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

Annexes

A COLLABORATIVE PARTNERSHIP BETWEEN IFRC, UNICEF AND WHO

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IFRC Strategic Planning Department
UNICEF Evaluation Office
WHO Evaluation Office

November 2023

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Table of Contents

Annex A: Evaluation Matrix _____ 1

Annex B: Bibliography _____ 3

Annex C: Interviews _____ 5

Annex D: Collective Service Theory of Change _____ 10

Annex E: Collective Service Indicators _____ 11

Annex F: Collective Service Guidance, Tools and Reports _____ 12

Annex G: Elements of Coordinated RCCE as Implemented by the Collective Service at National Level _____ 13

Annex H: Evaluation Principles, Management and Governance _____ 15

Annex I: Biographies of the Evaluation Team _____ 17

Annex J: Online Survey Report _____ 18

Annex K: Evaluation Risks, Mitigation and Limitations _____ 29

Annex L: Terms of Reference _____ 30

Annex A: Evaluation Matrix

		Means of verification			
		Doc. Review	*Inter-views*	*Online Survey*	*Case Studies*
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 subnational 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?		✓		✓
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 responses been?		✓	✓	✓

		Means of verification			
		Doc. Review	*Inter-views*	*Online Survey*	*Case Studies*
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?	✓	✓	✓	✓
EQ5.3	To what extent have previous studies, research, and other evaluations relevant to RCCE been assessed to inform the Collective Service's work?	✓	✓	✓	✓

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Annex C: Interviews

The following lists provide anonymised information on the interviewees of this evaluation. A sample interview protocol is also provided below.

Position	Organization	Gender
Senior Research Associate – Emergencies (Global Health)	Anthrologica	F
Deputy Director	Bill and Melinda Gates Foundation	F
Chief Executive Officer	CDAC Network	F
Head of Policy	CDAC Network	F
Co-Chair, IASC Results Group 2 on AAP	CHS Alliance	F
Global Coordinator, Collective Service Secretariat	Collective Service	F
Fundraising and Advocacy Consultant	Collective Service	F
Coordinator, RCCE ESAR	Collective Service	F
Former CS Global Coordinator	Collective Service	F
Information Management Lead	Collective Service	M
Consultant, RCCE, based in Burkina Faso	Collective Service	M
Consultant, RCCE, based in Guinea	Collective Service	M
Acting Team Manager	GOARN	M
IASC Head of Secretariat	IASC Secretariat	F
Technical Officer, CEA	ICRC	F
Community Health Senior Officer	IFRC	F
RCCE Inter-agency Regional Adviser	IFRC	F
CEA Coordinator	IFRC	F
Senior Officer, Community Engagement, Former CS Global Coordinator	IFRC	F
Manager, Community Engagement	IFRC	F
Former IFRC CEA Regional Manager	IFRC	F
Head of Strategic Planning and Evaluation	IFRC	M
RCCE Inter-agency Regional Adviser	IFRC	F
Director Health and Care	IFRC	F
CEA delegate, Country Cluster Delegation: Democratic Republic of the Congo, Rwanda, Burundi, Republic of the Congo	IFRC	F
Former IFRC CEA Regional Manager	Interagency	F
Coordinator of the IASC Results Group 2 on AAP	Interagency	M
CEA expert, Rooted in Trust	Internews	F
Programme Officer, Migrants, Refugees, Host Communities, Vulnerable Groups	IOM	M
Researcher	IRD	M
Researcher	IRD	M
Risk Communication and Community Engagement	John Hopkins	F
AAP Adviser	OCHA	F
Director, Health Policy and Communications	Rockefeller Found.	F
Migrants, Refugees, Host Communities and Other Vulnerable Subgroup	UNHCR	F

Position	Organization	Gender
M&E Specialist, Social and Behaviour Change	UNICEF	M
Former Chair of the steering group	UNICEF	M
Social and Behaviour Change Specialist	UNICEF	M
Former UNICEF Regional SBC Chief	UNICEF	M
Senior Adviser, Community Engagement and Accountability	UNICEF	M
Consultant, RCCE, deployed in Democratic Republic of the Congo	UNICEF	M
Social Science and Research Lead, CS Secretariat	UNICEF	F
Social and Behaviour Change/Coordinator RCCE TWG, West Africa	UNICEF	F
Social and Behaviour Change Specialist, UNICEF focal point	UNICEF	M
Director (a.i.), Public Health Emergencies	UNICEF	M
Collective Helpdesk Coordinator	UNICEF	F
Integrated Outbreak Analytics (under GOARN)	UNICEF	F
Global Lead, Social and Behaviour Change	UNICEF	M
Ebola Virus Disease working group	UNICEF	F
Regional Social and Behaviour Change Adviser for Latin America	UNICEF	F
Regional Communications Consultant	UNICEF	F
Social and Behaviour Change Specialist, UNICEF Central Africa	UNICEF	F
Acting Unit Head, Community Readiness and Resilience Unit	WHO	M
Risk Communication and Community Engagement Adviser	WHO	M
Head of Unit, Global Infectious Hazard Preparedness Department	WHO	M
Technical officer, RCCE ESAR WHO (hub level)	WHO	F
Senior Evaluation Officer	WHO	M
Technical Officer, Global Health Cluster	WHO	F
Technical Officer, WHO focal point	WHO	M
Communications Adviser, Infodemics	WHO	F
Director, Country Readiness Strengthening Department, WHE	WHO	F
Director, Pandemic and Epidemic Diseases, WHE	WHO	M
Chief Strategy and Impact Officer (former Steering Committee member)	WHO Foundation	M
Coordinator, Global Health Cluster	WHO/GHC	F
Former Manager, GOARN	WHO/GOARN	F

Uganda country visit

Position	Organization	Gender
Programme Officer	IOM	M
Project Officer	IOM	F
Programme Director	LWF	M
Project Manager	LWF	F
Acting Commissioner, Health Services	Ministry of Health	M
Assistant Commissioner, Health Services	Ministry of Health	M
Commissioner, Department of Community Health Services	Ministry of Health	M

Position	Organization	Gender
Director Health and Social Services	Red Cross Society	F
Chief Child Survival and Development	UNICEF	F
Community Health Consultant	UNICEF	F
Consultant	UNICEF	F
Deputy Representative Programme	UNICEF	F
Health Systems Strengthening Specialist	UNICEF	M
Health Systems Strengthening Specialist	UNICEF	M
Monitoring and Evaluation Specialist	UNICEF	M
OIC Chief SBC	UNICEF	F
Programme Officer	UNICEF	M
SBC Data Analyst	UNICEF	M
SBC Specialist	UNICEF	M
UNICEF Officer Community Health	UNICEF	F
Senior Adviser Monitoring, Evaluation and Learning	USAID / John Hopkins	F
Health Promotion Adviser, WHO	WHO	M

Acronyms and abbreviations:

AAP	accountability to affected populations
CDAC	communicating with disaster-affected communities
CEA	community engagement and accountability
CHS	Core Humanitarian Standard [Network]
Coll.	Collective, CS = Collective Service
ESAR	East and Southern Africa Region
F	female
GHC	Global Health Cluster
GOARN	Global Outbreak Alert and Response Network
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
IRD	Institut de Recherhe pour le Développement
LWF	Lutheran World Federation
M	male
OCHA	Office for the Coordination of Humanitarian Affairs
OIC	Officer in Charge
RCCE	risk communication and community engagement
SBC	social and behaviour change
TWG	Technical Working Group
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WHE	WHO Health Emergencies Programme
WHO	World Health Organization

Sample Interview Protocol

For country level (modified versions were used for regional and global/HQ level interviews)

Brief introduction

- Hello, thank you for sparing me time for this interview, etc…
- My name is ... I am a member of the independent evaluation team evaluating the Collective Service for Risk Communication and Community Engagement, also known as RCCE.
- As part of the evaluation, we are conducting interviews to try to assess how much difference the support from the Collective Service has made to the COVID-19 response in countries and regions since it started in 2020, and to learn lessons for the future of interagency risk communication and community engagement.
- This interview is confidential. If we use anything you say in our reports, it will be anonymous.
- The interview is for 45–60 minutes. Is that OK?
- Do you have any questions before we get started?
  Informants not from IFRC-WHO-UNICEF may need explanation.

QUESTIONS

1. **What is your current role and location?** How long have you been in post?

2. **Were you involved in your organization's COVID-19 response?** If so, how?

3. **Was your organization involved in communicating the risks of COVID-19 and how to minimize the risks of infection, how to seek medical care?** Has your organization implemented infection prevention and control? If yes, what did your organization do? How effective was this in your view? What enabled and limited success?

4. **Was your organization involved in engaging communities in how to manage the risks of COVID-19 and how to support those affected?** If yes, what did your organization do? How effective was this? What enabled and limited success?
   (If necessary, explain here that community engagement means outreach and sensitization through meetings, community talks, radio, social networks, and so on).

5. **How did your organization coordinate its own COVID-19 response?** For example, between HQ and regions, or between countries? How well did this work?

6. **Was your organization involved in coordinating its COVID-19 response with other organizations?** If yes, how was this organized? Was there a committee for risk communication and community engagement, with organizational focal points?
   - Which organizations were involved? (Check for engagement of NGOs, government, health workers, UN agencies, Red Cross/Red Crescent, local authorities)
   - Were there regular meetings? If so, how many attended? Who was leading?
   - How successful was this coordination?

7. **Did the government and/or partners prepare an operational strategy for responding to COVID-19**? Did this include risk communication and community engagement? Was there an operational plan for a vaccine campaign?

8. **Has your organization evaluated or reviewed its response to COVID-19?**
   If yes, which exercises were undertaken and what did the organization learn about:
   - Particular contributions made by your organization to the COVID-19 response?
   - How to communicate the risks of disease outbreaks, avoiding infection, seeking treatment?
   - How to engage, listen to and feed back to communities?
   - How to build the capacity of local actors?

9. **In your context, how could national and local preparedness for public health emergencies be improved?**

10. **In your context, how could national or local coordination for risk communication and community engagement be improved for the next public health emergency?**
    Where are the capacity gaps in government, local authorities, medical authorities, local or international agencies?

11. **Did you ask for, or receive, technical advice on risk communication or community engagement during the COVID-19 response?**
    If yes, from where and in what form? (from local, regional, HQ levels, from your own organization or others?)

12. **Did you use any of the following terms in the COVID-19 response, either within your organization or in coordinating with other organizations?**
    - Risk Communication and Community Engagement
    - Community Engagement and Accountability
    - Social Behaviour Change
    - Accountability to Affected Populations

    If yes, how clearly understood was the term by you, and in general by others?

13. **Do you know the name Collective Service?**
    (If relevant, ask if the Collective Service known by a different name such as Regional or Global Risk Communication and Community Engagement support?)
    How clear are you about what the Collective Service is for, and what it does?

