

IFRC Strategic Planning Department
UNICEF Evaluation Office
WHO Evaluation Office

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

A collaborative partnership between IFRC, UNICEF and WHO

Inception Report

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Abbreviations

AAP	Accountability to Affected Populations
CEA	Community Engagement and Accountability
CS	Collective Service
GOARN	Global Outbreak Alert and Response Network
LOA	Letter of Agreement
NGO	Non-governmental Organization
PHE	Public Health Emergency
RCCE	Risk Communication and Community Engagement
SBC	Social and Behaviour Change
SC	Steering Committee of the Collective Service
TOR	Terms of Reference
UNEG	United Nations Evaluation Group

Glossary

To facilitate the reading of the inception 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.

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.¹ Risk communication and community engagement (RCCE) refers to the processes and approaches to systematically engage and communicate with people and communities to encourage and enable communities to promote healthy behaviours and prevent the spread of infectious diseases during public health events.²

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 wellbeing.³

Following IFRC's 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."*⁴

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."*⁵

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.⁶

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 influences drivers of change and supports 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.⁷

¹ International Federation of Red Cross and Red Crescent Societies and the International Committee of the Red Cross (2021), [A Red Cross Red Crescent Guide to Community Engagement and Accountability](#), p.13

² IFRC (2020), [Risk Communication and Community Engagement](#). Guidance Note for the National Society & IFRC Response Teams, p.1

³ IFRC (2023), [Community Engagement and Accountability](#) [IFRC website]

⁴ IFRC (2021), [A Red Cross Red Crescent Guide to Community Engagement and Accountability](#), p.118

⁵ Ibid, p.11

⁶ Ibid.

⁷ UNICEF (undated), [Social and behaviour change](#). Helping families access the decisions that affect their lives. [UNICEF website]

1. Introduction

The Risk Communication and Community Engagement (RCCE) Collective Service is a 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)⁸, 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.

A formative outcome-oriented evaluation was proposed to assess the Collective Service's achievements, identify promising coordinated RCCE approaches during implementation in response to COVID-19, **and to inform the Service's strategic vision moving forward**. The evaluation is jointly conducted by the IFRC, UNICEF and WHO.

This inception report is a communication and planning tool that aims to establish a common understanding among the key stakeholders of the evaluation. It builds on the evaluation [terms of reference](#) (TOR), presents initial insights based on desk review and some exploratory key informant interviews, and further defines the methodology proposed for the evaluation. The report reflects some important variations from the TOR. The evaluation questions have been revised and rearranged to simplify and reflect the Collective Service partners' stated areas of interest and priorities (see [Section 5](#)).

The approach and timeline of this evaluation have been adjusted to make it as useful as possible. Since the start of 2022, the Collective Service Secretariat has been reviewing the progress of the Collective Service and developing new plans and options for the future. At present, the Secretariat plans to move ahead with a presentation of proposals to the Steering Committee in early March 2023, in preparation for a donor roundtable. Against this background, the evaluation was at risk of becoming partially irrelevant as an evidence base for making decisions on the future of the Collective Service. Therefore, the evaluation plan has been modified to provide preliminary results that can inform the Steering Committee's planning retreat.

Following the inception phase, **the planned data collection of the evaluation has been divided into two phases:** Phase 1 leading to preliminary results in March 2023, intended to inform the Collective Service Steering Committee deliberations on the future of the Service, and Phase 2 which completes the data collection, including case studies. Phase 3 covers analysis and reporting with an end date for the evaluation in July 2023 (see timeline in [Section 7](#)).

⁸ In this report, GOARN, IFRC, UNICEF and WHO are referred to collectively as the 'Collective Service partners'.

2. Overview of the Collective Service

2.1. Background and context

Having emerged as a global health crisis, an information crisis, and an increasingly wider socio-economic crisis, COVID-19 confronted humanitarian, development actors and national institutions with needs for coordination and community engagement mechanisms, building on the Ebola experience. One of the major lessons of the past decade is the need to engage communities affected from the very beginning of a response. To achieve long-term positive impacts from humanitarian responses, including public health emergencies (PHE), humanitarian organizations need to work together to ensure a community-centered approach. As such, it is essential to ensure that all decisions within the health emergency preparedness, response and resilience architecture are taken and adjusted according to community feedback, concerns, and priorities, as well as social insights. Risk communication and community engagement is aimed at enabling affected communities' participation in relief efforts, building trust in the health emergency response.

2.2. Origin

The interagency coordination of the Collective Service for the COVID-19 response was established under the partnership of WHO, IFRC, and UNICEF and GOARN. Its objective is to improve collaboration among key partners at all levels, support the data collection and analysis, and strengthen coordination at global, regional, and national levels.

The Service was launched in June 2020, with support from the Bill and Melinda Gates Foundation, and after the proposed approach was endorsed by the Inter-Agency Standing Committee (IASC) Principals in April 2020.⁹ It was launched in response to COVID-19 with the overarching goal “that people-centered 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”.¹⁰ The Service’s intention is to move from the directive, one-way communication, which characterized the early stages of the COVID-19 response, towards the community engagement and participatory approaches that have been proven to help control and eliminate outbreaks in the past.¹¹

Moreover, the Service intends 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.¹² The Collective Service strategy is aimed at global, regional, and national level audiences such as governments; the United Nations; local, regional, and international health and humanitarian NGOs, National Red Cross and Red Crescent Societies; civil society; and academia.¹³

Originally, the Collective Service’ work plan, funded by the Bill and Melinda Gates Foundation, covered a six-month period from June to December 2020. It was suggested that “six months after its establishment, lessons from the COVID-19 collective service¹⁴ 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.” Some consultations took place between the RCCE Collective Service and the Global Cluster Coordination Group & RG2. This has yet to be brought to the attention of the EDG and eventually the Principal.¹⁵ Since then, the Service has built coordination and support services at global and regional levels, particularly focusing on Africa regions.

⁹ Collective Service (2021), [A Collective Service for Risk Communication and Community Engagement](#), p.2

¹⁰ IFRC, UNICEF, WHO (2020), [COVID-19 Global Risk Communication and Community Engagement Strategy](#), p. 4

¹¹ Ibid.

¹² Collective Service (2021), [A Collective Service for Risk Communication and Community Engagement](#), p.2

¹³ IFRC, UNICEF, WHO (2020), [COVID-19 Global Risk Communication and Community Engagement Strategy](#), p. 6

¹⁴ ODI (2021), The Risk Communication and Community Engagement (RCCE) Collective Service. Rapid Learning Review.

¹⁵ Collective Service (2022), The future of the RCCE Collective Service [internal document], p. 2

According to the 2021-2022 CS Workplan, collaboration between the regions and the Secretariat was very successful during the initial phase, especially due to the existence of dedicated coordination mechanisms at the East and Southern and West and Central Africa regional levels that ensured the link with governments and partners involved in the response to COVID-19. The Workplan also refers to the Service's ability to bring together over 50 partners globally and regionally through several different mechanisms, including biweekly calls and regular webinars.

Tools, resources and services include: best practice guidance on a range of issues from tips for community engagement in contact tracing to preparing communities for COVID 19 vaccines, the COVID-19 Global RCCE Strategy with core indicators and a common list of questions to measure social and behavioural drivers and the RCCE knowledge hub (www.rcce-collective.net), a one-stop shop for resources, guidance, case studies & data, and dedicated regional libraries (i.e. <https://coronawestafrica.info>).

At regional levels, dedicated interagency teams have been established in West and Central Africa (WCA) and East and Southern Africa (ESA), as well as the interagency working group co-lead by WHO, UNICEF and IFRC in the MENA region, providing direct support to country level responses on demand.¹⁶ For 2023, the Collective Service will focus on three main areas: *Be collaborative*; *Be data-driven*; and *Be community-led*.

2.3. Rationale for the Collective Service

The development of an epidemic is directly influenced by social behaviours. A means to promote behavior change in the affected population is investing in RCCE. RCCE strategy aims to take into consideration that complexity of human behaviour and uses socio-behavioural data to identify ways to reduce risks by understanding people's changing perceptions and attitudes.¹⁷ Upon examining different sources of information on beliefs and perceptions around COVID-19¹⁸, the Service reached several conclusions: risk perception was declining, receiving information through appropriate channels was very important, pandemic fatigue was increasing, and inequalities were widening, stigma and discrimination remained a threat and were impacting social cohesion in many countries, etc. As part of their response efforts, countries around the world developed their own RCCE plans to meet these and other challenges.

As stated in the Letter of Agreement for the establishment of a collective service for RCCE for COVID-19, as the pandemic shifted into a humanitarian crisis with a continually evolving public health response, the unprecedented impacts on humanity required further coordination. The Service's rationale is anchored on the work of the Risk Communication and Community Engagement (RCCE) group, coordinated with support from GOARN and co-chaired by WHO, UNICEF and IFRC. From this precedent, the establishment of the Service seeks to:

- Formalize and recognize the group 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 needs¹⁹

The purpose of the Service is 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”.²⁰

¹⁶ Collective Service (2021), Work plan 2021-2022 [internal document]

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

¹⁸ Socio-behavioural data from various sources are centralized on the RCCE collective service portal. See [here](#).

¹⁹ IFRC, UNICEF & WHO (2020), Letter of Agreement for the establishment of a collective service for Risk Communication and Community Engagement for COVID-19 [internal document]

²⁰ Collective Service (2021), [A Collective Service for Risk Communication and Community Engagement](#), p.2

2.4. Strategic objectives

In the original strategy (2020), the Collective Service established four strategic pillars to meet its objective²¹:

Figure 1 Strategic objectives of the RCCE Collective Service



The Collective Service 2023 workplan foresees specific key results for three strategic areas:²²

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 SOPs that will make part of partnership framework/MOU across partners to serve as the established mechanism for RCCE coordination ensuring a predictable and sustainable coordination
- Expand the scope to other PHEs and humanitarian response as well as the base and diversity of partners of the Collective Service
- Strengthening of partnerships and networks (e.g., Youth & Women-oriented stakeholders), as well as interagency working groups.

2. Be data-driven: The key result in this area is to achieve a shared minimal capacity to collecting, organizing, analyzing and sharing data for community engagement for response coordination. To do so, certain 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 and adapted to EBOLA, 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 leveraging the UNICEF-led digital engagement platforms such as Internet of Good Things and U-Report
- Mainstreaming of RCCE data and Social Science capacity to multi-disciplinary group of actors (ex.: GOARN partners.)

²¹ IFRC, UNICEF, WHO (2020), [COVID-19 Global Risk Communication and Community Engagement Strategy](#), p. 12-16

²² The 2023 workplan does not explicitly include the 3rd strategic objective 'Reinforce Capacity and Local Solutions' presented in Figure 1 above since now the capacity strengthening has become an enabler and is a component of each of those three areas.

