GOVERNMENT OF SAMOA

NATIONAL RISK COMMUNICATION AND COMMUNITY ENGAGEMENT STRATEGY FOR COVID-19 PANDEMIC

For Financial Year 2021 / 22 - FY 2024 / 25

Ministry of Health

FOREWORD

Leausa Samau T. Dr. Take Naseri
DIRECTOR GENERAL OF HEALTH

During the first year of COVID-19 pandemic, the whole world experienced and endured many challenges. However, these challenges continue to daunt the efforts of many countries working to strengthen their health systems; especially the public health system. As Samoa observed the social and economic impacts of this pandemic in all affected countries, especially our neighbouring countries like Fiji, key lessons were learned. In particular, we learned that it is important to increase the public's awareness and knowledge of the COVID-19 pandemic's causes, symptoms and implications through strengthening risk communication and community engagement as a critical factor to preparedness and response.

A clear and integrated Risk Communication and Community Engagement (RCCE) Strategy is very crucial for the community's uptake of essential public health interventions to prevent and control the spread of infectious diseases. This Strategy aims to ensure dialogue and the participation of all partners, in both the public and private health sectors and especially the national community, during COVID-19 preparedness, response and recovery cycle.

We are well aware that infectious diseases like COVID-19 respect no borders, and viruses do not discriminate on host populations. At the same time, at-risk and affected populations need to be part of the solution to issues that affect them. Therefore, the community is viewed as a full and fair shareholder in the COVID-19 preparedness and response efforts, working closely with health workers and other partners in health, to implement protective measures and improve health seeking behaviours.

The development of this strategy follows the COVID-19 Global Risk Communication and Community Engagement Guideline (December 2020 – May 2021); Emergency Risk Communication institutionalization capacity building; is aligned with Samoa's National Epidemic and Pandemic Preparedness and Response Plan FY2020/21-FY2024/25; National COVID-19 Preparedness and Response Plan 2020 and the National Deployment of Vaccine Plan 2021.

Throughout the COVID-19 pandemic, the diverse range of knowledge, skills and other resources had already been mobilized within Samoa's community both in public and private sectors to strengthen pandemic preparedness and response capacity and mechanisms. The Ministry of Health as Samoa's health sector leader is supporting critical connections with other health sector partners and stakeholders as well as the community through a multi-sectoral approach. This is more important than ever as the Ministry strives to capitalize on the hard-won gains already made that hast kept it free of COVID-19.

I encourage all partners in health, at all levels (from the international to the community level), to use this National COVID-19 Risk Communication and Community Engagement Strategy as a guiding tool to go beyond traditional approaches and join hands with the community to maintain Samoa's COVID-19 free status.

Fa'afetai.

Leausa Samau T. Dr. Take Naseri
DIRECTOR GENERAL OF HEALTH

ACRONYMS

ACRONYMS	DESCRIPTIONS
ADB	Asian Development Bank
ADRA	Adventist Disaster Relief Agency
AEFI	Adverse Events Following Immunization
CBO	Community Based Organization
CCS	Country Cooperation Strategy
COVID-19	Coronavirus Disease- 2019
DAC	Disaster Advisory Committee
DMO	Disaster Management Office
ERC	Emergency Risk Communication
FAQ	Frequently Asked Questions
FBO	Faith Based Organization
FY	Financial Year
GoS	Government of Samoa
HEOC	Health Emergency Operation Centre
HR	Human Resources
IMS	Incident Management System
IPC	Infection Prevention and Control
KAPBS	Knowledge, Attitudes and Perceptions and Behaviour Survey
MAF	Ministry of Agriculture and Fisheries
M&E	Monitoring and Evaluation
MESC	Ministry of Education, Sports and Culture
MNRE	Ministry of Natural Resources and Environment
MOH	Ministry of Health
MOOCs	Massive Open Online Courses
MPE	Ministry of Public Enterprises
MPMC	Ministry of Prime Minister and Cabinet
MWCSD	Ministry of Women, Community and Social Development
NCDs	Non-Communicable Diseases
NEOC	National Emergency Operation Centre
NGO	Non-Governmental Organization
NOLA	Nuanua o le Alofa
PHSM	Public Health and Social Measures
PIP	Pandemic Influenza Preparedness Framework
PSC	Public Service Commission
RCCE	Risk Communication and Community Engagement
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SMAR	Specific, Measurable, Attainable, Relevant and Time-bound
SOP	Standard of Operating Procedures
SRCS	Samoa Red Cross Society
SVSG	Samoa Victims Support Group
ToR	Terms of Reference
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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INTRODUCTION

Background

The COVID-19 pandemic is more than a health crisis. It is also considered a socio-economic development crisis due to the negative and destabilizing social, economic and development impacts experienced globally. The World Health Organization forecasts that more than 100 million people will live in the extreme poverty in the coming years[1] as a result of a major global recession caused by this pandemic.