14. **Have you or your team engaged with the Collective Service?**
    If yes, have you or your team been involved in any of the following:
    - Coordination meetings or webinars? If yes, what difference did this make, if any?
    - Technical guidance – did you or your team consult the guidance materials provided by the Collective Service? If yes, what difference did this make, if any?
    - Technical support, in person or via webinars? If yes, what difference did this make, if any?
    - Data management – have you sent data to, or received data from, the Collective Service? Have you used the data provided on the Collective Service website? If yes, what difference did this make, if any?
    - Any of the following technical training? 1) RCCE, 2) Community Feedback; 3) Social Science, 4) Monitoring and Evaluation

15. **Did you also participate in other regional coordination bodies (Africa CDC, Operational Research Group - GRO)**

16. **What were the most and least useful of the services/products from the Collective Service?**

17. **To what extent will any positive results achieved with the Collective Service be sustained into the future?**

18. **Is there anything else you would like us to know about?**

Annex D: Collective Service Theory of Change

<table>
<tr><td>IF WE USE EVIDENCE AND RESOURCES</td><td colspan="5">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
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</td></tr>
<tr><td rowspan="2">AND IMPLEMENT THESE STRATEGIES</td><td>STRATEGIES / ACTIVITES</td><td>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 asssement completed Package of tools available

Surge mechanism identified Coordination mechanisms and sub-groups established</td><td>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</td><td>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</td><td>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</td></tr>
<tr><td>THEN THIS WILL HAPPEN</td><td>OUTPUTS</td><td>Joint strategies and workplans, improved synergies and a more formal, coordinated, inclusive and predictable service</td><td>Real-time social sciences analysis, strengthened community feedback. Effective management of infodemic and misinformation</td><td>Responsive leadership, improved decision making, amplification of messaging and approaches</td><td>Guidance and tools: Improved quality of participatory RCCE through guidance, minimum standards, tools</td></tr>
<tr><td rowspan="2">TO ACHIEVE THESE OUTCOMES</td><td rowspan="2">OUTCOMES</td><td colspan="4">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).</td></tr>
<tr><td>1. Strengthened common coordinated approaches</td><td>2. Improved quality and shift of focus - Availability of an evidence base for operations</td><td>3, Enhanced adaptation and amplification of strategies - Better use of evidence for decision making</td><td>4. Strengthened capacities for improved local response</td></tr>
<tr><td rowspan="4">THAT CONTRIBUTE TO THE CS VISION</td><td rowspan="2">RCCE systems strenghtening</td><td colspan="4">Quality and the consistency of RCCE approaches will be improved at country level</td></tr>
<tr><td>1. Active and effective coordination mechanism</td><td>2. Evidence-based national RCCE plan</td><td>3. Enhanced institutional accountability in decision-making</td><td>4. Strengthened local capacity to improve local response</td></tr>
<tr><td rowspan="2">population impact</td><td>People and communitie are informed on the risks</td><td>believe in recommended measures</td><td>take protective actions and are able to influence the response</td><td>participates and owns preventive and response measures to enhance people's knowledge, motivate action, promote and create an enabling environment for change</td></tr>
<tr><td colspan="4">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</td></tr>
</table>

Annex E: 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 and 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 the 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 COVID-19 response pillars
Output 3.1: Responsive leadership: decision-makers in the regions and in selected countries better understand the importance of, and know how to use and respond to, community feedback	Percentage 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	Percentage 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	Number of guidance and tools that are consolidated and shared for regional and local adaptation
	Number 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	Number of helpdesk users supported for rapid queries (estimated resolution time two days)
	Number of helpdesk users supported for in-depth queries (estimated resolution time one week)
	Percentage of users who found the helpdesk useful and satisfactory (through the feedback survey)
	Number of Collective Service partners engaged with the Collective Helpdesk

Annex F: Collective Service Guidance, Tools and Reports

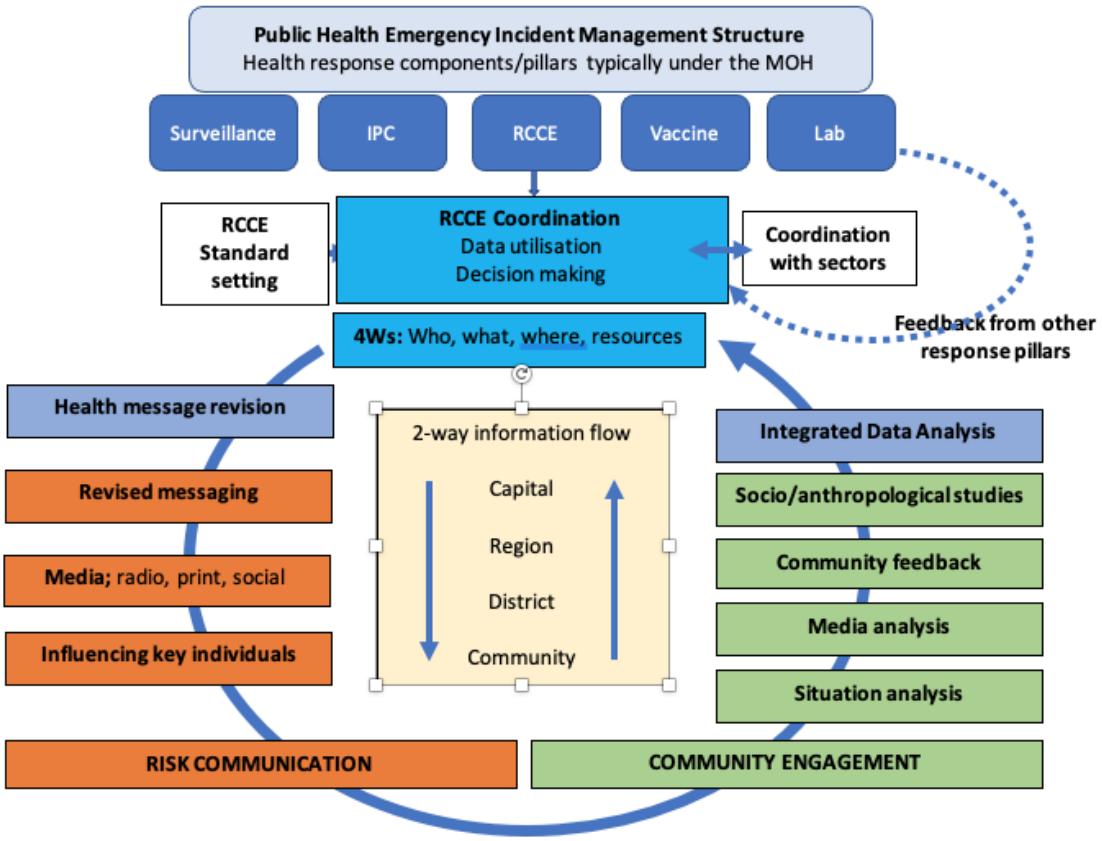
Source/Type of Document	Description
Collective Service	
Guideline	Operational Guidance Insights Drawn from Good Practices on Youth Engagement and Leadership in COVID-19 Response
Synthesis	Approaches to Scaling Up COVID-19 Vaccination: Experiences from Malawi, Kenya, and Uganda
Briefing	Social, Behavioural And Community Dynamics Related To The Cholera Outbreak In Malawi
Handbook	Data Handbook for Risk Communication and Community Engagement (RCCE)
Guideline	Risk Communication and Community Engagement Indicator Guidance for COVID-19
Briefing	Data for Action RCCE for COVID-19 Vaccine Demand in East and Southern Africa
Guideline	How to Use Social Science Evidence to Respond to Emergencies
Tool	RCCE Question Bank on Core Indicators
Guideline	COVID-19 Behaviour Change Framework
Tool	Cholera Question Bank
Strategy	Collective Service Strategy: Interim guidance for COVID-19 response, December 2020
Guidance	COVID-19 Behaviour Change Framework
Products from Subgroups	
Youth and Children	
Operational guidance	Good Practice Case Studies on Youth Engagement and Leadership in COVID-19 Response
Guideline	With Us & For Us: Working with and for young people in humanitarian and protracted crises (IASC)
Guideline	Operational Guidance on Youth Engagement and Leadership
Guideline	Engaging Adolescents and Youth in the COVID-19 Response (UNICEF)
Technical brief	Technical Brief: Invisible But Not Forgotten: RCCE with young people left behind during COVID-19 (UNFPA)
Briefing	Surveys and Assessments on Young People and COVID-19
Paper	COVID-19 Vaccines for Children and Adolescents in Africa: Aligning our priorities to situational realities
Paper	Impact of COVID-19 Pandemic Lockdown on Movement Behaviours of Children and Adolescents: A systematic review
Guideline	Risk Communication and Community Engagement Guidance on COVID-19 Vaccination in Marginalised Populations
Guideline	Practical Guidance for Risk Communication and Community Engagement (RCCE)
Contact Tracing	
Guideline	Operational Guide for Engaging Communities in Contact Tracing (WHO)
Guideline	Contact Tracing in the Context of COVID-19 (WHO)
Guideline	Risk Communication and Community Engagement for COVID-19 Contact Tracing: Interim Guidance
Guidance	RCCE Inter-agency Working Group Africa Region: How to collect and record community feedback
Report	Report on Communities' Challenges to Comply with Public Health Measures for COVID-19

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

One of the consensus findings of the evaluation is that the key target for the Collective Service is risk communication and community engagement (RCCE) coordination at national, subnational and community levels. Some key informants expressed their concern that too much energy was consumed in CS debates and meetings at HQ level that did not result in direct support to countries.

Key informants stressed that there is no one fixed model for national RCCE coordination and support; all depends on local context. None of the countries discussed during the evaluation had the same arrangement for the coordination of RCCE during the pandemic. Each country's configuration was based on the government's emergency response architecture as informed by its legislation, structures and implementation of the international public health regulations. Typically, the government established the response structure with advice and support from WHO, and with RCCE as one of the pillars. A key learning from the experience of country-level RCCE is that successful RCCE takes place where there is two-way feedback from community to national levels, as illustrated in the figure below.

The figure assembles the components of national level RCCE.[1] This and the accompanying table further below are derived by the evaluation team from the implementation of national and subnational RCCE coordination in the East and Southern Africa region, and, in particular, discussions during the team visit to Uganda. These are intended to provide the beginnings of a description of the elements that make up a well-functioning national RCCE system, against which national RCCE capacity needs assessments can then be made. This is not a one-size-fits-all model of coordinated RCCE but rather, an assembly of component parts of coordinated RCCE that have already been demonstrated in one or more example of national and subnational RCCE coordination.[2]



[1] The public health emergency response pillars are an illustrative, and not a complete, set.

[2] Amongst other sources to inform the discussion of the formulation of a model for RCCE coordination, see CDAC's 'How-To Guide on Collective Communication and Community Engagement in Humanitarian Action', February 2019. www.cdacnetwork.org/tools-guidance/how-to-guide-on-collective-communication-and-community-engagement-in-humanitarian-action, and the WHO Emergency Response Framework, p. 39.

As the Collective Service does not exist at country level, it does not appear in the diagram. Support to the national coordination structure is provided by the country-based RCCE, social and behaviour change and community engagement and accountability advisers from the core organizations (and others). If extra short-term coordination capacity is needed it must be deployed from the regional or HQ level. The table below describes each of the RCCE functions illustrated above.

