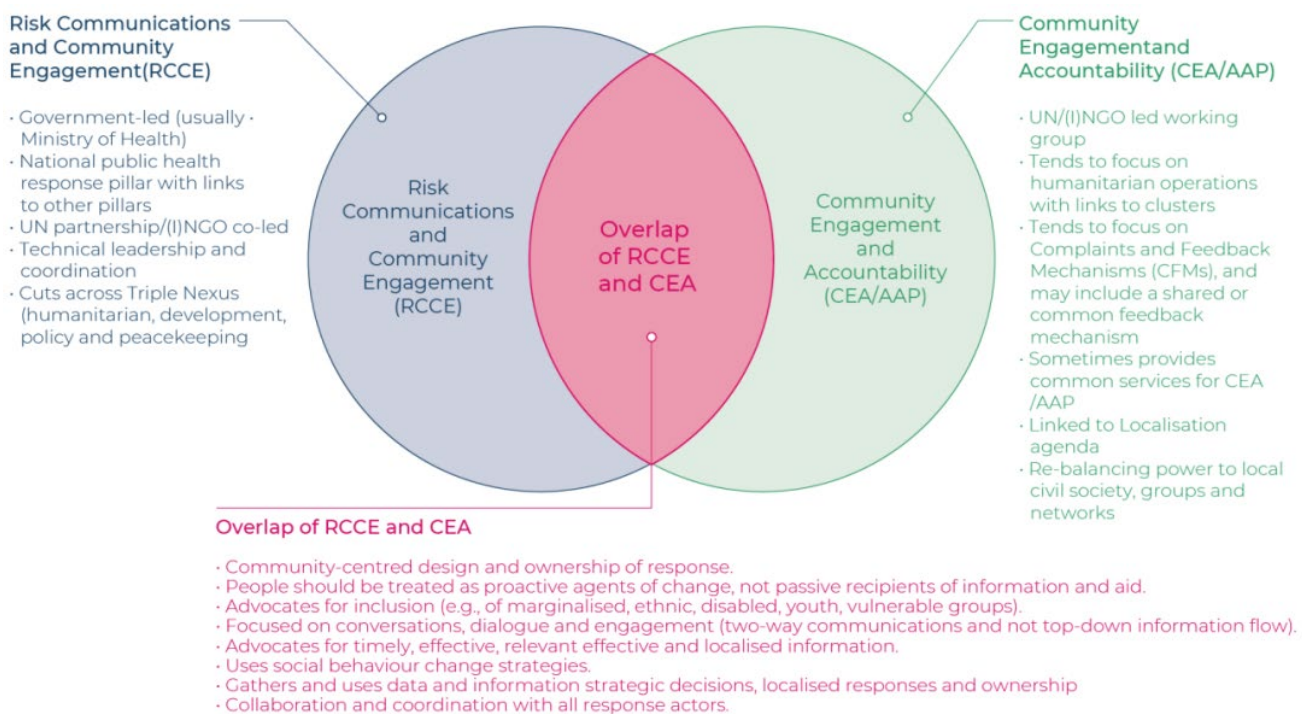
[94] COVID-19 Risk Communications and Community Engagement (RCCE) and the Humanitarian System: Briefing Pack, September 2020, p. 1.

[95] The Independent Panel for Pandemic Preparedness and Response reached a similar conclusion: "Countries which successfully managed the disease took whole-of-government and whole-of-society approaches, sought scientific guidance, engaged with community health workers and community leaders, involved vulnerable and marginalized populations, also in conflict-affected countries, and worked closely with subnational governments. The

At regional and country levels, these distinctions are less important because the same personnel work on both RCCE and AAP but at HQ the difference between RCCE and AAP has been at the root of disagreements about the future direction of the CS. Different concepts and terminology tie into agency agendas, given that the different organizations 'own' various overlapping approaches, and that their promotion is used to position organizations and to raise profiles and financial resources. There are also real differences of substance that can be glossed over at field level but not at HQ. For example, AAP does not cover behaviour change.[96, 97] RCCE can apply in stable or high-income contexts, while AAP under the IASC only applies to humanitarian settings.

In the pilot version of its interim guidance of 2022, drafted by core partners but not formally endorsed, the overlaps between RCCE and CEA/AAP functions are illustrated in the following graphic.[98]

Figure 12. Overlaps between RCCE and CEA/AAP compared



RCCE, CEA and AAP have different objectives but at their root all have community engagement that aims to enable and empower people to be active in addressing the risks they face. The building of capacity for coordinated and collective community engagement provides a common vehicle for greater effectiveness in all these disciplines and is therefore likely to be at the heart of the Collective Service, should it continue.[99]

extent to which the COVID-19 pandemic has exacerbated inequalities is an emphatic demonstration of the interconnectedness of social, economic, environmental and political factors in society.", Report of the Independent Panel for Pandemic Preparedness and Response: Making COVID-19 the Last Pandemic (2021), p. 58.