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

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

According to the Collective Service, there is no one-size-fits-all approach for effective community engagement. However, there are some **guiding principles** that apply to all different contexts when it comes to risk communication and community engagement as follows:²³

- Nationally led by governments supported by civil society and communities
- Community-centred working their knowledge, capacities, and vulnerabilities
- Participatory enabling community-led responses
- Nurturing trust as the critical component of the COVID-19 response
- Open and transparent about the knowns/unknowns, uncertainty, and mistakes
- Informed by data about the community needs, issues and perceptions
- Integrated as foundational approach for the entire response
- Coordinated to avoid duplication and gaps, and increase impact
- Inclusive of all vulnerable and marginalized groups
- Accountable to the affected communities.

Furthermore, the Collective Service places special emphasis on reaching those who are most vulnerable, considering two broad types of vulnerability: (a) those who are at a higher risk health-wise and (b) those who are more likely to be exposed from a socio-economic perspective.²⁴

2.5. Theory of Change

The Collective Service has a dedicated Theory of Change (see [Annex B](#)). The model assumes that if evidence and resources are used and strategies implemented – such as coordination and alignment, innovation and improved science, amplification and community partnership and capacity building, – then the quality and consistency of RCCE approaches will be improved. 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, this improvement will be achieved.

The ToC follows the following 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; (4) Expanding donor base and developing and 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. (4) Improved quality of participatory RCCE through 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; (4) Strengthened capacities for improved local response. Moreover, the quality and the consistency of RCCE approaches will also be improved at the country level.

²³ IFRC, UNICEF, WHO (2020), [COVID-19 Global Risk Communication and Community Engagement Strategy](#), p. 5

²⁴ Ibid, p. 18

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 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 Theory of Change 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:²⁵

1. **Active and effective coordination mechanisms**, leading to harmonized RCCE approaches and optimizing the integration of RCCE. This is achieved through:
 - a. A needs-based **common and coordinated ‘collective service’ approach** at global, regional and national level, delivering on a comprehensive and localized RCCE strategy and informing systems level changes.
 - b. Minimum **commitments, standards and indicators** for community engagement are adapted/adopted and applied in policies and programming for epidemics readiness and response
 - c. Enhanced **advocacy and stakeholder engagement** Including mobilization of champions and thought-leaders at all levels – global through to sub-national
2. **Evidence based national RCCE plans** through the generation, analysis and use of evidence on community perspectives, systematically informing policy and programming, and improving effectiveness and efficiency. This is achieved through:
 - a. **Creation of structures, knowledge, tools** and processes are made available for regional and country level rapid collection and analysis of social evidence (including community feedback)
 - b. **Community engagement** approaches are informed by community perspectives, risks, barriers and experiences.
 - c. **Evidence exists that strategic decision-making and course correction** are informed by the views and feedback from affected communities collected across the response (advocate for data disaggregation)
3. **Enhanced institutional accountability in decision-making**, improving the quality and consistency of risk communication and community engagement approaches, towards more responsive and flexible actions that fit the diverse needs, views, and capacities of communities. This is achieved through:
 - a. **RCCE standards of practice** are applied and amplified through strategic guidance, coordination and partnerships
 - b. **Timely, understandable scientific and public health information is widely available** (Infodemic Management).
4. **Strengthened local capacity to improve local response** through training, mentoring, peer learning and resource sharing. This can be done through:
 - a. **Guidance, minimum standards, tools and documentations of good practices** in participatory RCCE approaches.
 - b. **A reliable technical and coordination support** is available through a rapidly deployable RCCE surge capacity and help desk function.
 - c. **Coordinated capacity building**, timely advice, dedicated services and technical support for specific needs

The Collective Service Secretariat also adopted a set of key performance indicators against which to track its progress (see [Annex C](#)).

²⁵ Collective Service (2020), RCCE Collective Service Work Plan 2021-2022. [internal document]

2.6. Structure and activities

Currently, the Collective Service offers support around four areas: 1) Helpdesk, 2) Social science, 3) Monitoring and Evaluation, and 4) Information management:²⁶

- 1) **Helpdesk:** The Collective Helpdesk provides coordinated guidance and support on RCCE related queries. The Helpdesk gives you quick access to technical expertise, data, and knowledge bases. It is directed to anyone seeking rapid or in-depth RCCE technical support and resources that cannot be found at the country or regional levels. Specifically, the Helpdesk provides rapid, remote technical assistance to help in finding relevant and contemporary resources; as well as connecting individuals to regional or global RCCE experts for advice on design, implementation and monitoring of projects.
- 2) **Social science:** The Collective Service supports partners at the national, regional and global level to enhance standardized approaches to the systematic collection, analysis and use of socio-behavioral evidence. It is based on four pillars:
 - a. Delivering capacity building and training to support partners in applying social science evidence in health emergencies including data collection, analysis and operationalization of socio-behavioral information.
 - b. Data mapping and structuring to identify evidence gaps and to generate socio-behavioral trends and support the visualization of socio-behavioral variables through a dashboard.
 - c. Providing direct support to country-level teams to formulate research questions, develop research protocols, data analysis and quality assurance of research outputs.
 - d. 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 behaviors.
- 3) **Monitoring and evaluation:** The Collective Service has established a mechanism to provide in-depth RCCE monitoring and evaluation technical assistance for Collective Service partners. The range of M&E activities includes, but is not limited to:
 - a. Support the generation, analysis, and/or use of M&E evidence
 - b. Support the use of this evidence to influence strategic decisions
 - c. Build skills and system strengthening in M&E investment and implementation
- 4) **Information management:** The Collective Service provides the Information Management Service to strengthen evidence generation, which helps RCCE programme design and informs the decision-making process at global, regional and country level. They create data management standards, data analysis, and support the dissemination of information. The Information Management team provides technical guidance, design and implementation support, and training to strengthen existing information systems or develop responsive solutions for RCCE partners at country or regional levels.

The objectives are the following:

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

²⁶ Collective Service (2023), [Services](#) [website]

Under **Data for Action**, the RCCE-Collective Service database is reported to be a first-of-its-kind repository of social and behavioral data on COVID-19, covering 198 countries and consisting of over 250,000 data points from 411 different data sources. The **Social Behaviour Dashboard on Public Health Emergency** is an open access website developed by the Collective Service and is currently hosted on its official website²⁷. The dashboard gathers validated social and behavioural data from a large spectrum of data sources and explores social and behavioural trends across six dimensions and 35 indicators (see COVID-19 behaviour change framework). Please see [Annex D](#) for further details on Information Management at the Collective Service.

2.7. Funding and budgets

As this initiative progressed, the partner agencies planned and allocated financial and technical resources for the operation of the Collective Service annually. The integrated RCCE Collective Service budget planned for 2023 reaches \$5 million, composed of around \$4 million from the four Collective Service partners and \$1 million from donors (Bill & Melinda Gates Foundation and The Rockefeller Foundation). The evaluation will gather further information on budgets and spending.

Donor Funding

Table 1 - Donor Funding to the Collective Service

	2020	2021	2022
Bill & Melinda Gates Foundation	2,200,000	1,200,000	500,000
The Rockefeller Foundation	-	-	500,000
Solidarity Fund	-	1,350,000	-
Total (in \$)	2,200,000	2,550,000	1,000,000

CS partner budget allocations

Table 2 - Core partners financial allocations to Collective Service

	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 \$)	2,205,480	2,572,585	3,183,669

(*) This excludes funds from hiring a Risk Communication Lead.

For 2020, 2021, figures do not include in-kind contributions of technical lead staff time.

²⁷ Collective Service (2023), [Social behavioural dashboard](#) [website]

3. Evaluation purpose, objectives, and scope

3.1. Purpose

The purpose of the evaluation is 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 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 includes two interlinked areas of investigation: an analysis of the RCCE Collective Service organizational design and approach, and the assessment of the achievement of the intended outcomes, while taking note of unintended outcomes. In investigating such components, the evaluation will look at the arrangements that have been put in place to achieve the overarching goal and objectives (coordination, collaboration, resourcing, etc.) and the extent to which the Service used data and evidence. The evaluation will also learn lessons from comparable coordination and support service mechanisms that work at global, regional and country levels.

In line with the [terms of reference](#), the evaluation will focus on the strengths and weaknesses of collaborative approaches taken to RCCE at HQ, regional and country level, including, but not restricted to, COVID-19. The evaluation strikes a balance between past performance and learning and forward-looking proposals to inform the preparation of the renewed Collective Service approach and modality of operation.

3.2. Objectives

Expanding on the purposes of the evaluation, the specific objectives of the evaluation are 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**. Determine what has been achieved under the four Collective Service strategic areas, i.e. 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; reinforced national capacity for improved local solutions.
- **Resourcing**. Assess the extent to which the human and financial resources were adequate to the planned outputs and outcomes of the Collective Service.
- **Coordination and collaboration**. Assess the quality of coordination and management of the Collective Service at the global, regional, and country levels, comparing regions where interagency teams have been put in place versus areas without; in selecting and managing partnerships to advance the overarching goal and objectives of the Service in RCCE, during the COVID-19 and other public health emergencies; in the structures, governance and decision making and their impact at implementation level.
- **Value added of Data for Action**. Investigate the quality and overall coherence of the Data for Action approach used by the Collective Service (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 Collective Service.
- **Adequacy of internal M&E 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.

3.3. Evaluation use

The findings and recommendations from the external evaluation will be used to further shape the future of the Collective Service through high-level engagements with key partners in public health and humanitarian fields. There are two related groups of primary users of this exercise:

1. The core team(s) in the Collective Service Secretariat guides the implementation of the Service logical framework. This core team include IFRC, UNICEF, WHO and GOARN.
2. The members of the Steering Committee and technical groups that oversee the Service.

Secondary users range widely and bring together over 50 organizations involved in RCCE coordination mechanisms worldwide that participated in resourcing this service and using its products and organizations that may potentially participate in the Service in the future. They also include regional interagency teams established in West and Central Africa, Southern and Eastern Africa, and other regions where interagency teams have not yet been established, as well as country-level stakeholders such as governments, international and national non-governmental organizations, and other partners.

3.4. Scope

The evaluation will focus on the period 2020-2022 to inform the way forward for the Collective Service in the medium term. The subject scope of the evaluation is collective responses to public health emergencies, in particular the Collective Service. The evaluation is not limited to emergency and humanitarian response but will consider how the Collective Service has impacted on the development of national (government and non-government) capacities and preparedness for RCCE. The evaluation will largely focus on the Collective Service partners but will also engage with relevant external organizations and coordination mechanisms other than the Collective Service to gather perspectives from beyond the Collective Service partners. To ground the analysis, deep-dive case studies will be examined to provide an in-depth analysis of specific areas/pilots/themes to inform the Collective Service's work further.