To halt this pandemic, public education continues in earnest on the benefits of getting vaccinated and practicing all public health social measures (PHSM), also referred to as non-pharmaceutical interventions (NPIs) - such as cleaning hands, masking, physical distancing, cough and sneeze etiquette. However, it is the people's adoption of these measures, consistently, that is considered to be the most powerful weapon that will stop the transmission of the virus within countries, regions and globally. These measures cannot be understood, adopted and implemented without clear communication about their benefits versus the risk of COVID-19, and involvement of key stakeholders and communities in planning, guiding, decision-making and implementation of these measures. Hence, Risk Communication and Community Engagement are essential components of Samoa's preparedness and response actions to minimize the chances of coronavirus transmission in Samoa and mitigate its impacts upon our socio-economic development, and most importantly our health and well-being. For public health emergencies such as the COVID-19 pandemic, risk communication includes the range of communication actions required to be undertaken through the preparedness, response and recovery phases in order to encourage informed decision-making, positive behaviour change, and building and maintaining trust in health authorities.

This National COVID-19 Risk Communication and Community Engagement Strategy FY2020/21-FY2024/25 (RCCE Strategy) outlines the key RCCE strategies that will be employed to complement the National Epidemic and Pandemic Preparedness and Response Plan FY2020/21-FY2024/25 and COVID-19 Preparedness and Response Plan 2020 to address RCCE for COVID-19. Emphasis is particularly placed on improving communication between the Ministry of Health as the Health Sector leader and its partners, including the community, and strengthening COVID-19 preparedness and response capacity and mechanisms at the national and community levels.

Purpose:

This document is developed to guide the RCCE components of epidemic and pandemic prevention, preparedness and response for Samoa. It is intended to be used by all health and other partners who are involved in implementing epidemic and pandemic for instance COVID-19 pandemic preparedness and response at all levels, including the community and private sector. Accordingly, it supports the multi-sectoral approach that can address the widespread and enduring impacts of COVID-19 pandemic experienced by Samoa. In so doing, the strategy acknowledges that the challenges posed by COVID-19 pandemic will not be brought under control by short-term remedies alone. Rather, longer-term measures are needed to bolster multi-sectoral synergies that will help our community to navigate not only COVID-19, but a range of health, socio-political and economic impacts as well towards living with a new normal.

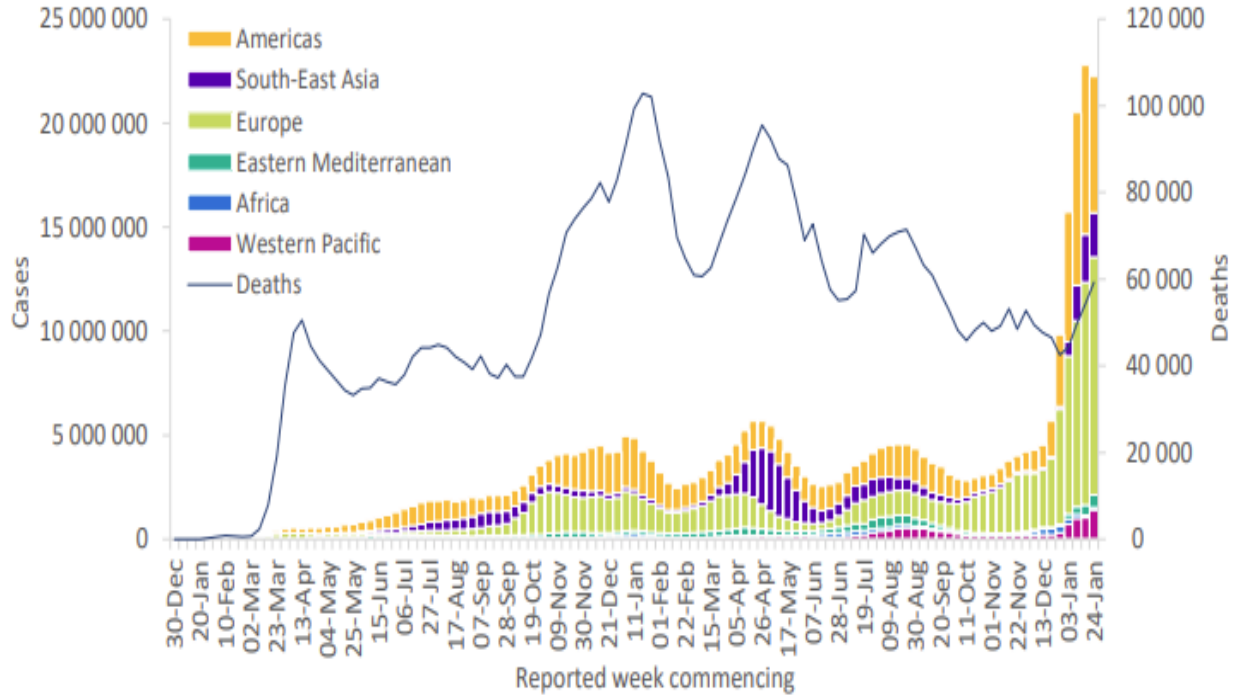
[1] WHO. 2021. *WHO Coronavirus (COVID-19 Dashboard). https://covid19.who.int (accessed on 23rd July 2021)*

COVID-19 EPIDEMIOLOGY

At the end of 2019, a novel coronavirus was identified as the cause of a cluster of pneumonia cases in Wuhan, a city in the Hubei Province of China. It rapidly spread, resulting in an epidemic throughout China, followed by a global pandemic. In February 2020, the World Health Organization designated the disease COVID-19, which stands for Coronavirus Disease 2019. The current COVID-19 pandemic is global human health crisis caused by Server Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2); previously, it was referred to as 2019-nCoV[2].