[96] "Respondents felt that there was an important enough distinction between the focus of RCCE and AAP/community engagement – with the behaviour-change objectives and methodologies of the former not really reflected in the latter – to justify a separate if complementary approach in the form of the Service." Overseas Development Institute (ODI), Humanitarian Policy Group RCCE Collective Service Rapid Learning Review (2021), p. 42.

[97] The evaluation team learnt of examples of countries that have had separate AAP and RCCE coordination groups, either at the instigation of an agency or, in one case, because the government assigned risk communication to one department in the Ministry of Health and community engagement to another.

[98] Collective Service (2022), Risk Communication and Community Engagement (RCCE) coordination in public health emergencies, including COVID-19, Interim Guidance, p. 19.

[99] There are currently insufficient incentives for a collective approach in humanitarian action. Donor funding and NGO accountability mechanisms have undermined collective accountability by focusing on individual organization accountability instead. Apart from a requirement to coordinate with other actors, there has been no other requirement for collective accountability within the Core Humanitarian Standard (although a new version of this soon to be released).

There are at least three possible choices for the future remit of the Collective Service:

1. Public health emergencies (PHE) only, including any declared epidemics or pandemics, with coordinated RCCE as one of the response pillars;
2. PHE plus other health emergencies not declared as a PHE, in any context, with responses led by government, communities or by coordinated humanitarian agencies; and
3. Community engagement for any emergency response at a scale that requires multistakeholder engagement.

IFRC and UNICEF prefer to see the IASC-led work on AAP and inter-agency work on RCCE (including the Collective Service) brought closer together, with a view to achieving more efficient and clearer coordination at both global, regional and country level. However, there is little motivation for WHO to engage in a Collective Service that is not focused on health. For the CS to maintain the full engagement of its three core partners, the remit must fit, or fit sufficiently, with their mandates and priorities. As soon the remit loses relevance for any partner, there is less incentive for them to engage fully. It would be possible to keep the CS entirely focused on PHE but this would not meet the IFRC and UNICEF desire to advance CEA and AAP in humanitarian settings. Equally, aiming CS support at all types of emergencies loses its salience for WHO, with its focus on health and specifically the HEPR agenda.

A focus on "PHE plus other health emergencies" appears to offer the most common ground in terms of fulfilling mandates of the core partners but for reasons explained above there is no consensus on this point. For WHO, the Collective Service is directly relevant to the HEPR, given the recognition by WHO of the need for community protection to include multisector engagement in health responses. This opens up the possibility of the deliberate engagement of humanitarian clusters in RCCE, including first and foremost the health cluster. For UNICEF and IFRC, the second of the three choices listed above brings into scope crises that cause health emergencies, such as mass displacement, conflict or food insecurity, which have been out of scope up to now. Pragmatically, it would also set a limit on the extent of CS work, which addresses the Secretariat's concern that widening the range of the CS operating contexts too far will overstretch its support capacity, especially as it has not been possible to maintain its 2020 level of capacity, let alone expand it.

The proposal therefore is for the Collective Service to set its remit within support to all types of health emergencies, but not to all emergencies. Just as the CS would not be limited to PHE, it would not be limited to humanitarian settings either. The CS would operate within the confines of the *functions* described in Figure 12, namely all those functions within the RCCE, CEA and AAP circles. This is not to suggest that the CS will have the capacity to cover all these functions but that they set the limit to what it might cover. None of these constraints affect what partners do outside the partnership. Whether setting the CS remit as health emergencies writ-large is appropriate and acceptable will need to be tested by partners as part of the CS redesign exercise set out in Recommendation 3 below.

In the remainder of the report, the term 'RCCE' follows the definitions given at the beginning of the report, i.e. it includes the wider set of functions covered by the RCCE, CEA and AAP circles illustrated above and in the glossary.

6.3 Strategic options

Below, the report describes three options for the future Collective Service. The options have been developed to show a range of possible ways forward, based on the findings and lessons learned presented in this report. They are provided as a tool for the Steering Committee to deliberate and make decisions. The final solution adopted may be a combination of the three options or none and the CS may evolve between the options over time.