4. Issues identified during the inception phase

The inception phase of the evaluation began with a mission of all evaluation team members to Geneva from January 11-13, 2023. The team met with representatives of all Collective Service partners and the Collective Service Secretariat. This section of the report reflects on the issues identified by interviewees during the visit, which have been used to refine the evaluation approach and the evaluation questions.

4.1. Enabling a joint evaluation

The evaluation was originally commissioned by UNICEF since it is leading the evidence-generation output of the CS. During the inception visit to Geneva by the evaluation team and the evaluation manager, it was clarified that all four Collective Service partners want the evaluation to be regarded and implemented as a joint evaluation. The relevant sections of the TOR were therefore duly amended. UNICEF, while being the sole funder, expressed itself committed to an evaluation process that provides a balanced and impartial outcome for all Collective Service partners.

4.2. Funding

As funding for COVID-19 from donors comes to an end, the Collective Service finds itself needing to agree new direction and strategy to give a firmer foundation to the service and allow for resource mobilization to assure the future of the service over the medium term. Funding is not secured beyond 2023 and funding for a few posts in the Collective Service Secretariat is not secured until the end of 2023. This adds to the pressure for directions to be set as soon as possible, so that resource mobilization can bear fruit before the end of 2023.

4.3. Implications of a rapid start up

The Collective Service was started quickly in response to the declaration of the COVID-19 disease pandemic. From its launch, the Collective Service was driven strongly by the enthusiasm of and consensus between counterparts in IFRC, UNICEF and WHO and GOARN at director/senior adviser level, and at technical level, with staff of all organizations determined to improve on the response to the West and Central Africa Ebola disease outbreaks of 2014, 2018 and 2019. The Collective Service was initiated to close gaps and was found to have done so by a 2021 ODI rapid review, stating that: "The Service has filled important gaps in terms of coordination, technical guidance and data."²⁸ The establishment of the Collective Service was made possible by a grant from the Bill and Melinda Gates Foundation (BMGF), which was first offered to WHO and subsequently applied to the Collective Service. The funding proposal for the BMGF was developed very quickly ('overnight') with limited consultation with regions, or broad communication across partner organizations.

We heard that, while the rapid startup was necessary, there is some legacy even today, in that the Collective Service is not always well understood, even amongst personnel of the Collective Service partners, and important issues remain unresolved. From the outset the Collective Service has been vulnerable to organizational challenges arising from the Collective Service desire to establish clear purpose and priorities.

The short-term funding of posts (1 year or less at a time) and unclear governance of the Collective Service, already identified by the ODI rapid learning review of February 2021, are still to be addressed. The rapid start up also meant that Collective Service partners' organizational commitment to the Collective Service at the highest levels of the organizations was not obtained (and perhaps initially not required). The Collective Service has provoked internal debates within the Collective Service partners, not all of whom are clear where the Collective Service best sits on their structures. There are also concerns that the Collective Service partners have not (perhaps still are not) communicating adequately within their organizations about the purpose and mode of operation of the Collective Service.

4.4. Institutional challenges

Various possible reasons were raised as to why management issues have not been resolved, including pressures 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 difficulty Collective Service partners have found in resolving their differences over the functioning, purpose and future of the service.

While the Collective Service has been welcomed by some countries and regions, there is also resistance to the Collective Service in parts of at least two partners at HQs and regional levels. The Collective Service has been seen as competition for the partners' own RCCE functions, or as duplication. We heard that this is one reason why funds have been sought from non-traditional channels, so avoiding competition (or appearance of competition) with the partners' bilateral funding. In future, the Secretariat aims to approach bilateral donors, e.g. FCDO. Resistance to the Collective Service, where found, may be some combination of lack of initial consultation, disagreement with the nature/structure of the Collective Service, and competition for resources. There are tensions balancing corporate and Collective Service interests because the Collective Service has been seen by some as an actor in its own right.

4.5. Letter of Agreement

The Letter of Agreement (LOA), dated September 23, 2020, outlined the respective responsibilities of each organization for the pilot phase (1 June 2020- 31 May 2021) of the establishment of a collective service for risk communication and community engagement for COVID-19. We heard that the LOA was developed quickly as a 'skeleton' agreement. It is regarded as serviceable for getting the Collective Service up and running but does not provide sufficient definition of purpose, structures, roles and responsibilities and accountability. The LOA

²⁸ Lough, O. and Holloway, K. (2021), The Risk Communication and Community Engagement (RCCE) Collective Service – rapid learning review. HPG Report. London: ODI, p.7

describes the basic structure of the proposed service at HQ and regional level for East and Southern Africa and West and Central Africa. The roles and responsibilities of the Steering Committee have since been further defined in a separate document.

4.6. Public health emergencies and humanitarian architectures

We heard that the public health emergency architecture led by WHO is not well matched to, or understood, within the humanitarian response architecture, and vice versa. A minority of actors are common to both systems, including Collective Service partners IFRC, UNICEF, and WHO (and also MSF and Save the Children) but many other organizations only take part in one mechanism. Concerns were expressed that there have been disconnects between the PHE and humanitarian staff within the same Collective Service partner organization.

This is illustrated by the discussion of the agendas for Accountability to Affected Populations (AAP) and RCCE. Predating the evaluation, and anticipated as a possible outcome of the evaluation, some Collective Service partners wanted to see the IASC-led work on AAP and interagency work on RCCE (including the Collective Service) brought much closer together, with a view to achieving more efficient and clearer coordination at country level. Others are not in favour of this position. The IASC has a set of commitments to AAP that dates back more than 10 years. There is an IASC AAP Task Force focused on extending and improving engagement with communities affected by humanitarian crises and to accountability to communities. (IFRC is a co-chair). The underlying issues that prevent the Collective Service partners taking a joint approach to AAP-RCCE seem not to have been properly explored by the steering committee to see where common ground and differences lie. These discussions will need to address mismatch of mission and language between the Collective Service partners.

IFRC, UNICEF, and WHO use the following terminology:

- IFRC: Community engagement and accountability (CEA)
- UNICEF: Social behaviour change (SBC)
- WHO: Risk communication and community engagement (RCCE)

All parties have adopted RCCE for the purposes of the Collective Service in epidemics. There are some differences of meaning and scope between these terms, which could usefully be debated between the partners, if this has not already been done.

4.7. Future scope

We heard that all Collective Service partners have agreed that the scope of the Collective Service can be broadened (and has already been broadening) to include support to PHE responses to other disease outbreaks, in addition to COVID-19, in particular, Cholera, Ebola, and Mpox.²⁹

4.8. Scope of changes to be considered by the evaluation

In discussing future options for the Collective Service, the majority of key informants wanted the evaluation to consider whether and in what form the Collective Service continues, rather than assuming that it continues. This represents a slight departure from the terms of reference, which asks for recommendations on how the Collective Service can best continue rather than asking the evaluators to consider a redesign or end of the partnership. We heard all partners questioning (and by implication asking the evaluation to question) whether there are better ways of achieving the same goals, including the coordination and support of RCCE at country level. There is also some resistance to the idea of closing the Collective Service, not just because this might mean job losses in the Collective Service secretariat but because of the risk of losing the progress already made in RCCE by the Collective Service and the partners working together. Key informants surmised that the Collective Service would have to be revived in some form for the next major PHE if it had been disbanded.

²⁹ The evaluation will use Mpox as the term preferred by WHO over Monkeypox, though several key informants referred to 'monkeypox'.

4.9. Governance

The governance structure for the Collective Service is a Steering Committee (SC) composed of a Director/Manager from each of the four Collective Service partners. The committee is the Collective Service' only governance mechanism. The committee was established as part of the Letter of Agreement, and it has become the principal decision-making forum. Key informants held differing views about the role and effectiveness of Steering Committee, with a lack of clarity for some about whether the committee is (or should be) advisory or executive in its function. Questions were also raised about whether the Collective Service partner institutions were giving their full backing to the Service. According to the document setting out the SC roles and responsibilities, the SC 'holds decision-making power'.³⁰

However, this document was self-authorized by the committee itself, rather than being assigned by a higher level in the Collective Service partners (the LOA stated that there should be a committee but not its remit). There have been several changes of membership since the formation of the committee, which we heard led to some loss of momentum. The SC is not seen to have been effective in tackling difficult issues between the partners. The Committee is now engaged in developing and agreeing a new strategy and priorities for the Collective Service and to address some of the outstanding structural and governance issues. The Collective Service Secretariat is preparing proposals for the future, which have yet to be shared with the evaluation team.

4.10. Mandate, policy, strategy for health emergencies

Looking to the future, a successful collective approach to RCCE needs to allow each partner to comply with its policy, strategy and guidance for public health emergencies. Collaboration is likely to go as far as these overlap between the partners. Therefore, ensuring alignment between the Collective Service or its successors and these core organizational documents is crucial. Equally acknowledgement of non-alignment is important. Reaching a proper mutual understanding depends on the partners articulating their commitments and approach to RCCE as part of their health emergency response to each other.

4.11. Other issues identified

- **Global Health Cluster:** It has proven challenging for the Service to align its work with that of the WHO-led Global Health Cluster, which is a key part of the health emergencies architecture, which might be a natural collaborator with, or client of, the Collective Service.
- **Collective Service as 'extractive':** We were told that some at HQ, regional and country level find the Collective Service 'extractive', that is, the Collective Service demands data but adds little value back to those providing the data. This then tends to lead country offices to disengage.
- **Publications:** There have been challenges over the clearance of a key publication. WHO clearance processes are lengthy, causing frustration for other partners. However, guidelines issued without the WHO logo are not seen as credible by health partners.

4.12. Expectations of Collective Service partners for the evaluation

The evaluation team has not yet interviewed stakeholders at country and regional level; therefore, this summary is based on HQ feedback only.

We heard that there is value in recording what has and has not worked in the Collective Service, especially to learn from the country level how collective RCCE has been or might be managed between health emergency actors, so as to make sure the HQ and regional support to RCCE is calibrated to field realities, rather than the other way round.

³⁰ Collective Service (2022), Steering Committee – Roles and Responsibilities [internal document]

HQ based key informants expressed various expectations for the evaluative elements of the evaluation. These include:

- Documenting the progress, achievements and shortcomings of the Collective Service
- Ensuring that progress made and lessons learned are not lost
- Understanding the extent to which the Collective Service performed against its set objectives and key performance indicators
- Understanding how countries have used and/or benefited from the Collective Service.