Elements of national and subnational RCCE

RCCE function	Description
RCCE standard-setting	Technical and operational guidance consistent with global standards but adapted to local context and legislation as necessary
RCCE coordination	Typically, government-led but often with coordination support and resources provided by WHO or UNICEF, which may co-lead with government. The coordination forum might typically include MOH, UN agencies, the RCRC, INGOs, NNGOs, academics, media, and the health cluster, where present
RCCE coordination with other sectors	Interface with other sectors beyond health that are also engaged in RCCE for health emergencies, for example, WASH, education, or camp management, depending on the context
Health message revision	Under a subgroup of the main RCCE coordination group, comprised of communications and health experts
Revised messaging	Collective messaging agreed and sanctioned by government
Messages issued via media	Including radio, print, social and media
Influencing key persons	Briefing media personalities, local leaders, religious leaders, teachers, etc. on the appropriate messaging to be used in their working context
Social/anthropological studies	Knowledge, attitudes, perceptions, surveys, behaviour change assessments
Community feedback systems	Ongoing in-person house-household visits, online social feedback, interviews
Media analysis	Review of messaging via radio, social media, etc. and its perceived effects
Country-level situation analysis	Capturing and analysing data on the local situation from local, regional and global data sources
Information Flow	A centre-periphery two-way information flow monitoring/reporting that operates from national, regional, district, local levels and back
Integrated data analytics	Collating and analysing all qualitative and quantitative data to assess community feedback, beliefs and response to health communications

Acronyms: INGO = international non-governmental organization, NNGO = national non-governmental organization, RCCE = risk communication and community engagement, RCRC = rapid rural community response, WASH = water, sanitation and hygiene, WHO = World Health Organization

Annex H: Evaluation Principles, Management and Governance

Guiding Principles

The evaluation was conducted in line with the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation, the UNEG Ethical Guidelines for Evaluation, and the UNEG Guidance on Human Rights and Gender Equality in Evaluation. To ensure a balanced assessment and to guarantee that voices from all levels are heard, equal weight was given to data gathered from HQ, regional office and country office levels.

In all interactions with stakeholders, the evaluation team members emphasised that all inputs would remain confidential to the evaluation team. The views and statements of individual key informants to the evaluation are anonymized. Quotes used in the report from interviews or from survey responses are unattributed. The evaluation team has assumed all data and reports provided to the team can be used and quoted in the evaluation report, unless the relevant correspondents have specified elements that are restricted. The evaluation team has ensured that any data provided by individuals is based on informed consent and is protected. Until the end of the assignment data has been stored on a dedicated UNICEF SharePoint, which is accessible to the evaluation team and designated members of the International Federation of Red Cross and Red Crescent Societies (IFRC), UNICEF, and World Health Organization evaluation offices.

The evaluation questions were aligned with the Organisation for Economic Co-operation and Development's Development Assistance Committee evaluation criteria and in particular with the criteria of Relevance (EQ1), Coherence (EQ1), Effectiveness (EQ2, EQ3, EQ4) and Efficiency (EQ3). In addition, the evaluation addresses fundamental considerations regarding continuation of the Collective Service in line with the sustainability criteria.

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 oversaw the conduct of the evaluation, ensuring independence, impartiality and transparency throughout the process. An Evaluation Specialist in the UNICEF Evaluation Office acted as the lead Evaluation Manager and supervised the evaluation team.

The main responsibilities of the Management Team were:

- 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; and
- Disseminate the evaluation findings and products, in particular the final report.

The Management Team assured the quality of the evaluation products. The Evaluation Team first shared deliverables with the Management Team for quality assurance and to address any immediate comments. The drafts of the inception and final evaluation reports were circulated for comments to the Reference Group, with the evaluation team then responding to each comment and the action taken (or not) to address them, in a comments table. The Evaluation Management Team ensured that comments were appropriately addressed.

Focal Points

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

The role of the Focal Points included:

- 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 as access to documentation and specific information needed to carry out the evaluation, and assist with coordinating data collection activities at large; and
- Liaise with the Steering Committee Members of the Collective Service to ensure they were kept abreast of the progress of the evaluation.

Evaluation Reference Group

An Evaluation Reference Group was established to support the Management Team and the Evaluation Team in an advisory capacity. The Reference Group was 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 Group consisted 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 were 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 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; and
- Participate in meetings for presentation, validation and discussion of emerging findings.

Evaluation Team

The Evaluation Team consisted of three professionals with dedicated and complementing expertise for this evaluation.

The main responsibilities of the Evaluation Team were as follows:

- 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; and
- 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 segments of work to each team member.

Annex I: 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 International Federation of Red Cross and Red Crescent Societies (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 United Kingdom; multilaterals (Food and Agriculture Organization, International Development Research Centre, IFRC, International Organization for Migration, United Nations Development Programme, UNICEF, United Nations High Commissioner for Refugees, World Food Programme, World Bank), and international non-governmental organizations (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 socioeconomist cumulating 15 years of professional experience in qualitative and quantitative research, social protection, poverty analysis, and social and behaviour 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 the Ebola virus disease 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 IFRC. 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 Angola, Burundi, Central African Republic, Democratic Republic of Congo, the Gambia, Mauritania and Mozambique. Magdalena speaks French, Spanish, English, and Portuguese.

Juan A. Seclen, Public Health Specialist

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

Juan worked for United Nations entities and carried out consultancies for several global non-profit organizations in sub-Saharan Africa, 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 in 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 J: Online Survey Report

Executive Summary

This survey was undertaken as part of a formative evaluation of the RCCE Collective Service, which was jointly managed by IFRC, UNICEF and WHO. An online survey was issued in English and French and circulated by the three organizations to relevant staff to obtain data from the range of implementing organizations and stakeholders involved in the work of the Collective Service, including management, staff, the Steering Committee and technical group participants. A broader set of participants was also contacted, especially those on the email lists of online coordination meetings and webinars, helpdesk users and newsletter recipients at all levels from HQ to regional and country. A total of 98 responses were received.

Key messages that emerged from the survey include:

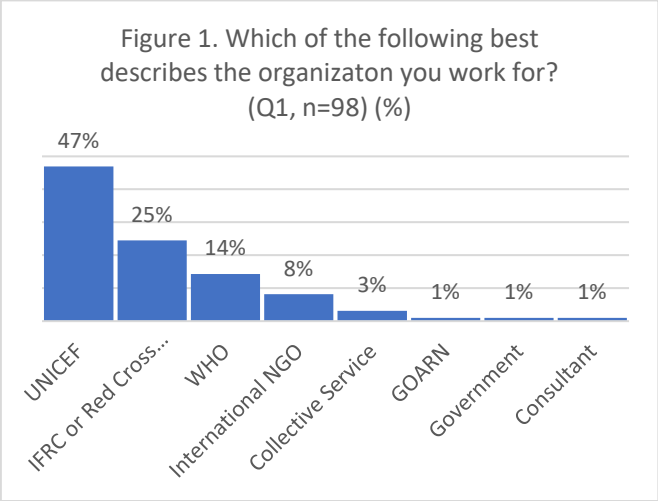
- Over 50 per cent of respondents reported that they engaged regularly with the Collective Service.
- The majority of respondents rated the support received from the Collective Service positively.
- Collective Service management functions such as "Strategy", "Governance", and "Raising additional funds" were rated positively by respondents. "Resolving problems and conflicts" was rated far lower.
- According to respondents, the Collective Service made an effort in addressing age and gender equity through RCCE. The effort made in addressing disability has been rated lower.
- Respondents highlighted success of the Collective Service during COVID-19 in: 1) resource and knowledge sharing; 2) country and regional support in RCCE practices; and 3) evidence gathering. As for the ratings for specific resources, those rated highest were the RCCE online resources and the data dashboards.
- On the other hand, respondents pointed out the lack of communication of the Collective Service roles and responsibilities; the lack of funding and/or resources; and the lack of real community engagement, as the major weaknesses of Collective Service during COVID-19.
- 82 per cent of respondents would use the Collective Service in a future public health emergency, and over 65 per cent affirmed that the Collective Service should continue beyond 2023.
- Most respondents considered that external RCCE support will be needed to respond to other public health emergencies in the future, mainly for cholera but also for Ebola and mpox.
- The most important weaknesses in RCCE pointed out by respondents were its top-down approach, coordination issues, and lack of knowledge and understanding around RCCE, as well as the lack of resources.
- The majority of respondents rated their own organization's capacity in RCCE as good or very good.
- Over 50 per cent of respondents believe that the Collective Service partnership should include additional partners.

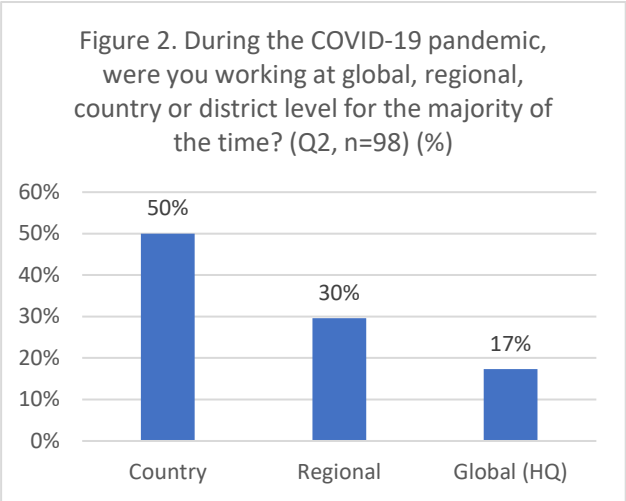
Survey Methods And Tools

The survey was submitted online with support from key stakeholders from the three agencies involved (IFRC, UNICEF and WHO). The survey was electronically sent to the evaluation focal points of the three organizations who disseminated it to selected technical staff at headquarters, regional and country levels. The survey was sent out via the Global Outbreak Alert and Response Network (GOARN) RCCE server list (approximately 160 people), and via the Helpdesk client list (36 individuals). The total number of recipients is unknown but is estimated at between 300 and 400. The tool used in the survey was a questionnaire with 27 closed and open-ended questions, which was developed by the evaluation team with validation of the three participating agencies staff.

The survey was analysed through quantitative and qualitative techniques. The qualitative data, coming from the open-ended responses in the survey, was explored through content analysis and all responses were assigned descriptive labels with the purpose of identifying common patterns among responses. Closed questions were analysed through descriptive statistical metrics using the Statistical Package for the Social Sciences (SPSS). Findings were weighted per total number of responses and were also disaggregated when applicable to global, regional and country level and by type of implementing organization.

Findings

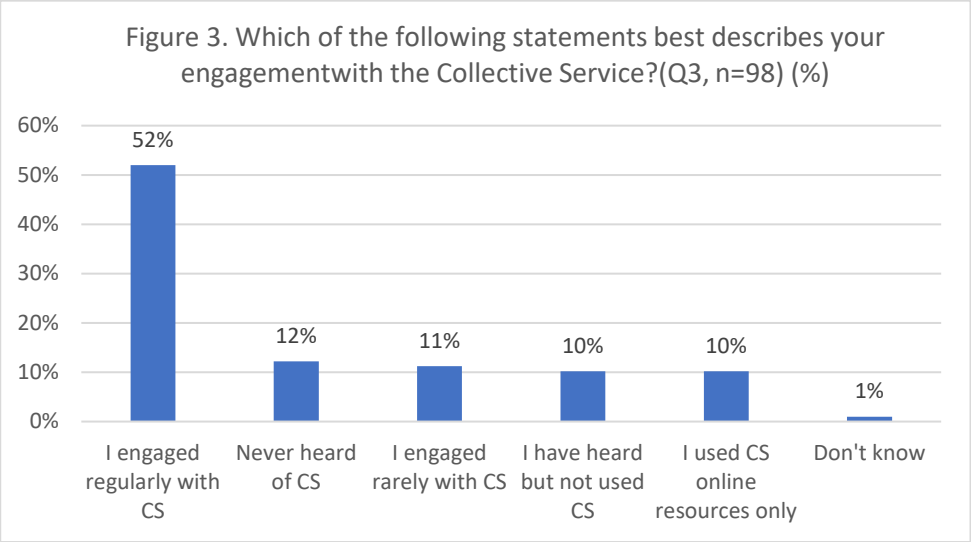




Profile of Survey Respondents

Of the total of 98 responses, almost half were from UNICEF (47 per cent), followed by IFRC (25 per cent), WHO (14 per cent), and international non-governmental organizations (NGOs) (8 per cent). Respondents from the Collective Service Secretariat were also represented in the survey (3 per cent). The rest of respondents belong to other organizations (figure 1). During the COVID-19 pandemic 50 per cent of the respondents worked at country-level, while 30 per cent worked at regional level and 17 per cent at global level (figure 2).