Option 1: Change the Collective Service model to implement proactive development of national partners' RCCE preparedness and implementation capacity

Option 1 is the 'nexus' option. It differs significantly from the current CS implementation and requires a longer term (three to five year) agreement to engage the CEA/SBC/RCCE/AAP capacities of the core partners, and other parts of the organizations, to develop government and non-government RCCE preparedness and response capacity. It is driven by assessments of (i) health risks and (ii) RCCE capacity that would inform plans for institutional development and systems change. It is applicable to countries already facing emergencies and to those not currently facing crises. It has a longer planning horizon than the current Collective Service. Under this option, collective and coordinated RCCE would be integrated into the workplans and performance indicators of the relevant country and regional offices of the core partners related to health systems development, including but going beyond the work of RCCE/SBC/AAP/CEA advisers.

The core partners' capacity as dual mandate emergency-development institutions would be brought to bear, utilizing their guidelines and capacity for progressive, medium-term institutional development.[100] This means engaging parts of the core partners not fully engaged so far in the work of the Collective Service, including institutional development and resource mobilization.

Option 1 is more ambitious than the current Collective Service implementation and would be more demanding in terms of planning, coordination, communication, measurement of results, and financing than the past implementation of the Service. It is included here as an option because of the potential to address multiple donor priorities, including the HEPR agenda, the localization agenda,[101] and the humanitarian-development nexus simultaneously. Because Option 1 is aimed at the level of systems change, it would be highly relevant to the newly agreed sources of pandemic funding.[102] The WHO pandemic preparedness accord covering prevention, preparedness, and response is in gradual development.[103] Significant grant and loan financing is being made available via the Pandemic Fund and the Global Fund.[104, 105] These funds could prove important in supporting RCCE as a component of health systems strengthening. IFRC, UNICEF and WHO could make a strong business case for the work of the Collective Service, in particular because future applications to the Pandemic Fund will need to show that they will engage civil society and coordinate with local actors, which the CS has already demonstrated it can do. This would seem to provide an open door for the implementation of a model of the Collective Service that addresses the goals of pandemic funds.

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[100] The IFRC has well-developed processes to support the development of the capacity of its National Societies. Taken together, the 2021 Community Engagement and Accountability (CEA) Toolkit and the 2021 Guidance on National Society Assessment and Development Processes provide a basis for CEA preparedness capacity development. Likewise, the UNICEF Health Systems Strengthening Approach defines health systems strengthening as "actions that establish sustained improvements in the provision, utilization, quality and efficiency of health services, including both preventive and curative care, as well as the resilience of the system as a whole". Similarly, WHO's Health System Building Blocks is an analytical framework used by WHO to describe health systems, disaggregating them into six core components: leadership and governance; service delivery; health system financing; health workforce; medical products; vaccines and technologies; health information systems.

[101] Originating in the World Humanitarian Summit Grand Bargain from 2016.

[102] Member States of the WHO have agreed to a global process to draft and negotiate a convention, agreement or other international instrument under the Constitution of the World Health Organization to strengthen pandemic prevention, preparedness and response. This is happening in response to shortcomings in preparedness for and response to the COVID-19 pandemic, including as described by the Independent Panel for Pandemic Preparedness and Response: making COVID-19 the last pandemic, (2021).

[103] According to the document 'Strengthening health emergency prevention, preparedness, response and resilience' recently released by WHO, "The launch of the Pandemic Fund in November 2022 promises to be a transformative moment in the effort to strengthen national HEPR capacities." WHO (2023), Strengthening health emergency prevention, preparedness, response and resilience, p. 6.

[104] The Pandemic Fund announced US$330 million for developing countries (from a total pledged of US$1.6 billion). The Global Fund has US$5 billion for pandemic preparedness and response against US$15billion pledged. (Based on an interview with a knowledgeable key informant, but figures are unverified.)

[105] The European Investment Bank will make available at least €500 million to support health systems strengthening and more specifically primary health care in sub-Saharan African countries, with the aim to mobilize at least €1 billion of investments, structured in cooperation with the European Commission and WHO, to support this initiative. WHO (2022), WHO Director-General's opening remarks at the European Investment Bank.

Option 2: Maintain and/or expand the current regional Collective Service model

Option 2 is the 'status quo plus' option. The current concept of the Collective Service is retained, with its remit expanded to respond to all types of health emergency, broadening beyond PHE and, potentially, increasing its geographic scope. Option 2 remains largely dependent on emergency funding sources. As now, an element of capacity development, namely specialized training for elements of RCCE, would be retained rather than attempting long-term capacity development (as in Option 1 above). Collective, coordinated RCCE would be labelled 'Collective Service' at the discretion of region and country coordination groups, depending on whether the name helps or hinders (see also Recommendation 11 below).