While appreciating the value of the summative backward-looking side of the evaluation, the focus of key informants' expectations was clearly on the formative side, with all key informants looking to the future and expecting the evaluation to add value to the process of the Collective Service partners defining new direction and strategy, informed by past learning, with special emphasis on structures and models that could work as well or better than the current arrangements. We heard that Collective Service partners hope the evaluation will answer forward-looking questions related to the Service itself:

- How can the gains already made by the Collective Service on RCCE be maintained?
- How can RCCE surge capacity be established, and where should it sit?
- How do perceptions of the Collective Service differ between regions?
- What is the likely future level of ownership, engagement, and commitment of the Collective Service partners to the Collective Service (in its current or another form)?
- How can the roles and responsibilities of the Collective Service partners be better defined?
- Can/should a fuller and more formal agreement be developed to supersede the original Collective Service Letter of Agreement?

And also questions about RCCE more generally beyond the immediate scope of the Service

- What is the level of interest and engagement with the RCCE at country level on the part of the UN and other agencies and the government? What engagement has taken place? What is the future interest in RCCE support and services and on what themes? How can collective coordinated RCCE be most effectively organized, coordinated and supported to enable preparedness for and response to future public health emergencies

4.13. Collective Service Partner Position Papers

Currently, efforts are underway to inform the way forward for the Collective Service. This evaluation is intended as part of that process. In advance of the preparation of new plans for the Collective Service, the IFRC, UNICEF and WHO each prepared a vision or position paper setting out their views on the need for RCCE coordination and support services, and some initial indications of how such support might be delivered. There is much in common between these papers, as well as a few important differences.

The position papers (appear to) agree on:

- RCCE as a means to empower communities and make PHE responses more effective
- All organizations are committed to coordinated preparedness, responses (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
- The need to avoid duplication and 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 1) coordination, 2) social science, and 3) data, information and knowledge management (the WHO paper also specifies joint strategy development and needs assessment)
- The need for (rapid) RCCE surge capacity

- The need for a broader partnership that incorporates additional partners (though none of the papers specify the potential new partner organizations needed nor an optimal size for the partnership).
- Any HQ structures dedicated to RCCE support should be limited in size

There are differences or lack of clarity regarding:

- WHO is more focused on the deficit in government capacity for RCCE than others
- WHO and UNICEF do not want formal coordination RCCE structures at regional level, and WHO also not at country level (what comprises ‘formal’ will be explored by the evaluation)
- How any new coordination mechanism would be led, and by whom
- Whether an HQ/global structure based around the new expanded partnership would be 1) accepted, 2) financed by all the partners
- Pre-agreed coordination delegation 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 are not specific on this point)
- As discussed above, UNICEF and IFRC are both keen in principle to align the IASC AAP agenda and processes with RCCE.

5. Evaluation questions

The evaluation will answer questions related to the purpose and objectives of the evaluation as set out in Section 3 and as informed by the issues raised in Section 4. The evaluation questions (EQs) have been updated from the terms of reference to:

- Reduce overlaps of content within the sub-questions
- Further align the sub-questions with the EQs
- Remove forward-looking questions (these are now reflected under Recommendations, see 9.3 below)
- Revise the sub-questions to allow data to be gathered on the issues raised 4.12 and 4.13 above.

The revised evaluation questions 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?**

The full set of evaluation questions and sub-questions are set out in the Evaluation Matrix in Table 3 below. The matrix reflects the data collection methods foreseen as means of verification for answering each question. It provides a framework to guide the analysis and ensure that all data collected is analysed, triangulated and then used to answer the evaluation questions, leading to conclusions and recommendations.

Table 3 - Evaluation matrix: Evaluation questions and sub-questions versus means of verification

		Means of verification			
		Document Review	Key informant interviews	Online Survey	Country/ regional visits
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?					
EQ1.1	To what extent is the Collective Service approach relevant and appropriate to achieve the intended results, including in the perceptions of stakeholders?	✓	✓	✓	✓
EQ1.2	To what extent has the Secretariat of the Service consulted key stakeholders across its core partners to build a common understanding of the RCCE services required at country or regional level?	✓	✓	✓	✓
EQ1.3	To what extent have stakeholders across the core partners (and beyond) engaged with the Service?		✓	✓	✓
EQ1.4	To what extent have the Collective Service theory of change, logical framework and guidance materials provided conceptual clarity for collective working on RCCE at regional and country level?	✓	✓	✓	✓
EQ1.5	To what extent are the approaches followed by the Service consistent with good practice and international standards for capacity development, health data management and preparedness for public health emergencies?	✓	✓		✓
EQ1.6	To what extent has the Collective Service design and approach, and RCCE design in countries supported by the Service, paid attention to gender, equity, inclusion and diversity?	✓	✓	✓	✓
EQ2: To what extent have the planned outcomes of the Collective Service been achieved, and by what means?					
EQ2.1	To what extent has the Collective Service contributed to strengthening RCCE systems in response to COVID-19 and other health emergencies under each of the strategic areas defined for the Service at regional, national and sub-national levels?		✓	✓	✓
EQ2.2	How has the RCCE Collective Service supported the achievement of outcomes?	✓	✓	✓	✓
EQ2.3	What comparative advantages have IFRC, UNICEF, WHO, and GOARN brought to the Service? Are there capacities required for successful implementation of the Service that lie outside the current capacities and reach of the current core partners?		✓	✓	✓
EQ2.4	How realistic were the goals, objectives and targets set for the Service, given the changing resources available?		✓	✓	✓
EQ2.5	To what extent have shared goals and differences in the core partners' mandates and ways of working helped or hindered the Collective Service?		✓	✓	✓
EQ2.6	What is the likelihood that results already achieved by the Service will be sustained in the medium-term?		✓		✓

		Means of verification			
		Document Review	Key informant interviews	Online Survey	Country/ regional visits
EQ3: How efficient and effective has the coordination and collaboration of the Service proven in delivering on the objectives of the Service?					
EQ3.1	How well has the Service collaborated with partners to advance its objectives (including interactions at HQ, regional and country levels)?		✓	✓	✓
EQ3.2	To what extent has the Service's coordination complemented or contradicted the RCCE coordination mechanisms within its core partners, as well as other RCCE mechanisms employed at HQ, regional and country levels?		✓	✓	✓
EQ3.3	How have the RCCE coordination working groups differed between countries and regions and what lessons can be learned from these differences? How well coordinated have public health emergency and health related humanitarian response been?		✓	✓	✓
EQ3.4	What level of corporate support has the Service received from its core partners? How equitable have the core partners' contributions been to the work of the Service? How well have the core partners promoted collective RCCE across countries and regions?		✓	✓	✓
EQ3.5	How effective was the management structure in achieving the Collective Service objectives, including the Steering Committee, the Coordinators and the Secretariat?		✓	✓	✓
EQ4: To what extent has the Data for Action approach been effective in informing RCCE decision making?					
EQ4.1	To what extent do the core partners and other stakeholders perceive added value from Data for Action?		✓	✓	✓
EQ4.2	To what extent have the core partners and other stakeholders utilized Data for Action for planning and decision-making in their work on RCCE?	✓	✓	✓	✓
EQ4.3	To what extent has the Data for Action approach contributed to realizing stakeholders' RCCE goals and objectives?		✓	✓	✓
EQ5: To what extent have the Service's internal data, M&E and knowledge management systems fostered accountability, learning and improved performance?					
EQ5.1	To what extent has the Service collected and utilized data on its own performance?	✓	✓	✓	
EQ5.2	To what extent has the Service compiled and shared good practices with RCCE practitioners at regional and country level?	✓	✓	✓	✓
EQ5.2	To what extent have previous studies, research, and other evaluations relevant to RCCE been assessed to inform the Collective Service's work?	✓	✓	✓	✓

6. Methodology

The evaluation methodology specifies the overall approach to the evaluation, what types of data will be collected, the methods used to manage the data, and how the collected data will be analysed (Figure 1 below summarises the evaluation phases, methodology and analysis methods).

As further described below, the proposed methodological approach for the evaluation combines several methods and approaches for data collection and analysis. The evaluation will use a **mixed methods** approach to collect, process and analyze both quantitative and qualitative data to draw on the strengths of each and obtain a comprehensive understanding building on many perspectives. Data analysis will be undertaken following ethical standards and confidentiality and anonymity (see section 10.1).

6.1. Desk review

The Collective Service's documents (management, technical and reporting docs) will be reviewed and assessed alongside external literature on good practices, definitions, and theoretical frameworks directly related to international cooperation, public health, humanitarian and development assistance, risk communication and community engagement. This documentation includes, but is not limited to, overarching strategies and frameworks, background papers, global results framework with the theory of change, RCCE learning review, etc. Selected regional- and country-level strategic materials will be requested, especially for the deep-dive case studies. Via the Collective Service secretariat and the evaluation manager, Collective Service partners have already started to provide relevant documentation, which is being held in a dedicated SharePoint folder on UNICEF's intranet to which the evaluation team has access. The evaluation will make use of evaluative materials that are already available from the Collective Service partners and the approx. 40 short case studies posted on the Collective Service website and the 2021 ODI review of the Collective Service. The management team will support the evaluation team in gaining access to the documentation and other budget, administrative and secondary data.

6.2. Online survey

An online survey will be issued in English and French to obtain data from the range of stakeholders involved in the work of the Collective Service, including management staff, steering committee, technical group, and broader implementing partners, help desk customers and newsletter recipients at all levels: HQ, regional and country. The survey tool will be employed to generate sentiment analysis from the survey responses. The management team will help with the dissemination of the survey to HQ, regions, and countries via their organizations to ensure the representativeness of the sample. The survey will also be issued via the Collective Service global listserv of around 280 contacts and via each Collective Service partner's communities of practice for PHE, social and behaviour change, community engagement etc.

6.3. Key informant interviews and group discussions

Interviews will be conducted with a selected sample of key informants, including 1) internal stakeholders across all levels of all the Collective Service partners, 2) key external partners directly contributing to, or recipients of, the Collective Service' work, 3) key external partners contributing to parallel or similar emergency health and other humanitarian coordination mechanisms. Where the evaluation team is able to meet with, for example, RCCE network members or RCCE coordination groups at country or regional level, facilitated group discussions will be held where possible. The evaluation team provisionally anticipates at least 30 more interviews with Collective Service team members, Reference Group members, donors, core partner staff at HQ, region and country level, and other agencies; and at least a further 30 interviews as part of the Deep Dive case studies.