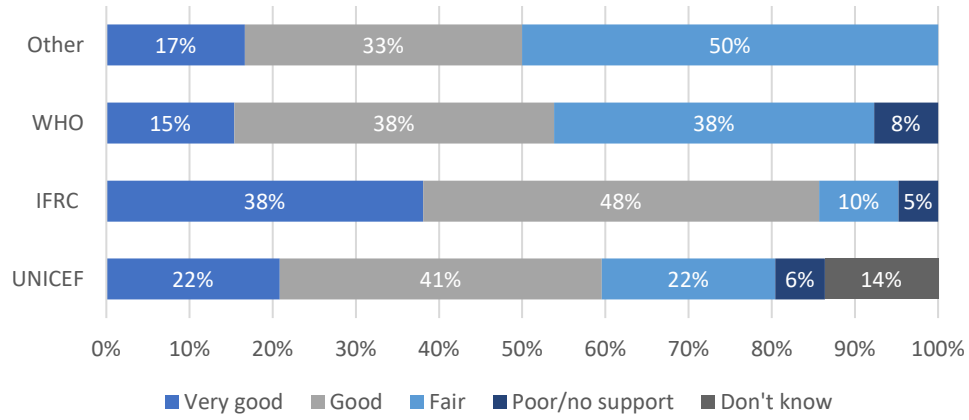
Engagement with the Collective Service



Regarding the respondents' engagement with the Collective Service (figure 3), 52 per cent of respondents engaged regularly with the Collective Service, while 11 per cent had never heard of Collective Service, and a further 10 per cent had heard of the Collective Service but had never used it.

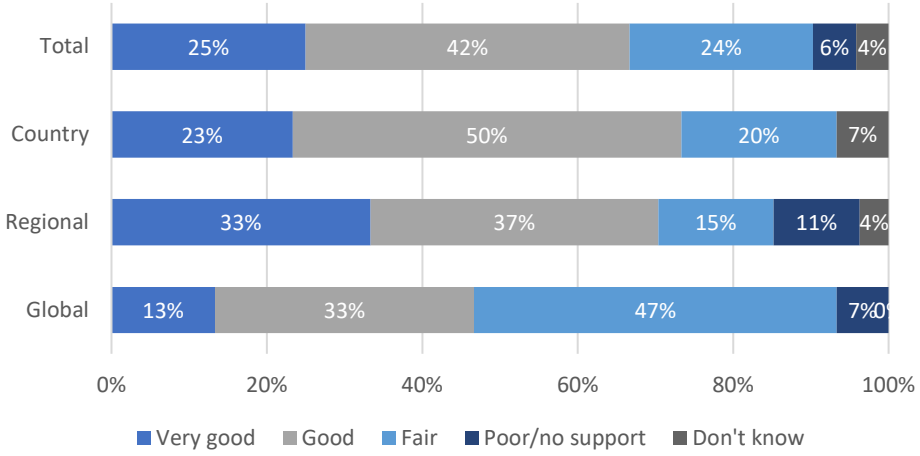
To the question**, *"Overall, how would you rate the support received from the Collective Service?",*** (figure 4) the following ratings were given by location and by organization (where 100 per cent = very good, 0 per cent = poor or very poor, depending on the question). Analysing by agency, respondents from IFRC gave the highest rating and WHO the lowest.

Figure 4. Overall, how would you rate the support received from the Collective Service? By agency (Q5, n=72) (%)



Broken down by organizational level, the ratings from country/field-level respondents were significantly more positive in their ratings than those based at HQ (figure 5).

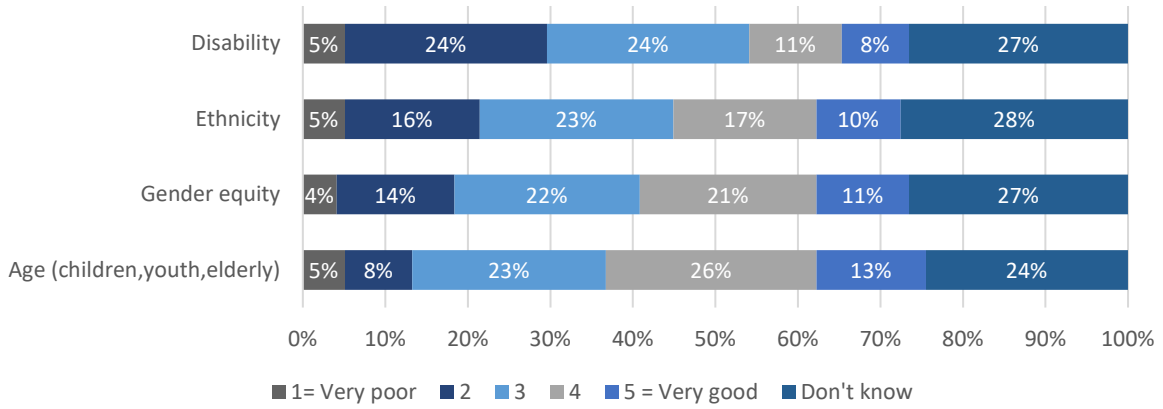
Figure 5. Overall, how would you rate the support received from the Collective Service? By organizational level (Q5, n=72) (%)



Respondents were also requested to ***"rate specific management functions within the Collective Service management"***, with 5 as "very good" and 1 "very poor". Only 45 per cent of the respondents answered this question, with generally a high rating. For instance, "Strategy"; "Governance"; and "Raising additional funds" were generally rated as 3 out of 5. "Managing resources" and "Timely decision-making" have had slightly higher ratings. The lowest rating was for "Resolving problems and conflicts", with 15 out of 44 respondents providing a rating between 1 and 2 out of 5.

For the question, ***"How would you rate the collective RCCE effort in your context in addressing gender equity, age, disability, and ethnicity?"*** (relating to RCCE in the operating context, not specifically to the Collective Service), there was a high ratio of "Don't know" answers (figure 6). Most of the ratings are mid-range. Addressing age and gender equity was rated more favourably, while disability has the lowest ratings, with over 50 per cent of respondents providing a rate of 3 or below, indicating that respondents do not perceive a strong link between the work of the Collective Service and dimensions of gender, equity and inclusion.

Figure 6. How would you rate the collective RCCE effort in your context in addressing: (Q21, n=98) (%)



COVID-19 and other diseases

To the open-ended question ***"In your view, what was the Collective Service's most significant contribution to the RCCE response to COVID-19 and other diseases?",*** respondents highlighted three main topics:

1) Resource and knowledge sharing (49 per cent);
2) Country and regional support in RCCE practices (37 per cent); and
3) Evidence gathering (35 per cent).

Half of the respondents pointed out that the Collective Service played a key role in sharing resources, knowledge and useful information on RCCE. Several country-level respondents mentioned the utility of technical assistance and other informative sessions on aspects such as setting up a community feedback mechanism. One respondent referred to the "materials that enabled adaptability for national context (…). Shared experiences were a great learning tool for all of us."

At the regional level, the convenience of a repository where resources were accessible was highlighted by various respondents. Having a team of deployable experts "has meant we have been able to provide tailored technical support to ministries of health and partners on demand". At the global level, stakeholders indicated that the Collective Service "allowed a space for information-sharing and connection that was very useful in the onset of the pandemic, as well as coordination of resources and guidelines". Another stakeholder highlighted "the attempted coordination among different institutions around RCCE, to harmonize actions, understandings and provide potential support to countries".

Almost 40 per cent of the respondents, mostly country and regional level respondents, pointed out that "country and regional support in RCCE practices" was one of the main contributions of the Collective Service. And, in particular, the utility of the technical guidance "on setting up innovative and timely mechanisms for coordination and data visualization including RCCE dashboards", "human resources capacity", etc.

One third of respondents, mostly at regional level, noted the impact of evidence-gathering by the Collective Service, appreciating the "standard and comparable information" provided, and especially the data dashboard as "extremely useful during the first year of the response" and the compilation of existing materials and studies. One fifth of respondents mentioned that the Collective Service was valued as a coordination mechanism in the RCCE response, mainly mentioned by global- and regional-level respondents.

As for the question ***"Can you mention a country where RCCE for COVID-19 was highly effective in your view? How was this achieved?",*** many countries were mentioned. Kenya, Malawi, Rwanda and Uganda were highlighted by three respondents each. Other countries and regions included:, Algeria, Bangladesh, Burkina Faso, Ethiopia, India, Lao PDR, Malaysia, Mexico, Nepal, Pakistan, Perú, Singapore, Tanzania, Togo and Zimbabwe. For Uganda, a regional-level respondent cited achievements as: "1. Development of district-level preparedness response plans that were well aligned to national response plan; 2. Exemplary leadership of the President

of Uganda who regularly delivered nation- wide media messages in addition to intensified campaign efforts by the Minister of Health, and timely delivery of prevention messages through electronic and print media." A country-level respondent added the "use of community-level structures for engagements". For Kenya, one respondent attributes the success to "a well-trained team". In Rwanda, the success is said to be due to "strong use of evidence-based practices" and "well-articulated systems and processes" so that "the RCCE was fully involved in one command post and decentralized at all levels", and that "there was a functional community structure".

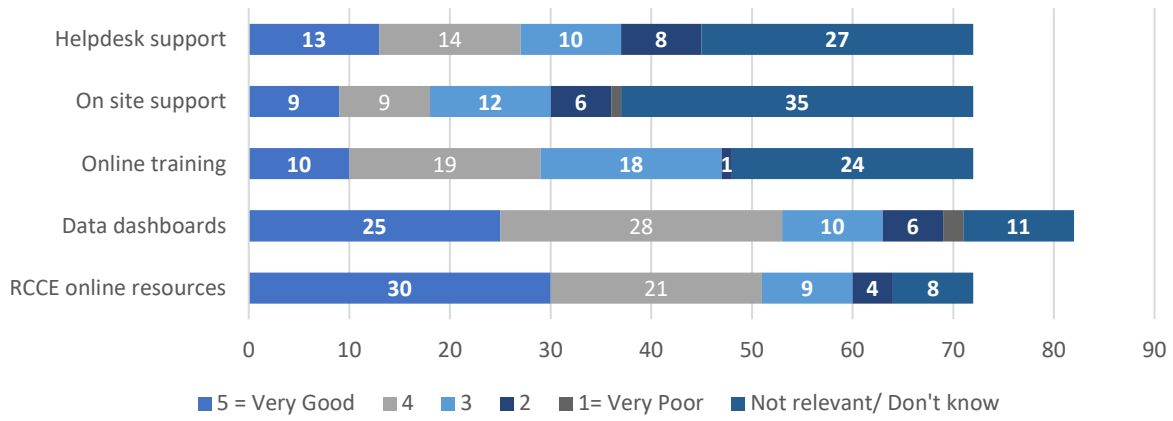
Regarding the weaknesses of the Collective Service in the COVID-19 response, more than 20 per cent of the respondents at all levels mentioned that a lack of communication of the Collective Service role and responsibilities was a key point to improve. The following examples from different levels illustrate this: "it was not clear at regional or country level the support or benefit of the Collective Service" (country); the lack of "explaining its role and responsibilities to the countries and regions" (regional); "the model is not clear and there is a constant 'identity crisis' linked to different views amongst partners" (global). A lack of communication/dissemination of the Collective Service resources and services linked to RCCE was mentioned by around 13 per cent of participants.