As key informants have pointed out, there are necessarily constraints on where the expansion of the Collective Service is relevant and/or possible. Therefore, it is proposed that three conditions should be adopted to help determine the potential expansion (and, equally, contraction) of the Service at a regional level. All three conditions would need to be met before dedicated regional CS capacity was implemented:

1) The core partners agree there is a need for additional capacity in the region (or subregion) to support the regional RCCE coordination structures. This agreement would require consultation with regional and country offices;
2) There is a demand (or the likelihood of demand[106]) for additional RCCE support from government and non-government partners in the countries of that region; and
3) Based on established need and demand, the necessary financial resources can be mobilized for the Service in the region and for any associated HQ support capacity required.

Within Option 2, three sub-options are considered: 2A, 2B and 2C. It is quite possible that the CS might evolve progressively through the sub-options as experience is gained.

Sub-option 2A: Maintain Collective Service capacity in East and Southern Africa

The Collective Service has demonstrated added value to country-level RCCE both for PHE and, to a limited extent, other types of emergencies, particularly in ESA. There is a good case for its continuation in ESA as long as the three conditions set out above continue to be met. According to the ESA case study, there is continued and potentially growing demand for CS services within the region, including from governments. However, core partners are not confident that the third condition on financing can be met, and if not, the current regional capacity would be discontinued.

Sub-option 2B: Expand the current Collective Service capacity and regional structure to the whole of Africa

Given the demonstrated progress made in ESA and the growing demand for CS support in the Africa region, which has the highest incidence of health emergencies, a case could be made for the core organizations to expand the model to the whole of Africa. If the region were free to raise funds from any source, it might well be able to maintain sufficient financing regionally. This model would fit with the WHO governance (where the vast majority of Africa is governed as one WHO region) and would require a regional-level MOU between the three agencies to define roles and responsibilities.

Sub-Option 2C: Expand the Collective Service model to other regions

Expanding the Collective Service to other regions beyond ESA and WCA was part of its original vision. RCCE coordination mechanisms in MENA, and parts of Asia Pacific have shown interest in the Service and have had some engagement with and support from the Secretariat and from each other since 2020. Expansion to other regions could well be considered but would see the CS structure implemented only where the three conditions were met. It is likely that one or more of these conditions will not be met in all regions.

Secretariat function. None of the three sub-options automatically justifies the continued need for an HQ-based Secretariat. If the CS model were implemented in ESA only, as per sub-option 2A, it could be argued that a Secretariat is not needed, in line with the logic of Option 3, where regions can determine their own strategy and build their own support.

[106] 'Likelihood of demand' because, as experience in ESA has shown, demand is stimulated as the number of successful examples of RCCE support at country level grows.

However:

- The more that regions (or sub-regions) implement the Collective Service, the greater the need for central guidance and support and optimisation of skills and resources across regions, to find technical resources at the global level to support specific countries, and to ensure CS products are maintained, updated and tailored to different emergency contexts (these are all functions the current secretariat has performed).
- A centralized resource mobilization capacity will continue to be needed as long as the main resource mobilization departments of the core partners continue to omit the Collective Service from their fundraising strategies and activities.

Given these considerations, an HQ secretariat function at some scale would be justified for sub-options 2B and 2C. The same arguments apply in relation to the retention of a Steering Group to ensure coherence of policy between the core partners and to help ensure close cooperation at regional and country levels.

Option 3: Continue regional RCCE coordination without additional support based on the Collective Service model

Option 3 is the 'autonomous region' option. If the Collective Service reverts to individual organization-led operation, collective and coordinated RCCE will continue in various forms in different regions. As the evaluation has found, regional RCCE coordination groups established themselves before the CS was launched. Due to the greater level of recognition given to RCCE since the pandemic, governments, local authorities, and communities will continue to come together to work on RCCE in some measure with the help of the core partners and other agencies, with or without the support of the CS.

Under Option 3, the RCCE/SBC/CEA/AAP advisers at all levels would work together across agencies, using similar approaches to those used in the past to support RCCE in regions and countries. Partners working together on RCCE in individual regions and countries would be free to create funding proposals for individual initiatives, in consultation with donors locally, or with advice from HQ based technical and resource mobilization advisers, as needed. In this option, a steering committee would not be required to give overall direction. Partners might agree to set up a reference or technical group at HQ level to continue the sharing of information and experience on RCCE between organizations, including to help maintain exchanges between regions, but without a governance function. Regional RCCE coordination groups would operate autonomously, using the CS guidance and tools already developed and available on the CS website, without a central secretariat. Sufficient capacity would need to be provided to make sure the Collective Service guidance, tools and website are maintained.

7 Recommendations

These recommendations build on the findings, conclusions, lessons learned of the evaluation, and the discussion on the remit and level of ambition of the future Collective Service in the preceding section. The recommendations are aimed at enabling a sustainable and effective future for the Service, based on a renewed consensus and agreement between the core partners.