6.4. Deep dive case studies

In line with the terms of reference, the evaluation will implement four deep dive case studies. These studies will present analysis of the design, implementation and results of specific RCCE strategies operating at the regional and/or country level as a response to covid-19 pandemic and other public health emergencies (for example, Ebola, Monkeypox, Cholera):

- **Deep Dive 1: Collective Service and the resurgence of Ebola in Guinea**, for which the regional RCCE coordination team created a repository of tools, capacity building assets, policy documents and minimum actions that were shared with all partners engaged at the country level and promoted through dedicated coordination staff of the Collective Service to enable collaboration, facilitate connections, and enhance awareness of partner activities in order to avoid the duplications of efforts. The deep dive will assess the extent to which the coordination model allowed agencies and partners to deliberate on the response together and speak with one voice to communities.
- **Deep Dive 2: Collective Service and disease Outbreaks in East and Southern Africa will assess:** 1) **Mpox and Ebola outbreak in Uganda**: remote and surge support on Coordination, Community Engagement and Information Management provided to Uganda to prevent and control the Ebola outbreak in Uganda, as well as the RCCE capacity building. 2) **Cholera outbreak in Malawi**: remote and surge support on Coordination, Community Engagement and Information Management in Malawi to prevent and control the Cholera outbreak, as well as in RCCE technical support and capacity building.
- **Deep Dive 3: Collective Service and the development of common goods**, including 1) the Social and Behavior Dashboard, which has consolidated COVID-19 data based on a social and behavioral analysis framework, using data from numerous local and global research projects conducted by partners and academic communities, and 2) the Community Feedback Mechanism (CFM) Tracker that monitors community feedback mechanisms led by the Collective Service's Partners to support RCCE response on public health emergencies and specifically COVID-19.
- **Deep Dive 4: The 'control' group, looking at alternative means of coordination, RCCE support and information management**, including potentially: 1) **Middle East**, which has a regional RCCE coordinator and has received some support from the Service, 2) Regional coordination of RCCE in the COVID-19 response in **Latin America** that took place without the engagement of the Collective Service, 3) coordination mechanism established for RCCE in the **Asia-Pacific region** (mentioned in UNICEF's position paper). Other **local RCCE coordination mechanisms** may be identified by key informants during interviews and country visits. The availability of data will determine which examples are included in the case study.

6.5. Country and regional visits

There is agreement that the field work element of the evaluation will be important to provide an impartial assessment of which services have been valued and to what extent, and to discuss alternative RCCE coordination models, where identified. The primary added value of the country and regional visits is to meet local staff and volunteers, local organizations and government. Two missions are proposed to gather data for Deep Dives 1 and 2 described above:

- West and Central Africa - Region (Dakar), and Guinea
- East and Southern Africa - Region (Nairobi), Uganda and Malawi³¹

It is proposed that two members of the evaluation team undertake each mission (it is also anticipated that the Evaluation Manager will accompany the team on one mission). The evaluation team will require logistical support for the planning and organization of the visits, primarily from UNICEF, but also from IFRC delegations and WHO offices in helping to set up interviews and meetings with their partners and networks. Collective Service partners will be asked to nominate country-based evaluation focal points.

³¹ All of the proposed countries are subject to change depending on the local situation. For example, at present it seems that the evaluation team may refrain from conducting a mission in Malawi, given the recent Cyclone Freddy and the ongoing cholera outbreak.

Country and regional visits will gather information on the implementation of Collective Service services and support, including meetings with parties involved in RCCE beyond the three partners, including UN, NGO and government (primarily MOH, and other disease outbreak response authorities). Other local informants would include RCCE networks and their members, and UN agencies and NGOs engaged in RCCE. Ideally, visits will reach beyond capital cities to at least one local area where several RCCE actors have been operating. Meetings with local actors with experience of or responsibility for RCCE would be anticipated. However, in line with the terms of reference, direct community engagement via focus groups or other participatory community exercise is not in scope.

Before any visits are further considered, it is foreseen that 1) Collective Service partners confirm that such visits can be accommodated by the offices concerned and what duration would be suitable, and 2) the evaluation team will confirm that there is sufficient activity and an adequate set of key informants to justify the visits, especially whether it will be possible access key informants beyond the Collective Service partners, especially government and local NGOs that it would be more difficult or not possible to interview remotely.

6.6. Data Analysis

Quantitative data will be drawn from the online survey, budget data, and numerical measures of Collective Service delivery. Charts (bar graphs, pie graphs, boxplot, others) will be employed to aid data visualization and interpretation. Budget analysis will present the financial resources managed by the CS by year and implementing agency alongside the external funds received from donors over time (2020-2022), to inform an assessment of the adequacy of resources compared with the agreed tasks. **Qualitative data** analysis will be drawn from interview notes and transcriptions, documentary evidence and feedback to open-ended survey questions, using content analysis.

During Phase 2, the approaches, guidance and tools developed by the Collective Service will be subject to **good practice review**, tested against documented good practice in capacity development, health and social data collection, and preparedness/ readiness for public health emergencies.

The evaluation will carry out a **force field analysis** to assess the forces working for and against a continued role for the Collective Service balancing, for example, the imperative to respond collectively as the most effective means of delivery against potential confusion caused by new initiatives, institutional interests, competition for resources and resistance to change.

All data will be **triangulated** across the various sources to inform an assessment of Collective Service:

- Design and implementation, including theory of change, strategic areas and activities conducted
- Strengths and areas for improvement
- Achievements and main contributions
- Lessons learnt from the field
- The way forward.

6.7. Data Validation and Stakeholder Engagement

Data will be validated on an ongoing basis through regular interaction with the evaluation management team and the evaluation focal points (see 7.1 below), and through comments invited from the Reference Group on the draft inception and evaluation reports.

Towards the end of the analysis phase, the evaluation team will formulate **a set of evaluation recommendations**. Based on the Phase 1 analysis, the evaluation recommendations are likely to focus on the following:

- Recommendations based on other interagency models of coordination
- Improvements to RCCE services theory of change and planning frameworks, as necessary.
- Delivery and expanded uptake of RCCE services, based on potential demand as understood through documentation, interviews, survey and case studies

- Further developing institutional ownership of RCCE
- Models of coordination, collaboration and partnership arrangements at country, regional and global levels, taking into account the mandates of the principal partners, other PHE actors, and existing coordination structures related to RCCE and PHE.
- How the core partners can resolve or manage the relationship between, coordination of RCCE and AAP at country level.
- How RCCE coordination services can be positioned for uptake in future emergencies, including how stakeholders can be better informed about the RCCE services available and gain access to them
- How RCCE services can be made relevant to donor expectations for supporting PHE, including, as far as possible, COVID-19, Cholera, Ebola and Mpox, including donor appetite for supporting RCCE.
- Potential for the alignment of RCCE and AAP agendas and mechanisms
- How to strengthen the Data for Action approach, including the relevance and utility of indicators and means of verification.

Other topics for recommendations will emerge as Phases 2 and 3 of the evaluation proceed.

During Phase 3, a minimum of two validation workshops will be held, one fully virtual for region- and country-based stakeholders and a second hybrid workshop for HQ based stakeholders. The evaluation results will be presented and discussion held to engage stakeholders in the key issues raised by the evaluation, and to draw comments and stimulate discussion on the draft findings and recommendations of the evaluation. Based on past precedent, these workshops should generate considerable value by helping all participants to understand the basis for the evaluation findings, for the evaluation team to understand whether they are communicating them effectively, and for the participants to test the relevance and feasibility of the recommendations.

6.8. Guiding principles

Recognized standards and ethical considerations

The evaluation will be conducted in line with the [United Nations Evaluation Group \(UNEG\) Norms and Standards for Evaluation](#). It will also adhere to the [UNEG Ethical Guidelines for Evaluation](#), as well as the [UNEG Guidance on Human Rights and Gender Equality in Evaluation](#). As the evaluation will not be interacting with affected communities, the participatory approaches will be applied where possible to meetings with partners, for example local NGOs, and the principle of informed consent applied. Data validation involving HQ, RO and CO levels will be especially important to ensure voices from all levels are heard and that a measure of consensus can be achieved, as far as possible, on ways forward for the RCCE coordination and services.

Confidentiality and data protection

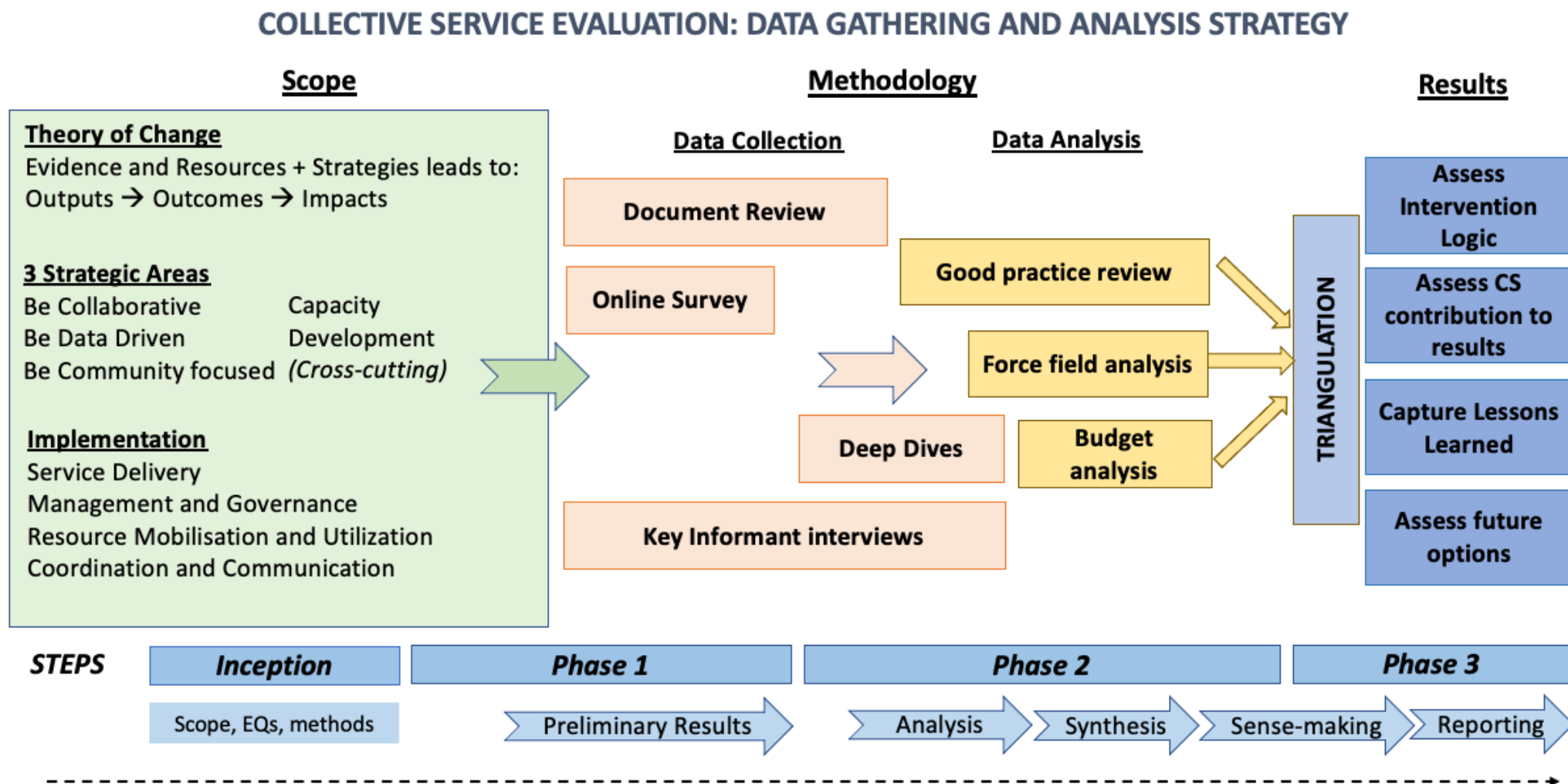
The evaluation team members are bound by confidentiality clauses in their contracts. The views and statements of individual key informants to the evaluation will be anonymized. Any quotes from interviews or from survey responses used in evaluation products will be unattributed. The evaluation team will assume all data and reports provided to the team can be used and quoted in the evaluation report, unless Collective Service partners specify elements that are restricted.