The second weakness highlighted was the lack of funding and/or resources. "I think they were short staffed, we had to wait for some time for in-country support" (country). The "lack of longer-term funding meant that there was pressure on the regional team to demonstrate country-level impact in a very short space of time" (regional). Further weaknesses mentioned were the "lack of long-term commitment from leading partners, the reliance on one donor, and the lack of investments from leading partners to stabilize the partnership" (global).

Some respondents (13 per cent) across all levels pointed to the lack of real community engagement as a key weakness of the Collective Service. For example, at the regional level, a respondent expressed the need for "more proactive outreach to communities". Other issues included the lack of coordination among the leading partners and the lack of long-term vision and leadership.

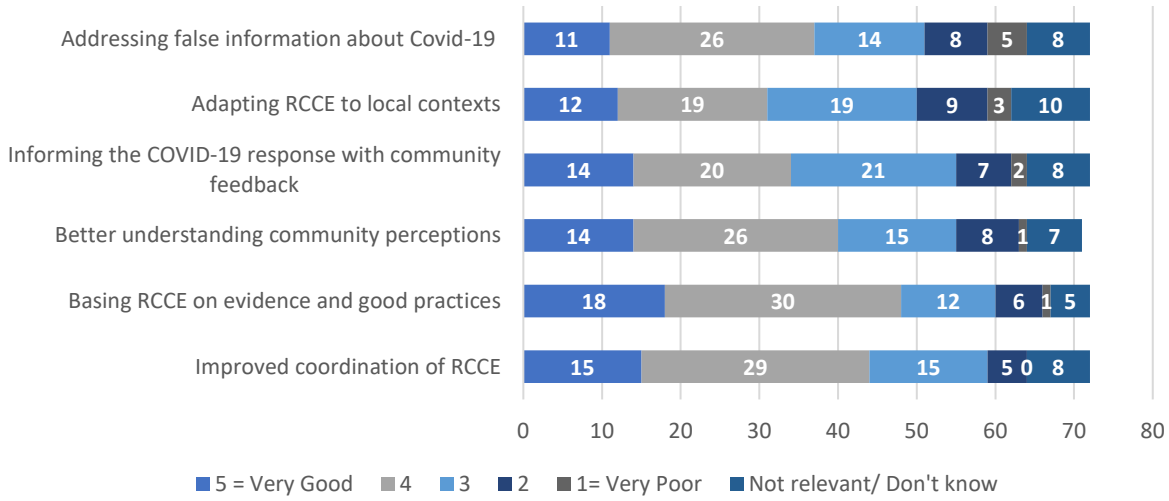
When **rating the resources provided by the Collective Service** (figure 7), the top-rated resources were the "RCCE online resources" and the "data dashboards". On-site or helpdesk support were rated lower, with many respondents selecting "Not relevant/Don't know", perhaps reflecting that only a minority of respondents were recipients of these services.

Figure 7. Please rate the resources and services provided by the Collective Service (Q9, n=72) (absolute numbers)



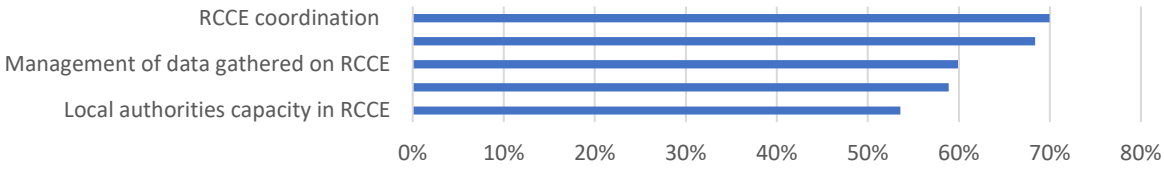
Respondents were asked to rate the extent to which **the Collective Service contributed to a pre-selected set of outcomes** (figure 8)**.** The highest ratings went to improved coordination of RCCE and basing RCCE on evidence and good practices. Addressing false information about COVID-19 and adapting RCCE to local contexts were scored significantly lower.

Figure 8. To what extent did the work of the Collective Service contribute to the following? (Q10, n=72) (absolute numbers)



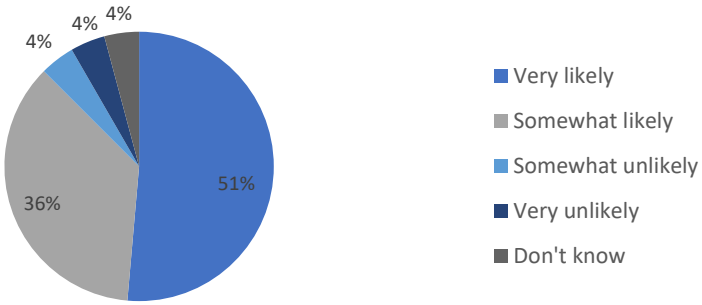
Asked to **rate aspects of the Collective Service in their work context,** RCCE coordination and risk messaging were rated 70 per cent and 68 per cent respectively (figure 9). The ratings lay between 50 per cent and 60 per cent for contribution to preparedness and local authorities' capacity in RCCE (figure 9).

Figure 9. Please rate the following aspects of collective RCCE in your working context (Q17, n=98) (%) Ratings from the question 1=Very Poor, 2, 3, 4, 5=Very good correspond to 0%, 25%, 50%, 75%, 100%

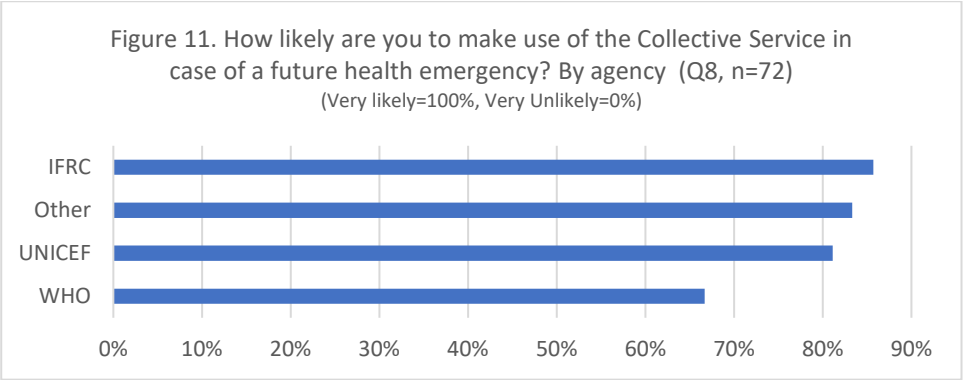


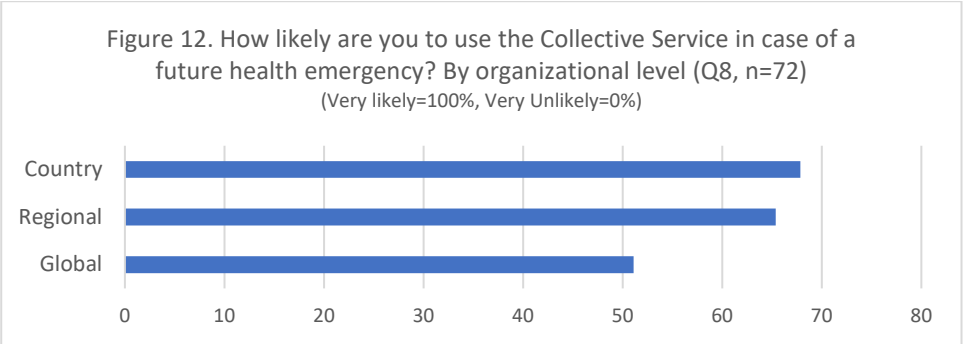
In response to the question ***"How likely are you to make use of the Collective Service in case of a future health emergency?"***, 87 per cent of the respondents answered, "very likely" or "somewhat likely" (figure 10).

Figure 10. How likely are you to make use of the Collective Service in case of a future health emergency? (Q8, n=72) (%)

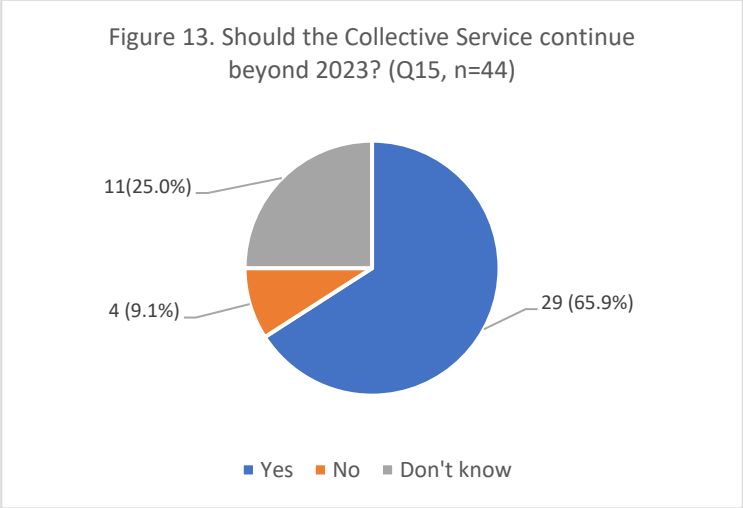


Over 50 per cent of the respondents from UNICEF and IFRC answered "very likely", compared with 38 per cent for respondents from WHO (figure 11). Analysed by level, the percentage likelihood for the future use of the Collective Service was highest for country-level respondents and lowest for those based at HQ (figure 12).

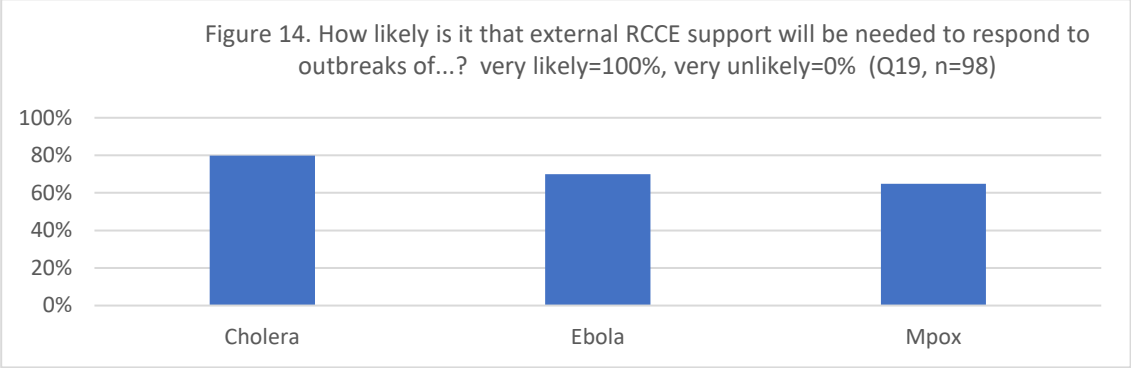




Asked whether the Collective Service should continue beyond 2023, two thirds answered 'Yes' (figure 13).



Almost half of the respondents answered that it was "very likely" that external RCCE support would be needed to respond to cholera outbreaks, with lower scores for Ebola and mpox (figure 14).