These recommendations are made to the Collective Service Steering Committee as the most appropriate recipient. It is therefore not appropriate for the evaluation to assign tasks to departments within the core partners, which is why no such specific indications are included. The evaluation focal points agree that the Steering Committee, as the appropriate instrument to develop a specification of tasks, timescales and resources required to advance the Service, will provide a joint management response to the evaluation. The recommendations should be read in conjunction with the Decision Table at the end of this section.

Recommendation 1. Agree a joint policy statement on the need to coordinate RCCE

The core partners should commit to working together on RCCE in all countries and crises where it is relevant, especially those countries regarded as high risk, whichever of the three options for the Service is adopted, and whether or not it is supported in-country by the Collective Service. The partnership should ensure that governments understand that this joint commitment is in place. This will set an expectation that organizations should make collective, coordinated RCCE part of 'business as usual'.

Recommendation 2. Base the future of the Collective Service on demonstrated success criteria

Any future operating model for the Collective Service should conform to the criteria that the evaluation has demonstrated are required for the Service to be effective. IFRC, UNICEF and WHO should adopt the following criteria within a new MOU:

- Base the future of the Collective Service on local and national RCCE-CEA-AAP needs in high-risk countries. The litmus test for any future implementation of the Collective Service becomes whether it adds value to RCCE at national and community level.
- Reach consensus on the elements that make for effective RCCE/community protection at national and subnational levels so that there is clarity on what a collective and coordinated effort in support of national and subnational RCCE is trying to achieve. (Annex G provides an example to modify or develop further.)
- Redefine how the contribution of the Collective Service is measured, so that its effect in enabling teams at national and subnational level to reduce risks and engage communities is assessed, rather than setting goals for the direct impact on RCCE by the Collective Service, which has proven unrealistic and inappropriate, and tempts the CS to make claims about situational change that it cannot achieve by itself.
- Recommit to designated inter-agency coordination capacity, at any level, supporting all partners in an RCCE coordination mechanism equally, not the employing agency preferentially. ('Double-hatted' roles that mix interagency coordination with agency-specific support should be clearly communicated as such.)
- Preserve the gains in terms of knowledge and intellectual property already achieved by the Collective Service by collating and keeping up to date relevant guidance and tools as developed by the CS at global and regional levels, and by capturing country-level experiences, documenting their strengths and weaknesses. The Collective Service could also usefully capture relevant evaluations from core partners and beyond.

Recommendation 3. Develop a new vision and model for the Collective Service, and endorse and communicate the result

Using the analysis presented in this report, IFRC, UNICEF and WHO should establish a mechanism that enables the formulation and agreement of a new vision and model, as well as MOU for the Collective Service, to conclude by March 2024.

- The partners should engage professional, external facilitation services to enable the necessary debate to take place and to reach resolution, using the evaluation and any other resources necessary to inform the debate. Given that the core partners have found it very difficult to resolve some of their differences, a new approach is needed. This is not a matter of hiring a consultant to make a plan but rather to help facilitate the Steering Committee and senior advisers in agreeing a plan. Regional and country-level voices should be heard in the process.
- The partners should start by debating a new vision of what they can (and cannot) achieve together via a revised Collective Service partnership. Which health, humanitarian or other agendas can they adopt and use to their comparative advantage to fulfil working together? This discussion should raise expectations for the future, placing goals and strategy before determination of precise focus, individual mandates, structures etc. A new vision should provide the motor that drives the relaunch of the Collective Service.
- The partners will need to reach a compromise on the target areas for the Collective Service. It is unlikely that any partner will have their individual agency expectations met fully.
- Within this process, the core partners should decide which other organizations should be asked to join the partnership, and for what purpose. The interest of potential partners should be tested and their views on the shape of a new partnership should be sought as part of the design process.
- The partners should define their principal roles and the division of labour within the partnership, including at HQ, regional and country level.
- In developing any new Collective Service partnership design, MOU and associated organizational aspects, the discussion should engage the relevant Under-Secretary-General (IFRC), Assistant Secretary General (UNICEF), and Assistant Director General (WHO), who ideally would provide their final endorsement with a joint communication announcing and explaining the new partnership to their own organizations.
- Once agreed, any new model and associated MOU should be communicated widely within the partner organizations and beyond to all relevant stakeholders to make sure the scope of the Collective Service is understood, and as a first step in advocating for the partnership. Staff of all the partners (current and new) should know what to expect of the CS. The MOU should include an elaborated description of purpose, goals, partnership arrangements and mutual obligations, with much greater detail than the 2020 Letter of Agreement.
- Once the MOU is agreed, the partners should devise a new set of standard operating procedures (SOPs) (for Options 1 and 2). These would include how decisions are agreed and by whom, how to decide which countries will receive support, and how to approve and specify the scope of a support mission. The SOPs should include how to manage challenges occurring at the boundaries of PHE-humanitarian-development systems,[107] and the resolution of inter-agency disputes.