The evaluation team will ensure that any data provided by individuals is based on informed consent and is protected. Data will be stored on the UNICEF SharePoint until the end of the assignment, which is accessible to the evaluation team and designated members of the IFRC, UNICEF, and WHO evaluation offices.

6.9. Data gathering and analysis strategy

The overall data gathering and analysis strategy for the evaluation is captured in Figure 1 below.

Figure 1- Collective Service Evaluation: Data Gathering and Analysis Strategy.



7. Evaluation process

7.1. Management and governance arrangements

This section describes the management arrangements for the evaluation. It defines the roles and responsibilities of the Management Team, the Focal Points, and the Evaluation Team contracted to conduct the evaluation. It also explains the role of the Reference Group, which serves as a critical mechanism to improve communication and transparency during the evaluation process, and to promote its quality and the benefits and learning that come from it. Members of the Management Team, Focal Points and Reference Group are listed in [Annex E](#).

Management team

This evaluation is jointly managed by the IFRC Strategic Planning Department, the UNICEF Evaluation Office, and the WHO Evaluation Office. A Management Team has been formed, consisting of one staff member from each of these offices. The Evaluation Management Team will oversee the conduct of the evaluation, ensuring independence, impartiality and transparency throughout the process. An Evaluation Specialist in the UNICEF Evaluation Office acts as the lead Evaluation Manager and supervises the evaluation team.

The main responsibilities of the Management Team are:

- Coordinate and manage the Evaluation, serving as a nexus between the three core agencies of the Collective Service and the Independent Evaluation Team;
- Ensure that key stakeholders are kept informed throughout the evaluation process;
- Ensure that the Reference Group is formed, and that they can provide input and technical support through virtual or in-person meetings and feedback mechanisms;
- Gather comments on draft evaluation products from stakeholders and provide them to the evaluation team for their consideration and response;
- Monitor and assess the quality of key deliverables to ensure they meet quality standards;
- Provide the approval of deliverables, provided they comply with the agreed approach and required standards;
- Solicit input needed from critical stakeholders to prepare a management response to the evaluation;
- Disseminate the evaluation findings and products, in particular the final report.

Focal points

Focal Points have been designated to serve as key contacts for coordinating matters related to the implementation of this evaluation. Their role will be to provide access to information and key informants and support the coordination of the data collection. The Focal Points will be closely engaged during the evaluation process and their inputs and collaboration will be very valuable to ensure that the different perspectives of key stakeholders are duly considered and inform the process and related decisions.

In summary, the role of the Focal Points includes:

- Provide support to the Evaluation Team, including an orientation on the subject of the evaluation from the perspective of their organization;
- Facilitate the Evaluation Team's access to key informants, including at HQ, regional and country levels, as well access as to documentation and specific information needed to carry out the evaluation, and assist with coordinating data collection activities at large;
- Liaise with the Steering Committee Members of the Collective Service to ensure they are kept abreast of the progress of the evaluation.

Reference group

An Evaluation Reference Group will be established to support the management and the evaluation team in an advisory capacity. The Reference Group is typically composed of critical internal and external stakeholders knowledgeable about the subject to ensure that the evaluation receives credible advice, guidance, and transparency throughout the process. The Reference Group consists of key stakeholders of the Collective Service and other partners, in particular members of its Steering Committee, as well as staff members from the core members at regional level and external experts in RCCE and public health.

The responsibilities of the Evaluation Reference Group will be to:

- Offer views and insights on issues under discussion at key stages of the evaluation, especially in the inception phase where the methods, design, and data to be sought are to be determined;
- Review key deliverables produced, including the inception report, the emerging findings summary, and the final report, and provide feedback and technical input according to agreed timelines;
- Participate in meetings for presentation, validation and discussion of emerging findings.

All correspondence related to the evaluation and key deliverables should be directed to the Management Team, who will liaise with the Evaluation Team and coordinate the comments and review process.

The duration of this engagement will span the entire evaluation process, whereas the workload of each Reference Group member will be focused on and limited to a total time effort of approximately 2-3 days. The Reference Group will mainly communicate by email and meet for two or three (in-person or virtual) meetings, which are expected to be held at the inception stage; validation of preliminary findings, and to discuss final conclusions and recommendations.

Evaluation team

An Evaluation Team has been recruited to conduct the evaluation. It consists of three professionals with dedicated and complementing expertise for this evaluation (see biographies in [Annex F](#)).

The following are the main responsibilities of the Evaluation Team:

- Ensure the quality of data collected and the integrity of their analysis;
- Ensure that evidence gathered, both qualitative and quantitative, is comprehensive and robust enough to allow for an informed assessment in line with the evaluation's objectives, and in support of the conclusion and recommendations put forward by the evaluation;
- Manage all data collection (e.g., desk review of related documents, literature search, interview processes, focus group discussions, surveys, and workshops), as well as data analysis and reporting;
- Organize travel arrangements, accommodation, and equipment for the evaluation (in coordination with the Evaluation Management Team and the Focal Points).

In the inception and parallel Phase 1 of the evaluation, the evaluation team had to move rapidly to achieve tasks with frequent interaction and assignment of tasks on an as needs basis. For Phase 2 more detailed and deliberate planning is under way to assign themes and blocks of work to each team member.

Quality assurance and commenting process

Quality control protocols and processes established by the IFRC, UNICEF and WHO evaluation functions will be followed to ensure quality assurance and close management through all stages of the exercise.

The Evaluation Team will share draft deliverables first with the Management Team for quality assurance and address any immediate comments before the report is then circulated for comments to the Reference Group. The circulation and commenting process will be managed by the Management Team. A comment deadline will be agreed and specified to those wishing to comment. The evaluation team will provide a response to each

comment and the action taken (or not) to address them, in the comments table. Any comments received by the Evaluation Team after the agreed comment deadline will not be addressed.

Deliverables will only be approved when they are judged to be of sufficient quality by the Evaluation Management Team and if comments have been adequately addressed.

7.2. Timeline and phases

The evaluation timeframe is January to July 2023. The phasing of the evaluation has been organized as follows:

Inception phase

The inception phase included a 3-day inception mission to Geneva (a list of interviewees is available in [Annex A](#)). Key strategy documents, position papers, reviews and plans have been briefly reviewed. A summary of key informants concerns and expectations for the evaluation was developed ([Section 4](#)). A revised set of evaluation questions and an evaluation matrix were developed ([Section 5](#)). A revised and detailed workplan was drawn up (see below) and evaluation risks from the terms of reference revisited ([Section 7.5](#)). Data collection tools are currently under development.

This inception report forms the conclusion of this phase and was reviewed and commented on by the Reference Group of the Evaluation to inform its finalization.

Phase 1

Phase 1 will be based largely on stakeholder perceptions of the benefits and performance of the Collective Service, and future options, with the added value of summarizing inputs from HQ, regional, and country levels that are not currently available to any of the partners or the Collective Service Secretariat at HQ. Preliminary evaluation findings will be based on semi-structured key informant interviews at HQ, regional, and country levels (perhaps 20 in addition to the inception visit interviews), results of an online global survey, and on a partial document review.

In this way, early results can be made available to the Collective Service Steering Committee to feed into its strategy process. It is now agreed that the Steering Committee planning retreat which was to have been conducted in February will be delayed to early March to take advantage of the preliminary evaluation findings.

Phase 2

Phase 2 will include country and regional visits, further document review, data analysis, and testing of the evaluation findings and proposals in one or more workshops. Additional primary and secondary data will be collected, using instruments developed during Phase 1.

Phase 3

Phase 3 will include preparation of the draft final report, validation workshops, with the main findings, conclusions, recommendations, and lessons learned presented to the Reference Group, to test the findings and increase organizational understanding and ownership of the evaluation results. The final evaluation report will comprise not more than 40 pages (25,000 words), excluding the Executive Summary, plus annexes.

Figure 2 below presents the evaluation workplan, with phases, steps and key dates and deliverables.