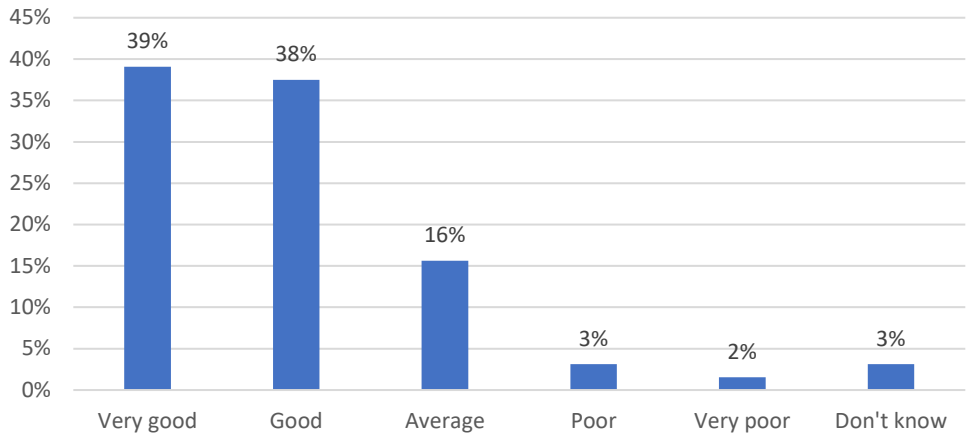
Respondents were asked ***"What is the most important capacity gap in RCCE?" as an open-ended question***. The most common answers are presented in descending frequency below:

- RCCE practices still have a top-down approach, with not enough community engagement and without local-owned practices (10 responses). One comment included: "focus on real-time community engagement support, rather than sharing information at high levels"
- Problems with coordination (9 responses)
- Lack of knowledge and understanding around RCCE, lack of knowledge in data analysis and use of data (9 responses)
- Lack of resources (7 responses)
- Lack of monitoring and evaluation practices (6 responses)
- Lack of proper dissemination practices, outreach (5 responses)
- Lack of long-term vision of RCCE (4 responses)
- Others (27 responses): Lack of preparedness and root cause analysis, lack of capacity-building, lack of capacity in areas like advocacy and governance, lack of humanitarian-development nexus, lack of sub-national level capacity, etc.

Risk communication and community engagement within the organization

Asked ***"How would you rate your own organization's capacity in RCCE?"*** (figure 15), the majority of the respondents gave a very positive assessment.

Figure 15. How would you rate your own organization's capacity in Risk Communication and Community Engagement? (Q23, n=64) (%)



Respondents working at regional level self-assessed their organization's capacities in RCCE more positively than those working at country or global level (figure 16, figure 17). Respondents from WHO rated their organization's capacity in RCCE lower than other organizations' self-assessments.

Figure 16. How would you rate your own organization's capacity in Risk Communication and Community Engagement? By agency (Q23, n=64)

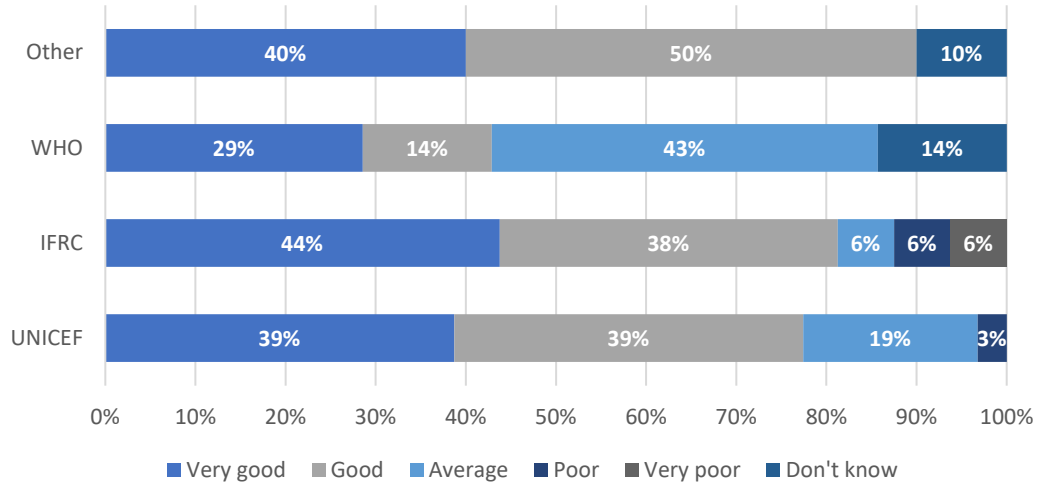
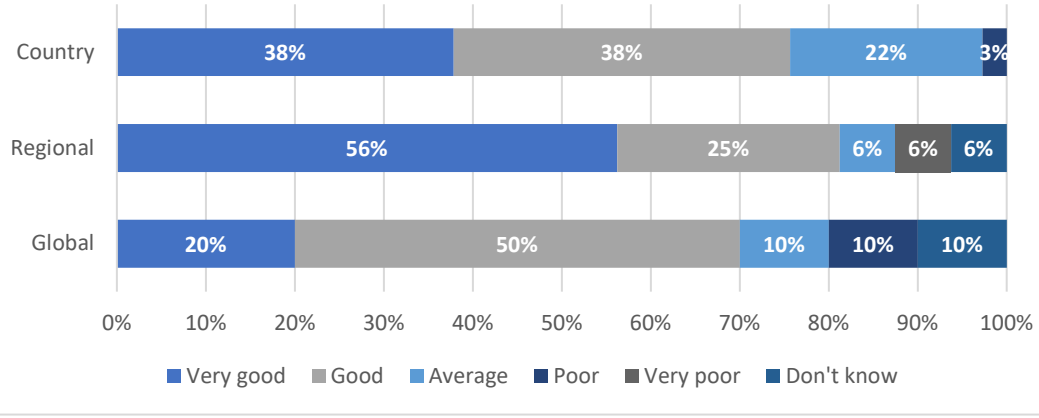


Figure 17. How would you rate your own organization's capacity in Risk Communication and Community Engagement? By organization by level (Q23, n=64)



The survey also included questions on respondents' perceptions of the most and least successful activities in RCCE within their organizations. The responses were in free text without ranking tables. The most frequent responses to ***"In which parts of RCCE was your organization most successful?"*** are presented below in descending order:

- Community engagement (29 respondents): including social listening, adaptation to local context, female engagement, community feedback management, etc.
- Coordination (13 responses)
- Capacity-building activities (9 responses)
- Data creation/gathering (8 responses)
- Awareness-raising (7 responses)
- Social mobilization (5 responses)
- Project planning, implementation and monitoring and evaluation (5 responses)
- Government/country support (4 responses)
- Resource mobilization (4 responses)
- Others, e.g. building partnerships, information-sharing (9 responses).

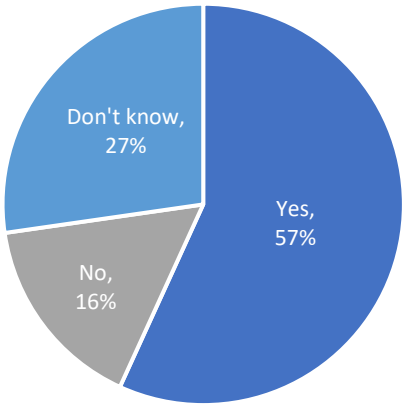
Responses to ***"In which parts of RCCE was your organization least successful?",*** were fragmented, with the most frequent presented in descending order below:

- Coordination (7 responses). For example: coordination amongst international organizations; coordination and human resources; harmonizing our approach with other coordination systems; coordination of data management for different implementing partners, etc. This was pointed out by respondents from global, regional, country and district levels.
- Capacity-building (5 responses)
- Management (4 responses)
- Monitoring and evaluation (4 responses)
- Awareness-raising (3 responses)
- Others (26 responses): harmonization of tools, advocacy, visibility, outreach, building trust, documentation, sharing information, etc.

Broadening the Collective Service partnership

The survey asked: ***"Should the Collective Service partnership expand to include additional partners beyond the IFRC, UNICEF and WHO and GOARN?"*** Out of the 44 respondents, 57 per cent answered "Yes", 16 per cent, "No" and 27 per cent "Don't know" (figure 18).

Figure 18. Should the CS include additional partners? (Q15, n=44)



The follow-on question ***"Which organizations could usefully be added to the partnership? With what purpose?"***, elicited a variety of answers about which organizations should be included. Several organizations are mentioned more than once: UN High Commissioner for Refugees (3 responses), UN Office for the Coordination of Humanitarian Affairs (OCHA) (2 responses), International Organization for Migration (2 responses). Other organizations mentioned by one respondent were World Food Programme, UN Population Fund and Food and Agriculture Organization. One global-level respondent said that by including the READY Initiative, the partnership could be expanded to include more NGOs and connect with a network that has a similar mandate, and that including OCHA would be good to ensure the connection with the humanitarian system. Another respondent at the global level indicated the need to include "more IOs and even NGOs – it should not be centralized. Also, some decisions were taken by some people from the leading agencies without discussing them with their partners." In the same vein, another respondent pointed out that "if the Collective Service stays, and it is called Collective then it should be representing the collective and not just a few IOs. The collective is actually majority local organizations and local actors". Other respondents also pointed to including more community-based organizations, as well as other humanitarian organizations.

Final remarks

The last survey question was: **"Please add any final remarks about the Collective Service in particular, or how to improve RCCE generally"**. Some common themes emerged:

- The Collective Service needs to improve on communicating its role, responsibilities and the resources it offers.
- The Collective Service needs more funding and human resources to develop its mandate.
- RCCE should be improved through effective community engagement, community participation, and community feedback mechanism. Tailored, context-specific and well-informed RCCE strategies and engagement of the key stakeholders (community level) will then create ownership and sustain the RCCE approaches at all levels.
- The Collective Service should include more RCCE stakeholders (e.g. youth organizations, academic research, other).
- Other remarks included:
    - The Collective Service should strengthen coordination at regional and country levels.
    - Avoid duplication with other organizations or RCCE networks, activities, more integration needed.
    - Given the financial challenges, "the Collective Service should be refocused on a global cluster-type mechanism, with surge support deployment mechanisms".
    - Have a global approach without focusing on specific areas such as East and Southern Africa.

Annex K: Evaluation Risks, Mitigation and Limitations

In the inception phase of the evaluation, the evaluation risks and mitigation measures were assessed, as are presented in the table below. The table has been updated to show the extent to which the risks were realised and, where possible, mitigated.

Evaluation risks, mitigation and limitations

Risk	Risk mitigation and limitations
Lack of reliable or informed sources or key informants	Several key informants contacted for interview did not respond, including some staff of the core partners – though overall their response was relatively good – but also external partners and parallel mechanisms, several of which did not respond. As already noted in the Inception Report, some information on the performance of the Collective Service (CS) is partial.
Timeframe of the evaluation means the evaluation comes too late for CS decision-making on future strategies, priorities and ways of working	The evaluation team kept the Reference Group and the Steering Committee informed of preliminary and evolving results as the evaluation progressed.
Multiple log frames, theories of change, and models arising from the need to put in place an agile management approach to the Collective Service	The evaluation provides some commentary on the application of theory of change. As the theory of change was not widely used for RCCE beyond the HQ developments of guidance materials, its efficacy did not prove central to the evaluation.
Expectations of the evaluation will not be met: the evaluation cannot be a substitute for the more difficult discussions between CS partners which 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 evaluation team clarified that the results of the evaluation provide the evidence base on which the CS organizations can build for the future, and cannot resolve all challenges associated with the CS. It does not provide solutions. As far as possible, alternatives and options have been crafted for consideration by the Steering Committee.
Expectations of the evaluation will not be met. 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.	Alternative options for future RCCE coordination are proposed for consideration, and the pros and cons of each discussed. The evaluation has had limited success in interviewing alternative mechanisms but the functioning of some is well known to the team leader.
Challenges with availability of data and its quality	The level of participation in the online survey was relatively good, perhaps 20 per cent of the target audience, which is typical for such surveys. Only one field mission was agreed to by the CS organizations (Uganda). Given the key informants' emphasis throughout the evaluation on the centrality of the CS advancing country-level RCCE coordination, this represents a significant weakness in data gathering. The regional and country-level remote interviews and good documentation of some country examples partially closed this evidence gap.
The short timeframe for the exercise	The limited time allowed for the evaluation has been a constraint throughout, especially in reducing the time for reflection and analysis. The original timeline for the evaluation was not found to be realistic and the end date was put back by 3 weeks.