[107] Including, for example, where WHO assumes leadership of RCCE during a PHE, while UNICEF is already co-coordinating RCCE with government. This transition needs to be managed when a PHE is declared and when it is deactivated.

Recommendation 4. Base the Collective Service offering on assessed demand for RCCE support

For Options 1 and 2, the core partners should carry out an assessment of the demand for CS services across regions and countries. This should cover: (i) government, partner and civil society capacity in RCCE/CEA/AAP; (ii) the capacity of the core partners themselves; and (iii) most importantly, national and local appetite for support for improvement. Using this analysis, any deployments of CS capacity should meet the following conditions:

1) The core partners agree there is a need for additional capacity in the region (or subregion) to support the regional RCCE coordination structures. This agreement would require consultation with regional and country offices;
2) There is a demand (or the likelihood of demand[108]) for additional RCCE support from government and non-government partners in the countries of that region; and
3) Based on established need and demand, the necessary financial resources can be mobilized for the Service in the region and for any associated HQ support capacity required.

The result may be that: one region needs a full complement of RCCE coordinator, surge coordinator, social scientist, and information management expert; another might need only a regional coordinator; another only technical support; and another no support. Decisions on the CS support capacity required for any region should be based on evidence and analysis. Without such analysis, core partners are 'flying blind' in planning the appropriate version of the CS for each region.

Recommendation 5. Expand the membership of the Collective Service

Most key informants considered that the partnership should expand, as did the core partners vision statements. The partners need to decide the priority purposes of expanding the partnership. This could include adding additional expertise, increasing geographical or grass-roots reach, greater financial resources, and coherence with other inter-agency initiatives. The first place to look for new partners is amongst the organizations that most actively engaged in the various HQ-level CS subgroups in the first year of the pandemic.

It is proposed that the core of the partnership should continue to include those ready to make a financial investment, with a strategic advisory group (as with some humanitarian clusters) or similar, providing guidance, challenge and technical capacity. Suggestions of potential new partners are provided in the Decision Table below. The organizations proposed are illustrative rather than definitive. The core partners should bear in mind that the larger the partnership, the larger the secretariat capacity required to support it.

Recommendation 6. Develop inter-agency funding proposals for the Collective Service

All partners face the reality check of whether Collective Service HQ and regional capacities can be funded. The Steering Committee is concerned that funding may not be forthcoming either from their own budgets or externally. If it is true that 'there is no more money', then Option 3 is the only viable option. For Options 1 and 2, the CS needs to be 'brought in from the cold', that is, it should be an acknowledged part of core partners' corporate resource mobilization, not left to find funding from sources that don't compete with the partners normal fundraising. For Option 1 to work, and even for Option 2, the core partners would need to find a new sense of optimism that a revived Collective Service can continue to play an important role and that donors will buy into it. Because Option 1 offers a more complete, larger scale and ambitious concept that addresses multiple donor priorities, it may be more viable than Option 2, but this will need to be tested. Equally, it will take longer and will be harder to develop than Option 2.

In practical terms, funding for each option would be achieved as follows:

- Option 1: IFRC, UNICEF and WHO should jointly devise funding proposals that cover the operation of the Collective Service and the unique potential for RCCE preparedness for epidemics and other disease outbreaks (under the label of 'pandemic preparedness') offered by the three organizations' combined

[108] 'Likelihood of demand' because, as experience in ESA has shown, demand is stimulated as the number of successful examples of RCCE support at country level grows.

mandates and capacities, to meet the challenge of the HEPR agenda. This will include community engagement and will emphasize the potential of the CS to build sustainable national and community capacity and preparedness for health emergencies, based on a medium term (three to five year) investment. The proposals should target pandemic preparedness funds (both the Pandemic Fund managed by the World Bank and other pandemic preparedness funding sources, especially the Global Fund) and other bilateral donors and foundations. These funding proposals could also include resources for Collective Service HQ Secretariat functions.

- Option 2: For HQ, partners will need to continue to contribute to the Secretariat from core budgets. Partners can build on past regional experience to demonstrate that, where emergency responses can be shown to benefit from RCCE at country level, short-term crisis-related funding has been forthcoming. The core partners should engage their resource mobilization teams to raise funds for regional implementation of the Service, or for a group of high-risk countries in more than one region.
- Option 3: Regional RCCE coordination groupings would be left to raise funds regionally, perhaps with support from HQ resource mobilization teams.