Figure 2 - Evaluation Workplan

2023	Jan					Feb				Mar				Apr				May				Jun				Jul				
week beginning	2	9	16	23	30	6	13	20	27	6	13	20	27	3	10	17	24	1	8	15	22	29	5	12	19	26	3	10	17	24
Inception Phase																														
Kick off meeting for evaluation team via Teams	x																													
Inception visit Geneva		xxx																												
Draft Inception Report/Submit					x																									
Reference Group meeting 1 - present draft inception report									x																					
Comment period																														
Finalise inception report												x																		
Phase 1 Preliminary Data Collection and Results																														
Key informant interviews																														
Collect further contacts data																														
Select Phase 1 key informants interviews, approx 20							x																							
Draft and agree KII questions							x																							
KIIs Phase 1 (29 conducted)													x																	
Online survey																														
Design, translate, test							x	x	x																					
Launch date, Reminder date, Close date								x		x		x																		
First analysis and prelim report													x																	
Deep Dive mission preparation, discuss options, agree and fix dates									x																					
Preliminary Findings Report																														
Prepare and review with focal points													x																	
Present preliminary findings to Steering Committee													x																	
Phase 2 Further Data Collection and Analysis																														
Document review - verifying CS is in line with good practice, norms and standards in:																														
Capacity development																	x													
Health data collection and analysis																	x													
Preparedness/readiness for public health emergencies																	x													
Key informant interviews second round																														
Deep Dives																														
Deep dive 1 TBC - inc mission 1 - East and Southern Africa - Country 1 + Country 2 tbc approx 10 days																														
Deep dive 2 TBC - inc Mission 2 - WCA - Region+Country 1 - approx. 8 days																														
Write up deep-dive reports 1 and 2																														
Deep Dive 3 - Data for Action (remote)																														
Deep Dive 4 - RCCE in regions with limited or no supported from the Collective Service (remote)																														
Present Initial deep dive results to Reference Group meeting 2																														
Phase 3 - Sense-making, Reporting and Presentation																														
First draft evaluation report																														

7.3. Key deliverables and their use

The deliverables for this evaluation are:

Table 4 - Evaluation Deliverables

Evaluation Product		All dates 2023
Completed		
1	Draft inception report	January 20
2	Draft Inception report presentation to the Reference Group	March 3
3	Final inception report	March 20
4	Presentation of preliminary results to the Collective Service Steering Committee	March 6
Planned		
5	Preliminary feedback on deep dive results to the Reference Group	June 1
6	Draft evaluation report for sharing with stakeholders for comments	June 16
7	Stakeholder validation workshops	June 20
8	Presentation of evaluation results to the Reference Group	
9	Final evaluation report	July 28
10	Communication products (presentation and brief)	July 28

Other interim products include:

- Minutes of the Reference Group meetings
- Regular updates to the management team against the workplan by the team leader
- Copy of the anonymized data collected during the evaluation; and
- Presentation materials for the meetings with the Reference Group.

7.4. Utilization and Dissemination of the Evaluation

The findings and recommendations from the external evaluation will be used to further shape the future of the Collective Service through high-level engagements with key partners in public health and humanitarian fields. The anticipated **primary users** of the evaluation will be the managements of IFRC, UNICEF, WHO and GOARN, in particular, the Collective Service Steering Committee and the Collective Service Secretariat.

Each Collective Service partner is foreseen to generate a **management response** to the evaluation, setting out the actions to be taken in response to the evaluation recommendations (the management response will be made publicly available along with the evaluation report, in line with UNEG standards).

The evaluation and its summary will be disseminated widely with all Collective Service organizations and RCCE stakeholders including:

- Over 50 organizations involved in RCCE coordination mechanisms worldwide that participated in re-sourcing this service and using its products and organizations.
- Regional interagency teams established in West and Central Africa, Southern and Eastern Africa, and other regions where interagency teams have not yet been established
- Country-level RCCE stakeholders such as governments, international and national non-governmental organizations, and other partners.

7.5. Risk management

Evaluation risks and mitigation measures are presented in the table below.

Table 5 - Risks and Mitigations

Risk	Risk Mitigation Measure
Lack of reliable or informed sources or key informants given	Seek additional key informants including those not yet engaged with the CS to understand other coordination models and possible future formulations of the CS.
Timeframe of the evaluation means the evaluation comes too late for CS decision making on future strategies, priorities and ways of working	The evaluation has phased, with Phase 1 focused on providing early evaluation results to inform the Steering Committee's strategy process.
Multiple log frames, theories of change (ToCs), and models arising from the need to put in place an agile management approach to the Collective Service	The evaluation will develop good practice reviews and interrogate the relevance of the existing CS TOC/frame-works.
Expectations of the evaluation will not be met: The evaluation cannot substitute for the more difficult discussions between CS partners will inevitably arise as they resolve the future of the CS where their organizational agendas for RCCE do not overlap, or where competitive pressures undermine their partnership working.	The CS partners make it explicit from the outset that the evaluation will attempt to capture and explain the challenges the partners experience in their RCCE partnership, and that others experience from the CS, but the evaluation cannot resolve them.
Expectations of the evaluation will not be met CS: CS partners want the evaluation to consider if there are alternative models of interagency partnership, joint projects, or networks from which the CS can learn, whether formal or informal structures, including how they are governed, managed and funded.	A comprehensive analysis of possible models for RCCE is beyond the evaluation scope. With the agreement of the management team, the evaluation team will need to select a sample of coordination mechanisms to investigate during Phase 2.
Challenges with availability of data and its quality	This risk may already have been realized in that the evaluation team was informed that data has not been gathered or reported against the CS service performance indicators. Feedback gathered from key informant interviews, the online survey and field missions will partially substitute.
The short timeframe for the exercise	It is important that work does not get held up at the boundaries between Inception-Phase 1 and Phase 1-Phase 2 and that the evaluation team can continue while the inception report and preliminary findings are discussed and commented on.

Annexes

Annex A: Inception phase interviewees

Position	Organization
Chief Executive Officer	CDAC Network
Head of Policy	CDAC Network
Co-Chair, IASC Results Group 2 on AAP	CHS Alliance
Global Coordinator, Collective Service Secretariat	Collective Service
Collective Service Fundraising and Advocacy Consultant	Collective Service
Coordinator, Risk Communication Collective Service Eastern and Southern Africa Region	Collective Service
Former Global Coordinator	Collective Service
Collective Service Information Management lead	Collective Service
Acting Team Manager	GOARN
Manager, Community Engagement	IFRC
Head of Strategic Planning	IFRC
Senior Officer, Community Engagement; Former CS Global Coordinator	IFRC
Director, Health and Care	IFRC
Coordinator of the IASC Results Group 2 on AAP	Interagency
Senior Advisor, Community Engagement and Accountability	UNICEF
Social Science and Research lead, Collective Service Secretariat	UNICEF
Social Behaviour Change/ RCCE Coordinator, West Africa	UNICEF
SBC Specialist, UNICEF focal point	UNICEF
Director (a.i.), Public Health Emergencies UNICEF	UNICEF
Collective Service Helpdesk Coordinator	UNICEF
Global Lead, Social and Behavior Change	UNICEF
Senior Evaluation Officer	WHO
Technical Officer, Global Health Cluster	WHO
Technical Officer, WHO focal point	WHO
Coordinator, Global Health Cluster	WHO
Communications Adviser, Infodemics	WHO
Director, Country Readiness Strengthening, WHO Health Emergencies Programme (WHE)	WHO
Director, Pandemic and Epidemic Diseases	WHO
Chief Strategy and Impact Officer	WHO Foundation

Annex B: Theory of Change

IF WE USE EVIDENCE AND RESOURCES	Evidence Base: Multiple workstreams - social monitoring/listening, polling, community feedback loops - standardized framework and analysis Human Resources: Plans to scale up coordination, social science and community engagement capacity at Global and Regional Levels - phased approach Strategic Partnerships: Strategic cooperation with leading experts - Fondazione Bruno Kessler, Ryerson University, Media Measurement, HUB Financing: Initial financing for proof of concept from BMGF, work ongoing to expand donor base and develop investment case				
AND IMPLEMENT THESE STRATEGIES	STRATEGIES/ ACTIVITIES	1. COORDINATION AND ALIGNMENT Global and regional staff recruited and in post Global strategy revised to include wider humanitarian sector goals Workplans coordinated and strengthened Needs assessment completed Package of tools available Surge mechanism identified Coordination mechanisms and sub-groups established	2. INNOVATION AND IMPROVED SCIENCE Data collection tools and guidelines for operational research developed Best practices for data handling and analysis established for operational action Global dashboard developed Integrated analysis and meta synthesis of data sets produced Social research agenda defined Support provided to priority regions and countries to establish data hubs	3. AMPLIFICATION AND COMMUNITY PARTNERSHIP Weekly RCCE updates produced Orientation of senior leadership within organizations Define RCCE in policies, structures and procedures Engage networks and sectors with tools and products with appropriate contextualized messaging Promote engagement and local contextualization	4. CAPACITY BUILDING Consolidate available guidance on CE and protective behaviours Pillar guidance regularly revised to ensure research considerations and community insights are taken into consideration Tools guidance developed based on assessment of needs requests from country regions Oversee coordinated capacity building w regions and priority countries Joint emodules and learning tools developed
THEN THIS WILL HAPPEN	OUTPUTS	Joint strategies and workplans, improved synergies and a more formal, coordinated, inclusive and predictable service	Real-time social sciences analysis, strengthened community feedback. Effective management of infodemic and misinformation	Responsive leadership, improved decision making, amplification of messaging and approaches	Guidance and tools: Improved quality of participatory RCCE through guidance, minimum standards, tools
TO ACHIEVE THESE OUTCOMES	OUTCOMES	More consistent, systematic and predictable support to partners at Global and Regional levels involved in the public health, humanitarian and development responses to the COVID-19 pandemic (and beyond).			
		1. Strengthened common coordinated approaches	2. Improved quality and shift of focus - Availability of an evidence base for operations	3. Enhanced adaptation and amplification of strategies - Better use of evidence for decision making	4. Strengthened capacities for improved local response
THAT CONTRIBUTE TO THE CS VISION	RCCE systems strengthening	Quality and the consistency of RCCE approaches will be improved at country level			
		1. Active and effective coordination mechanism	2. Evidence-based national RCCE plan	3. Enhanced institutional accountability in decision-making	4. Strengthened local capacity to improve local response
	population impact	People and communities are informed on the risks believe in recommended measures take protective actions and are able to influence the response participates and owns preventive and response measures to enhance people's knowledge, motivate action, promote and create an enabling environment for change People-centred and community-led approaches championed widely resulting in increased trust and social cohesion and ultimately a reduction in the negative impacts of COVID-19			