Annex L: Terms of Reference

Summary

On behalf of the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), the UNICEF Evaluation Office is commissioning an evaluation of the Risk Communication and Community Engagement (RCCE) Collective Service, jointly managed by the three agencies.

The RCCE Collective Service is a collaborative partnership between IFRC, UNICEF, WHO, and key stakeholders from the public health, humanitarian and development sectors. It is supported by the Global Outbreak Alert and Response Network (GOARN) and the Bill and Melinda Gates Foundation. Created in response to the COVID-19 pandemic, the Collective Service was designed to strengthen ongoing global, regional and national efforts and ensure support is available to existing mechanisms in regions and countries as they tackle the pandemic.

An evaluation has been solicited to assess the Service's preliminary outcomes and identify promising coordinated RCCE approaches based on their effectiveness during implementation in response to COVID-19, as well as to inform the future strategic vision of the Service. These Terms of Reference (ToR) describe the background, purpose and objectives, suggested evaluation questions and methodological approach, management and governance arrangements, the required profile of the evaluation team and the timeline of the evaluation.

Background and Rationale

Communicating and engaging with affected communities is seen as an important and central component of crisis response. For this reason, Risk Communication and Community Engagement (RCCE) focuses on informing and engaging the public on how to reduce their risk and better protect themselves. Without community engagement, misinformation, confusion, and mistrust can undermine efforts to ensure an uptake of lifesaving tools, services, and information.

Experience from previous outbreak responses highlights the need to strengthen risk communication and community engagement as a collective effort in which the work of different actors is aligned, complementary, and well-integrated. People's needs regularly cut across different mandates or programme priorities of individual actors and organizations, and confusing or conflicting information can easily undermine trust and hamper effective responses. Moreover, consistent participation and empowerment of affected communities is essential to understand local contexts and ensure an informed, people-centered response.[1]

In recognition of this need, IFRC, UNICEF and WHO, with support from GOARN, have established a joint RCCE Collective Service (hereafter also referred to as 'the Service'). The Service is a collaborative partnership between its core partners (IFRC, UNICEF and WHO), and key stakeholders from the public health and humanitarian sectors, which aims to deliver, for the first time, the structures and mechanisms required for a coordinated community-centered approach that is embedded across public health, humanitarian, and development response efforts.

The Service was founded in June 2020 during the COVID-19 pandemic, after being endorsed by the Inter-Agency Standing Committee[2] Principals in April 2020, and with support from the Bill and Melinda Gates Foundation. The three core partners have a long history of supporting coordinated community-centered approaches across a broad range of emergencies, contexts, and regions. The Service was intended to ensure that the strengths of each partner are leveraged to deliver the greatest impact, reduce duplication and increase effectiveness of localized action.[3]

Created in response to the COVID-19 pandemic, the Collective Service was designed to strengthen ongoing global, regional, and national efforts and ensure support is available to existing mechanisms in regions and countries as they tackle the pandemic. The Service was intended to support, rather than replace, established coordination mechanisms. Globally, the Service hosts an RCCE coordination forum, which has been operational since February 2020. Regionally, there are RCCE coordination groups that support national-level coordination mechanisms, which are typically led by the Ministry of Health and co-led by WHO, UNICEF and IFRC. Two pilot Collective Service hubs have been established with dedicated coordination, information management and social sciences capacity in the East and Southern Africa region. The Service is guided by a Steering Committee at director level with responsibility for strategic decision-making.

To achieve its goals, the Service has set out **four strategic priorities**:

1. **Strengthen common and coordinated RCCE approaches** to maximize the sharing of resources, inter-agency standards, monitoring frameworks and expertise at global, regional and country levels.
2. **Generate real-time data on community perspectives** and use it to influence decisions about COVID-19 responses, policies, and programming, to improve effectiveness and efficiency.
3. **Improve the quality and consistency of community engagement approaches** towards more responsive and flexible actions that fit the diverse needs, views, and capacities of communities; and
4. **Strengthen the capacity of national governments, institutions and organizations and reinforce local solutions** through training, mentoring, peer learning and resource sharing with local actors.

The Collective Service has a range of M&E tools in place: There is a **logical framework** which was generated in collaboration with partner agencies, and which defines a comprehensive set of **outcomes/outputs and associated indicators** (see Annex A). There is also a dedicated **theory of change** (see Annex B) which is built on the assumption that if certain evidence and resources are used, and specific strategies implemented, 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.

The Service has set aside resources for learning and evaluative exercises, including, in 2021, a **learning review**[4] of the Collective Service, which has been carried out by the Humanitarian Policy Group at the Overseas Development Institute (ODI). The study provided a snapshot of the Service after six months of operation. It concluded that the Service's goal and objectives were worth pursuing and that it should continue beyond the COVID-19 response. However, it also highlighted vital recommendations to inform its medium-to-long-term development to remain relevant and effective over time. These include strengthening the partnership between core agencies, external buy-in and integration. The review also noted the need to move to a more demand-driven and bottom-up model, nurturing monitoring and evaluation (M&E) processes and considering which role the Service might play beyond the COVID-19 pandemic.

Evaluation rationale

After more than two and a half years in operation, and with the ambition to expand the role of the Collective Service beyond the COVID-19 response to support other public health and humanitarian emergencies, a formative, outcome-oriented evaluation has been requested to provide credible evidence on the extent to which the Collective Service is achieving results against its key objectives.

The evaluation is expected to generate a credible, impartial, and independent reflection point for the Service's secretariat and implementing partners. It is also an equally important exercise in promoting learning and determining the way forward regarding the Service's future vision and strategy. The evaluation will take stock of the progress towards outcomes, build on the learning review and provide evidence-based, forward-looking recommendations.

Purpose, Objectives and Scope

This formative, outcome-oriented evaluation serves two complementary purposes: the first is to confirm the theory of change of the Collective Service and its implementation (the practice of change), in order to assess the Service's contribution to the overarching goal of strengthening RCCE systems in public health, humanitarian, and development responses to the COVID-19 pandemic. The second purpose is to assess the Collective Service's positioning and readiness, and to inform its future strategy and vision by providing credible and reliable evidence and by identifying concrete good practices and lessons learned.

The evaluation will thus ultimately try to strike a balance between backwards-looking elements focused on accountability and forward-looking aspects concerned more with learning and incorporating good practices into the new Service vision. The evaluation will inform the preparation of the new strategy in 2023 by understanding what worked well (and less well) and how since the creation of the RCCE Collective Service.

More specific **objectives** of the evaluation include the following:

- **Quality of the design and approach**. Assess the Collective Service design (theory of change, logical framework) and strategy, the level of alignment to international practices in providing coordination and support services, and the comparative advantage of the Service positioning and role in the COVID-19 response. Recommendations will help the Service increase its relevance and efficiency through strategic planning and positioning for future emergencies and further improve the donor-driven design (theory of change and logical framework) of the Collective Service.
- **Achievement of preliminary outcomes**. Determine the level of preliminary achievement of the intended overall outcomes (i.e. strengthened collaborative RCCE approaches to increase quality, harmonisation, optimisation, and integration of RCCE; availability of evidence to inform policy and programming and improve effectiveness and efficiency systematically; improved quality and consistency of risk communication and community engagement approaches; reinforced national capacity for improved local solutions). Recommendations will advise on the scale-up of the Service moving forward, good practices and lessons learned.
- **Wide coordination and collaboration**. Assess the quality of coordination and cooperation at the global level primarily and then at the regional levels comparing regions where interagency teams have been put in place (West and Central Africa and Southern and Eastern Africa) versus areas where interagency teams have not been put in place yet; in selecting and managing partnerships to advance the overarching goal and objectives of the Service in RCCE, during the COVID-19 public health emergency. Recommendations will address actions to strengthen means of coordination and collaboration at different levels and partnership arrangements moving forward.
- **Management, governance, and resourcing arrangements**. Examine the quality and efficiency of the Collective Service management and control in attaining the expected outcomes based on similar comparative experiences. This includes an assessment of resources (human and financial) expected to be invested for the RCCE Collective Service to be scaled up beyond COVID-19, risk management and mitigation measures. Recommendations will advise on the strategic management and resourcing of the Collective Service to cover other crises beyond COVID-19.
- **Adequacy of Data for Action approach**. Investigate the quality and overall coherence of the Data for Action approach used by the Collective Service and the use of evidence and knowledge management because of this approach to inform RCCE. Recommendations will advise how to strengthen the Data for Action approach moving forward.
- **Adequacy of internal M&E and knowledge management systems**. Assess the quality and overall coherence of internal M&E and knowledge management systems utilised by the Collective Service. This covers the quality of indicators, baseline data, comprehensive data collection systems, data governance and management, equity-inclusiveness in data systems, timeliness of data and knowledge management processes, the utility of evidence, and plans for complementary studies, research, and other evaluative activities. Recommendations will help the Collective Service to improve existing indicators, means of verification, and evidence utility.

Evaluation use

The findings and recommendations of the 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 Collective Service Secretariat and the colleagues involved from 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 inter-agency teams have not yet been established, as well as country-level stakeholders such as governments, international and national non-governmental organizations, and other partners.

Scope of the evaluation

The evaluation will be articulated along **two main and interlinked areas of investigation**, on the one hand the analysis of the RCCE Collective Service's organizational design and approach, and on the other hand the assessment of preliminary or emerging outcomes achieved as well as any unintended positive and negative effects of the Collective Service.

In assessing these 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 not assess achievement of results at the impact level since two and a half years of implementation are not considered sufficient for this.

Moreover, the evaluation will look at **various organizational levels and partners**, paying attention to coordination and support services built at the global and regional levels, mainly focusing on the African region. The focus will be on how these various levels collaborate to achieve a cumulative effect. The evaluation is also expected to be participatory and solicit the view of all partners on the Collective Service. A subset of partners may be sampled to provide their opinions through in-depth interviews.

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. Their exact number and nature will be determined in the inception phase of the evaluation. Tentatively, these will include COVID-19 responses in West and Central Africa and East and Southern Africa, as well as other regions where interagency response teams were not formally established; information management and communication in Malawi; the Ebola response in Guinea; or the COVID-19 database and dashboard.

RCCE systems-strengthening goals apply to both **development and humanitarian contexts**. The evaluation will need to be attentive to the fact that RCCE services are provided across various settings, including public health emergencies. At the same time, they need to be targeted and tailored to each operational environment.

The evaluation will focus on the **2020–2022 period and beyond** to inform the way forward for the Collective Service. Any experience of coordinated information services before 2022 may be used as a comparator where relevant to examine the design and approach of the RCCE Collective Service.