Recommendation 7. Link rather than merge the work of the Collective Service and the IASC

The Collective Service concerns the delivery of services and support, while Task Force 2 on AAP is a policy/strategy group under the IASC. However, while different in nature, the two are complementary and should be intentionally linked. OCHA should be encouraged to ensure liaison and learning from the four pilot countries within the Emergency Relief Coordinators Flagship Initiative on the empowerment of crisis-affected people would also gain from the Collective Service experience. The CS should not be subsumed into the work of IASC Task Force 2 on AAP because the mandate of the Service overlaps with, but differs from that of the Task Force, including the need to continue to serve countries with health emergencies in countries where there is no humanitarian capacity or machinery and where no humanitarian emergency has been declared.

This does not prevent the two bodies from undertaking joint activities or from raising funds together for common activities. A merger might be possible but only if (i) all parties agree that a full spectrum of development, humanitarian, and PHE operating environments are incorporated; and (ii) there is sufficient trust for all sides to feel confident that there is no 'takeover' by another organization (which might again point back to the value of a facilitated process).

Engagement with the IASC should not relate only to Task Force 2. The most relevant humanitarian clusters should be purposefully engaged, first the Health Cluster, but also others whose work has a clear link to RCCE (potentially WASH, camp management, education, among others).

Recommendation 8. Determine whether a pooled fund would be beneficial for the Collective Service

The Gates Foundation found it problematic to divide its grants between three organizations. In the past, two pooled funding options were considered briefly by the Collective Service: (i) setting up a joint fund under the WHO Foundation; and (ii) using UNDP's multi-donor trust fund facility.[109] If the CS is to be renewed for the longer term, the feasibility of using a joint fund should be reconsidered because of its potential to bring several benefits. A joint fund:

- Is easier and more logical for donors as they prefer to put funds into one pot
- Would allow more strategic allocation of resources and reallocations according to need
- Avoids the problem of not being able to transfer funds between organizations
- Could accept private sector contributions
- Provides a 'home' for financial contributions from new partners and their donors
- With a competent fund manager would add value to monitoring and accountability for spending and results.

[109] United Nations (undated), website of the Multi-Partner Trust Fund Office Gateway.

Set against these benefits, creating a joint fund will require additional work and ongoing management of the fund manager, who will/may charge overheads on an ongoing basis. The larger the scope of activities and funding, and the more integrated the work of the partners becomes, the more relevant a joint fund would become. For Option 2, therefore, it is advised and for Option 1 recommended.

Recommendation 9. Implement a Collective Service standby mechanism

A standby roster or other mechanism is required for the deployment of skilled personnel to support RCCE coordination, social sciences, information management and community engagement. This mechanism should cover the roles of: (i) neutral inter-agency RCCE coordination; (ii) social scientist (including community engagement specialists); and (iii) information management officer, all with sufficient experience and skill to work productively with a range of stakeholders, including government. A stand-by roster becomes all the more important if no further support is provided by the Collective Service (Option 3) or if dedicated regional resources are no longer part of the CS model. Conversely, the more expert capacity is embedded in regions (Option 1), the less standby capacity is needed. No specific recommendation is made on how a standby or surge roster should be managed, pending the outcome of the current UNICEF consultancy on advancing the IFRC-OCHA-UNICEF 'Roadmap'.

Recommendation 10. Revise the Collective Service theory of change

The theory of change for the Collective Service needs to be updated to close the gaps identified in the evaluation, most importantly to (i) include steps for the engagement of governments and civil society in collective, coordinated RCCE-CEA-AAP; and (ii) include a more comprehensive approach to capacity development, especially in the case of Option 1 being adopted.

Recommendation 11. Consider changing the name of the Collective Service

The name 'Collective Service' has been both an advantage in raising the profile of the Service and a source of confusion to many within the core partners during the life of the Service as to its purpose. The partners therefore need to consider whether the name of the Service should be changed. On the plus side, the adoption of a more descriptive title will allow a clearer understanding of the purpose of the Service and improve communication across and beyond the partners. Any new partners joining the Service may well ask why such a non-specific name is being used. On the other hand, a change of name risks having to re-explain the Service to partners, especially governments, which have become familiar with the service. In any event, deciding on a change of name should not become a distraction from more strategic decisions or remits, ambitions, and resourcing. If agreement on a name change cannot be reached this should not delay progress on more important issues.

Recommendation 12. Extend the current Collective Service to allow time for a new agreement

Whichever Option is adopted, the current CS arrangements and contracts for the Geneva-based Secretariat should be extended for at least six months to allow time for debate and decision-making. Given the ongoing demand for support in ESA, the three staff contracts there should be extended if funding can be found until the appropriate future options are determined.