Annex C: Collective Service indicators

Outcome/Output	Indicators
Outcome 1: Strengthened collaborative RCCE approaches to increase quality, harmonisation, optimisation, and integration of RCCE	# of countries where an RCCE coordination mechanism and RCCE national plan is active and formally implemented
Output 1.1: Common strategy and work plan: Improved planning & expanded coordination platform delivering on a comprehensive RCCE strategy	RCCE strategy and work plan, adopted by all partners, with specifics on roles & responsibilities and approaches to respond to health/humanitarian crises in different contexts RCCE plan fully reflected in global appeals Global Workplan prepared and approved by the 3 RCCE partners linked to health and emergency response operations at global, regional, and national levels # steering group meetings held between 3 partners at global level RCCE collective indicator/s in revised response plans (HRP/SRP)
Output 1.2: Coordinated approaches	# partners involved in RCCE coordination and sub-working groups % of global partners who report through a survey that coordination is useful and has impact on collective outputs Pillars/clusters have RCCE elements integrated into their work plans
Outcome 2: Availability of evidence to systematically inform policy and programming and improve effectiveness and efficiency	Regular compilation of operational social research findings and community feedback and perceptions are converted into recommendations and made available to inform decision-makers across pillars
Output 2.1: Structures, knowledge, tools, and processes are made available for regional and country-level collection and analysis of social evidence (including community feedback)	A coordinated, open platform (linked to the knowledge management hub) with assets for operational social research and available partners to support regional and national capacity to collect, analyse and use social evidence
Output 2.2: Shared understanding of current risks, barriers, and perceptions	Social data regularly informs strategic approaches across regions
Outcome 3: Improved quality and consistency of risk communication and community engagement approaches	Regular compilation of operational social science findings, community feedback and perceptions are converted and made available to inform decision makers across COVID19 response pillars
Output 3.1: Responsive Leadership: Decision-makers in the regions and in selected countries better understand the importance and know how to use and respond to community feedback	% of GOARN and IASC senior leadership meetings with RCCE considerations and recommendations on the agenda RCCE is situated in the strategies and long-term staffing structures within each organization RCCE collective service mechanism endorsed by IASC and GOARN
Output 3.2: Community engagement standards of practice applied and amplified through coordination and partnerships	Under consideration
Outcome 4: Reinforced national capacities for improved local solutions	% of global partners who report that they: a) know where to find guidance; b) take their own decisions based on guidance; c) are satisfied with technical support.
Output 4.1: Guidance and tools: Improved quality of participatory RCCE through guidance, minimum standards, tools	# of guidance and tools that are consolidated and shared for regional and local adaptation # of guidance and tools from other response pillars/topics that contain RCCE-specific considerations
Output 4.2: Technical support: Coordinated capacity building, timely advice, dedicated services, and technical support for specific needs	# of helpdesk users supported for rapid queries (estimated resolution time two days) # of helpdesk users supported for in-depth queries (estimated resolution time one week) % of users who found the helpdesk useful and satisfactory (through the feedback survey) # of Collective Service partners engaged with the Collective Helpdesk

Annex D: Information management at the Collective Service

The Collective Service includes an Information Management (IM) Service supporting 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 tasked to provide technical guidance, design and implementation support, and training to strengthen existing information systems or develop responsive solutions for RCCE partners at regional or country levels. The Collective Service - IM team works with direct support from global and regional teams, and outsourced technical support with service providers or IM stand-by partnerships. The key resources produced in this theme are data for action and the RCCE dashboard.

Data for Action: The RCCE-Collective Service database is reported to be a first-of-its-kind repository of social and behavioral data on COVID-19, covering 198 countries and consisting of over 250,000 data points from 411 different data sources. The database, and the dashboard that visualizes this data, is an initiative borne out of the Collective Service commitment to provide critical social and behavioral information to partners working to end the COVID-19 pandemic. Insights drawn from the dashboard and the database have come to influence how partners design interventions, make investment decisions, and incorporate RCCE into broader public health programming.

Social Behaviour Dashboard on Public Health Emergency: The dashboard is an open access website developed by the Collective Service and is currently hosted on its official website (<https://www.rcce-collective.net/>). The four are the objectives of the dashboard are:

1. Gathering existing and validated social and behavioural data from a large spectrum of data sources.
2. Exploring social and behavioural trends across six dimensions and 35 indicators (see COVID-19 behaviour change framework). <https://www.rcce-collective.net/data/social-behavioural-data/>
3. Tracking socio-behavioural changes over time and by country.
4. Showing indicators disaggregated for example by gender, age and specific population groups, if data is available (e.g., migrants, health workers, etc.).

Data can be obtained at global, regional and country level for a specific period or 12-month trend. Data is rigorously evaluated for inclusion in the database and classified according to how well it matches the COVID-19 Behavioral Change Framework. It includes a comprehensive set of 35 RCCE core indicators, along with six dimensions for each indicator, characterize quantitative data concerning perceptions, knowledge and practices, and social and structural factors that influence health behavior in the context of the COVID-19 pandemic and other diseases.

The products displayed in the dashboard are aimed at helping monitor social behaviour change on public health emergencies, currently for diseases such as Covid-19, Ebola, Cholera, and Monkeypox, from compilation and summarizing data from research, fieldwork or opinion polls carried out by humanitarian partners, academic and scientist communities. The dashboard provides access to contextual (epidemiologic) indicators and Social Behavioural indicators from the six UN regions and countries. For covid-19, there is also a global map for one covid-19 morbidity indicator. (<https://dashboard.collective-service.net/>)

RCCE-Collective Service Helpdesk: This is a Collective Service technical service available for any user from the regional or country level. The Collective Service website shows options for the helpdesk (<https://www.rcce-collective.net/collective-helpdesk/>). The Collective Service Helpdesk supports users worldwide to submit enquiries and requests for technical advice and to gain access to Collective Service technical expertise, resources, data, and knowledge bases. There is a knowledge base of technical resources from country experiences.

RCCE-Collective Service Newsletter: The biweekly newsletter provides updates on RCCE experiences, events and relevant studies from the whole world.

Annex E: Management Team, Focal Points and Reference Group Members

Management Team

Name	Role/Affiliation	Organization
Miki Tsukamoto	Coordinator, Monitoring and Evaluation, Strategic Planning Department	IFRC
Simon Bettighofer	Evaluation Specialist, Evaluation Office (Lead Evaluation Manager)	UNICEF
Anand Sivasankara Kurup	Senior Evaluation Officer, Evaluation Office	WHO

Focal Points

Name	Role/Affiliation	Organization
Diane Le Corvec	Global Coordinator	Collective Service
Ombretta Baggio (until March 2023)	Senior Advisor, Community Engagement and Accountability	IFRC
Alexandra Sicotte-Levesque (from April 2023)	Team Lead, Community Engagement/Accountability Unit	IFRC
Humberto Jaime (until March 2023)	Social and Behavior Change, Risk Communication Specialist	UNICEF
Charles Antoine Hofmann (from April 2023)	Senior Adviser, Accountability & Community Engagement	UNICEF
João Rangel de Almeida	Technical Officer	WHO

Reference Group

Name	Role/Affiliation	Organization
Eva Niederberger	Senior Research Associate - Emergencies (Global Health), former Collective Service	Anthrologica
Muhammad Shafique	RCCE Inter-agency regional advisor	Collective Service
Rachel James	RCCE Inter-agency coordinator	Collective Service
Armand Bejtullahu	Coordinator (a.i.),	GOARN
Petra Khoury	Director, Health and Care	IFRC
Sophie Everest	Community Engagement and Accountability Senior Adviser, Africa Region	IFRC
Viviane Fluck	Coordinator Community Engagement and Accountability, Asia Pacific	IFRC
Carlos Van der Laat	Programme Officer, Migrants, Refugees, host communities and other vulnerable groups	IOM
Kathryn Bertram	Senior Programme Officer, Risk Communication and Community Engagement	Johns Hopkins Center
Veronique Durrux	Coordinator	OCHA
Oliver Lough	Senior Research Fellow	ODI
Rocio Lopez Inigo	CEA expert	Rooted in Trust Internews
Charles Antoine Hofmann	Senior Adviser, Accountability & Community Engagement	UNICEF
Jerome Pfaffmann	Director (a.i.), Public Health Emergencies	UNICEF
Naureen Naqvi	Social & Behavior Change Specialist,	UNICEF
Nedret Emiroglu	Director, Country Readiness Strengthening Department, WHO Health Emergencies Programme (WHE)	WHO
Thomas Moran	Risk Communication and Community Engagement Advisor	WHO

Annex F: Biographies of the Evaluation Team

Simon Lawry-White, Team Leader

Simon Lawry-White has 40 years' international experience in project, team and senior management in development and humanitarian programmes, policy and strategy development, and process redesign. He is an expert in organizational performance and evaluation, and manager and leader of more than 50 organizational management reviews and humanitarian and development evaluations, including of multi-agency partnerships.

Simon is a former senior evaluation officer in UNICEF and has conducted several consultancy assignments for UNICEF (including on how to integrate humanitarian programming, and on linking humanitarian and development programming) and for the IFRC (including the Mid Term Review of the Federation's corporate 'Strategy 2020'). He has worked in short and long-term assignments in more than 50 countries in Asia, Africa, Europe, Middle East and Latin America. Programme experience includes water supplies for refugees in Thailand, soil and water conservation in semi-arid Kenya, and humanitarian coordination of the international flood response in Punjab, Pakistan (2010).

Past consultancy clients include the governments of Germany, Netherlands, and the UK; multilaterals (FAO, IDRC, IFRC, IOM, UNDP, UNICEF, UNHCR, WFP, World Bank), and INGOs (ActionAid, Christian Aid, Disasters Emergency Committee, Danish Refugee Council, Oxfam, Tearfund, World Vision). His qualifications include a Master of Arts, Master of Science, and a Master of Business Administration.

Magdalena Isaurralde, Social Sciences Specialist

Magdalena Isaurralde is a socio-economist cumulating 15 years of professional experience in qualitative and quantitative research, social protection, poverty analysis, and social and behavioural change. She has a PhD in Development Studies, focusing on the role of community participation in accessing services.

In her previous professional experiences, Magdalena worked closely with IFRC and UNICEF to strengthen the RCCE coordination mechanisms at the regional level during COVID-19 and Ebola outbreak in 2021. She gained this experience first as a social science specialist seconded to UNICEF West and Central Africa Region, and then as a team leader for the coordination of a multi-country research project on community engagement and accountability for the Federation. Through this experience, she gained a thorough understanding of how agencies work in the field of community engagement and the challenges faced by RCCE interventions at national, regional and global level.

Magdalena has extensive experience working as an independent consultant in social policy, evaluation, and research. As a development practitioner, she supported the implementation of several social protection programmes (Child sensitive interventions in Niger, school feeding and Valor Criança cash transfer programmes in Angola). She also conducted various evaluations for cash transfer and shock responsive social protection in Mozambique, The Gambia, Central Africa, Mauritania, Burundi, Democratic Republic of Congo and Angola. Magdalena speaks French, Spanish, English, and Portuguese.

Juan A. Seclen, Public Health Specialist

Juan A. Seclen, M.D. is a physician, global public health, and monitoring and evaluation specialist with more than 25 years of global, national, and sub-national experience.

Juan worked for UN entities and consulted several global non-profit organizations in Africa sub-Saharan, Latin America, and the United States. His technical experience includes health evaluation, infectious diseases prevention and control (Covid-19, HIV, TB, Malaria), and Health Systems Strengthening targeting public health systems from developing countries.

In his role as a health researcher, he has published numerous articles and technical documents related to health programme evaluation. Juan is a fluent speaker of English, Portuguese, and Spanish, and has a working knowledge of French.

Annex G: Terms of Reference

The full terms of reference for the evaluation can be accessed here: [Terms of Reference](#)