Evaluation Questions

The evaluation is expected to answer a set of questions to meet its purpose and objectives. The proposed evaluation questions are tentative and expected to be refined during the inception phase of the evaluation, based on initial exploratory findings and careful consideration of which questions appear to be most helpful. The following set of high-level questions is suggested for this evaluation:

1. **To what extent is the Collective Service design and approach to address community engagement coordination and support, both during COVID-19 and moving forward, clear, relevant, coherent, and appropriate, as well as equity, gender, and disability-inclusive?**
2. **To what extent and how have the preliminary outcomes of the Collective Service been achieved?**
3. **To what extent has the Collective Service-wide coordination and collaboration been managed efficiently, effectively, and sustainably to achieve the overall goal and objectives of the Service?**
4. **To what extent are the Collective Service management and governance systems, as well as human and financial resources and commitments, relevant, efficient, effective, sustainable, and equity-inclusive in attaining the expected outcomes?**
5. **To what extent and how has the Data for Action approach been effective and efficient in fostering accountability and learning?**
6. **To what extent are internal data, M&E and knowledge management systems in place to foster accountability and learning?**

Methodology and Approach

The evaluation is expected to use a **mixed methods** approach, so to collect and analyse both quantitative and qualitative data, to gain convergence and increase validity through triangulation, using the strengths of each technique to overcome the weaknesses of the other and, in the end, obtain a fuller picture.

The following **data gathering methods** and approaches are suggested:

- **Desk review:** The Collective Service's documents will be reviewed and assessed alongside evaluative evidence already available and literature on good practices, definitions, and theoretical frameworks in 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 included, especially the deep-dive case studies that will be identified. The Service's core partners will supply all information identified as relevant and may provide the evaluation team with access to their intranet and management information systems for direct examination and searching.
- **Survey:** A survey aimed at obtaining the 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, will be conducted. The management team will help with the dissemination of the survey to ensure the representativeness of the sample.
- **Administrative and secondary data:** The use of administrative and secondary data will be essential to minimise the primary data collection to the greatest extent possible. The management team will support the evaluation team in gaining access to the administrative and secondary data.
- **Key informant interviews (KIIs) and focus group discussions:** Consultations will be conducted through interviews with a selected sample of key informants, including internal stakeholders across all levels of all the organisations involved and key external partners directly contributing to the Collective Service's RCCE work. Focus group discussions are encouraged.
- **Field missions for deep-dive case studies (under discussion):** The evaluation team may undertake field missions to collect data, especially for the deep-dive case studies that will be further identified during the inception phase. The discussions on the field missions are ongoing.
- **Readiness analysis**, grounded in techniques measuring readiness, and assessing the status of the Collective Service and its preparedness for scaling up to other crises beyond COVID-19.
- **Sentiment analysis using machine learning methods:** Sentiment analysis is encouraged to be undertaken using natural language processing (NLP) or any other innovative machine-learning-based methods. It will be important to work closely with the management team to create 'dictionaries' to capture links to the Collective Service's work when traceability could be challenging.

The team carrying out this evaluation is encouraged to suggest specific **methodological approaches** that they consider suitable and helpful, such as contribution analysis and/or process tracing, outcome mapping, outcome harvesting, or realist evaluation. Likewise, they may propose further strategies, methods or ideas to achieve the evaluation's purpose and objectives.

In addressing some of the formative, forward-looking elements of the evaluation, the analytical framework of the **readiness assessment** (Figure 1 below) could be used to capture the status of the Collective Service and its preparedness for scaling up to other crises beyond COVID-19). The readiness assessment framework includes the dimensions of positioning, approach, technical capacity, partnerships, and resources.

The positioning dimension may investigate the Service's comparative advantage vis-à-vis other stakeholders and how this dimension could be further enhanced. The dimension on approaches may showcase the current methods utilised to support the goals, outputs, and outcomes of the Collective Service and determine challenges, gaps, needs, and aspirations to enhance outcomes. The dimension on technical capacities could examine information on current human and technical capabilities and gauge gaps against conditions/aspirations about knowledge, skills and behavioural traits to help the Collective Service to optimise its work. The partner-

ships dimension could explore the broad range of internal and external collaborations to support RCCE in response to COVID-19 and the future in the transitioning phase. The resources dimension may focus on resources that are deployed, envisaged and collected through the Collective Service. The readiness assessment uses a quick and learning-based analytical logic to demonstrate a snapshot of the current situation and provides a forward-looking approach to challenges and needs that could inform the new vision for the Service.

Risk management assessment

The evaluation is facing several risks of which the most relevant are listed below, together with the corresponding mitigating measures anticipated.

Table A: Risks and mitigation measures

Risk	Risk Mitigation Measure
Lack of reliable or informed sources or key informants given	Augment key informants that could engage with the same issues in the same way.
Multiple log frames, theories of change, and models arising from the need to put in place an agile management approach to the Collective Service	Impose a standard or typical frame to carry out the analysis. Emphasise flexibility and adaptation in the review of the logical framework, ToC and models that have been used.
Challenges with availability of data and its quality	In case of data availability and quality challenges, primary data collection would be encouraged. Various data collection tools, including field missions, can mitigate this challenge.
The short timeframe for the exercise	In case of challenges with the timeframe proposed, the evaluation phases could be overlapped. For instance, during the inception phase, data collection and documentation review can be commenced so as not to lose traction between the evaluation phases.

Ethical considerations

The evaluation will be expected to follow UNEG Ethical Guidelines, as well as the UNEG Guidance on Human Rights and Gender Equality in Evaluation. The process is expected to include the following mechanisms:

- Respecting gender and human rights principles throughout the evaluation process, including the protection of confidentiality, the protection of rights; the protection of dignity and welfare of people; and ensuring informed consent.
- Data validation will take place at all levels with participant consent.
- Maximizing the degree of participation of stakeholders in the evaluation itself wherever feasible and a commitment to using participatory approaches in field studies.
- Examining the potential to disaggregate data by gender, disability, equity, and human rights-relevant factors, where that will be important to advocacy success.
- Ensuring that outputs use human rights and gender-sensitive language.
- Ensuring privacy protocols and compliance with all legal data management rules and considerations.
- Applying the principle of 'do no harm' into practice during the duration of the exercise.

Confidentiality

The evaluation will assess critical internal data and perspectives. These must be held with the utmost confidentiality. Likewise, the willingness of internal and external stakeholders to speak to these issues critically will depend on the provision of absolute confidentiality. The evaluation team must sign the non-disclosure agreement (NDA) and ensure that sensitive data is protected.

Management and Governance Arrangements

This evaluation will be jointly managed by the IFRC Strategic Planning Department, the UNICEF Evaluation Office, and the WHO Evaluation Office. An Evaluation Specialist in the UNICEF Evaluation Office will act as the lead Evaluation Manager and supervise the evaluation team. The lead Evaluation Manager may delegate oversight duties to other persons for portions of the work but will retain overall approving authority.

A **Management Team** will be formed to coordinate the evaluation. As this is an interagency evaluation, the team will be composed of members from the evaluation function of each core partner to provide for a balanced basis for the evaluation's governance. Hence, the team will consist of the UNICEF lead Evaluation Manager and an Evaluation Manager from both the IFRC Strategic Planning Department and the WHO Evaluation Office.

Focal Points for the Collective Service and its core partners will be 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.

An **Evaluation Reference Group (ERG)** will be created to support the evaluation in an advisory capacity. The ERG will consist of key stakeholders of the Collective Service, in particular, members of its Steering Committee, as well as experts in RCCE and public health.

The role of the ERG will be:

- Offer insights on issues under discussion, especially in the inception phase where the methods, design, and data to be sought are determined.
- Review key deliverables (i.e. draft reports) and provide comments.
- Participate in a presentation of preliminary findings and conclusions for validation and contribute to the joint development of recommendations.

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.

Timeframe and Key Deliverables

A timeline of around seven months is envisaged for the evaluation, from December 2022 to June 2023 (tentatively). The evaluation team should allocate reasonable effort to ensure the timely submission of all the deliverables. The proposed organization of the evaluation phases is as follows:

Inception phase: During this phase, the evaluation team is expected to gain a deep understanding of the proposed documentation, assess possible information gaps, refining the scope, methods, and critical stakeholders. The main deliverable for this phase will be the inception report. It is expected to hold a short meeting with the Reference Group for a presentation and discussion of the inception report.

The **draft inception report** should include (i) an initial overview and analysis based on a review of critical documents, other related available data, and possibly a few scoping interviews, (ii) the final set of evaluation questions to be answered, and (iii) the envisaged evaluation methodology and approach, including the design, data collection methods and draft data collection tools, foreseen indicators to measure performance and results, an evaluation matrix, and the suggested timeline for the evaluation.

Data collection and analysis: Additional primary and secondary data is to be collected, using instruments developed during the inception phase. All data gathered shall be duly analysed, stored in a secure repository, cleaned, and processed to ensure the anonymity of key informants. To conclude this phase, a presentation with preliminary findings and conclusions is foreseen.

The **presentation with preliminary findings and conclusions** is intended to validate findings and strengthen the ownership of key stakeholders. It is foreseen to be shared with key stakeholders during data analysis and

early stages of report drafting. The presentation is to be shared beforehand and then discussed in a workshop, which can also be used to develop recommendations based on the preliminary findings and conclusions jointly.

Reporting and dissemination: The main deliverables for this phase are the preliminary draft of the final report and the final agreed report. In addition, it is expected that the main findings, conclusions, recommendations, and lessons learned will be presented to the Reference Group and other relevant stakeholders, with a stand-alone presentation and evaluation brief.

The **draft evaluation report** is expected to present the evidence found in response to all evaluation questions and should be relevant to decision-making needs. The report will include an Executive Summary and evidence-based recommendations that have been jointly developed with key stakeholders and were directly derived from the evaluation findings and conclusions. It will preferably comprise not more than 40 pages (25,000 words), excluding the Executive Summary and annexes.

In line with the process described above, the expected key deliverables for this evaluation will be:

1. a draft inception report
2. a final inception report
3. a presentation with preliminary findings and conclusions
4. a draft evaluation report
5. a final evaluation report
6. a final presentation and an evaluation brief

Other interim products are:

- Minutes of key meetings with the Reference Group;
- Regular progress reports (at least monthly);
- Copy of the anonymised data collected during the evaluation; and
- Presentation materials for the meetings with the Reference Group.

Draft deliverables are first to be shared with the Management Team for quality assurance and, once approved, will be more widely disseminated to key stakeholders for comments. Comments received are expected to be transparently addressed by the evaluation team when providing the revised version of the reports (for example, by providing an additional track-change revision or an audit trail). Deliverables will only be approved when they are judged to be of sufficient quality and if comments have been adequately addressed.

All reports must be in Microsoft Word format and presentations preferably in Microsoft PowerPoint. The evaluation team will submit no PDF or hard copy (if so, only in addition). All data collected for the evaluation, documentation gathered, photos/videos taken, and analyses produced will be made available to the Evaluation Office. Graphs and maps must be in editable format for layout purposes.

Deliverables must be in professional-level standard English and written in a concise, clear and easy-to-understand language. **Using reader-friendly techniques** such as bullet points, tables, graphs, photos, or videos embedded in presentations, reports, and other visualisation methods **is strongly encouraged and desired**. PowerPoint presentations should include notes below each slide to make them easy to understand for people who could not attend the meeting. Annexes should be used to include evaluation tools and secondary information that is not directly related to the evaluation findings, or for any technical documentation intended for a specific audience.

The final evaluation report will be made available on the core partners' websites and widely disseminated to key stakeholders (such as staff, partners or target groups). UNICEF as the commissioning agency, together with IFRC and WHO as joint partners in managing this evaluation, will have the copyright of the report, presentation and data collected. The members of the evaluation team will be acknowledged in the report.

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