Decision Table

The following table builds on the three strategic options and the twelve recommendations presented above and provides the Steering Committee with an aid to decision-making.

Table 6. Decision Table

	Option 1 Change CS model to proactive development of RCCE capacity	**Option 2** Maintain the CS and/or expand to other regions	**Option 3** Continue regional RCCE coordination without additional CS support
Applicable to all options			
Policy commitment on collective, coordinated RCCE	Yes	Yes	Yes
RCCE applied to health emergencies in stable and humanitarian settings	Yes	Yes	Yes
Ensure CS and IASC AAP consult	Yes	Yes	Yes
Agree SOPs to trigger expanded RCCE response for major emergencies	Yes	Yes	Yes
Preserve CS products and intellectual property	Yes	Yes	Yes
Structures/organization			
Retain CS Secretariat	Yes - larger	Depending on scale of regional implementation	No
Retain Steering Committee	Yes	Yes	Reference group only
Reference (or Strategic Advisory) Group	Yes	Yes	Possibly
Regional structures	In regions that meet three conditions (see Recommendation 4)	In regions that meet three conditions (see Recommendation 4)	No
RCCE surge capacity (refers also to UNICEF consultancy on the Roadmap)	Yes – managed by HQ and regions together	Yes – managed by regions	Yes - managed by subcontract
Expand core CS partner membership	Yes	Depending on the scale of implementation	No
Adopt a new name for the CS	Advised	Optional	Optional
MOU/TOC/Strategy			
New Memorandum of Understanding	Yes	Yes	No – policy commitment only
Revise theory of change	Yes – add capacity development theory	Yes – add how to engage actors	No
Analyze demand for RCCE support	Yes – selected high-risk countries	Yes – selected high-risk countries	No
Integration of CS in corporate strategy	Yes	No	No
Embed coordinated RCCE in core partner country office strategies	Yes	No	No

	Option 1 Change CS model to proactive development of RCCE capacity	Option 2 Maintain the CS and/or expand to other regions	Option 3 Continue regional RCCE coordination without additional CS support
Capacity development			
Technical RCCE training (coordination competencies in health emergencies)	Yes	Yes	Determined by regions
Longer term developmental approach to RCCE preparedness capacity	Yes	No	No
Engage institutional development experts (internal/external) in CS RCCE strategy	Yes	No	No
Resource mobilization			
Joint CS fund	Yes	Advised	No
Time frame for funding proposals	3–5 years	0.5–2 years	Determined by regions
Joint fund raising for RCCE for specific health emergency responses	Yes – HQ led	Yes – by regions, with HQ advice	No
Joint fundraising based on HEPR and accessing pandemic funds	Yes	No	No
Engage corporate resource mobilization capacity	Yes	Advised	No
Partnership			
New partners	As Option 2, plus e.g. WASH and Education clusters, Ground Truth Solutions, 1–2 regionally based organizations, READY[110]	Health Cluster, OCHA, 1–2 INGOs,[111] UNHCR, IOM, CDAC	Not relevant

[110] The READY initiative, an important collaborator in 2020–21, is closing but the project leader suggested other relevant organizations that could be consulted or included: 1. Breakthrough Action and Research, working with governments to strengthen RCCE at country level, a global capacity-building project for SBC programming and research that focuses on multiple health areas; 2. Johns Hopkins Center for Communication Programs; and 3. Prevent Epidemics, providing bilateral support to countries on their RCCE strategies.

[111] During the evaluation various INGOs were mentioned as potential partners including, Médecins Sans Frontières, Save the Children, International Rescue Committee, International Medical Corps.

Annexes and Case Studies

Annexes and Case Studies are published in separate reports. These include:

Annexes

Annex A. Evaluation Matrix

Annex B. Bibliography

Annex C. Interviews

Annex D. Collective Service Theory of Change

Annex E. Collective Service Indicators

Annex F. Collective Service Guidance, Tools and Reports

Annex G. Elements of Coordinated RCCE as Implemented by the Collective Service at National Level

Annex H. Evaluation Principles, Management and Governance

Annex I. Biographies of the Evaluation Team

Annex J. Online Survey Report

Annex K. Evaluation Risks, Mitigation and Limitations

Annex L. Terms of Reference

Case Studies

Case Study 1. The Collective Service in East and Southern Africa

Case Study 2. The Collective Service in West and Central Africa

Case Study 3. Data for Action in the Context of the RCCE Collective Service

Case Study 4. Covid-19 RCCE Response in Non-collective Service Settings

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