Global Status

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 30 January 2022**



Source: WHO COVID-19 Weekly Update for 1st February 2022

Globally, during the week of 24 to 30 January 2022, the number of new COVID-19 cases remained similar to the number reported during the previous week, while the number of new deaths increased by 9% (figure 1). Across the six WHO regions, over 22 million new cases and over 59 000 new deaths were reported (table 1). As of 30 January 2022, over 370 million confirmed cases and over 5.6 million deaths have been reported globally.

Regional Status

At the Regional level, increases in the number of new cases were reported by the Western Pacific (37%) the Eastern Mediterranean (24%) and the European (7%) Regions, while decreases were reported by the Region of the Americas (20%) and the South-East Asia Region (8%). The number of new cases reported in the African Region remained similar to that of the previous week. The number of new weekly deaths continued to increase in the South-East Asia Region (41%), the Eastern Mediterranean Region (32%) and the Region of the Americas (16%), while the African Region

[2] World Health Organization. 2020. *Director General's Remarks at the Media Briefing on 2019-n-CoV on February 2020.* Geneva. http:www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-11-feb-2020 (accessed on 4th August 2021)

reported a decrease of 7%. The incidence of deaths remained similar to the previous week in the European and the Western Pacific regions[3].

Local Status

To date, there are 31 (6 health workers and 25) confirmed cases of COVID-19 in Samoa which are all linked to the Qantas flight on 19th January 2022. These are all asymptomatic and in managed isolation. There is no community case reported.

Variants:

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has evolved rapidly into new variants throughout the pandemic. The Omicron variant has more than 50 mutations when compared with the original wild-type strain and has been identified globally in numerous countries[4].

On 26 November 2021, the World Health Organization (WHO) designated the SARS-CoV-2 variant B.1.1.529, named Omicron, as its fifth variant of concern (VOC). This decision was based on the evidence presented to health officials and researchers that Omicron had numerous mutations with potential implications for the ongoing pandemic. The Omicron variant has now been identified globally including countries throughout Asia, Africa, Europe, North America and in Pacific Island Countries including Samoa.

The current global epidemiology of SARS-CoV-2 is characterized by the continued rapid global spread of the Omicron variant. All other variants, including VOCs (Alpha, Beta, Gamma and Delta) and VOIs (Lambda and Mu) continue to decline in all six WHO regions.

Modes of Transmission:

Current evidence suggests that the virus spreads mainly between people who are in close contact with each other, for example at a conversational distance. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. Another person can then contract the virus when infectious particles that pass through the air are inhaled at short range (this is often called short-range aerosol or short-range airborne transmission) or if infectious particles come into direct contact with the eyes, nose, or mouth (droplet transmission).

The virus can also spread in poorly ventilated and/or crowded indoor settings, where people tend to spend longer periods of time. This is because aerosols can remain suspended in the air or travel farther than conversational distance (this is often called long-range aerosol or long-range airborne transmission).

People may also become infected when touching their eyes, nose or mouth after touching surfaces or objects that have been contaminated by the virus.

Further research is ongoing to better understand the spread of the virus and which settings are most risky and why. Research is also under way to study virus variants that are emerging and why some are more transmissible. For updated information on SARS-CoV-2 variants, please read the weekly epidemiological updates.

Preventive Measures:

The public is encouraged to practice the following basic COVID-19 preventive measures:

(i) Cleaning hands diligently using an alcohol-based hand sanitizer or soap and clean water;
(ii) Practicing respiratory hygiene by covering mouth and nose when coughing or sneezing;

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[3] WHO. 2022. *COVID-19 Weekly Epidemiological Update for 1 February 2022.* 20220201_Weekly_Epi_Update_77.pdf (accessed on 8 February 2022)

[4] Sun, Y. et al. 2021. *Origin and evolutionary analysis of the SARS-CoV2 Omicron Variant.* Journal of biosafety and Biosecurity 4 (2022) pp.33-37. 1-s2 0-S2588933821000558-main.pdf (accessed on 21 January 2022)

(iii) Avoiding touching the face in particular eyes, nose and mouth;
(iv) Cleaning and disinfecting objects and surfaces that are frequently touched;
(v) Avoiding crowds, physically distancing by 2 metres in public spaces;
(vi) Wearing masks, and correctly, in public places, especially important in a community transmission scenario; and
(vii) Ventilating enclosed spaces and avoiding closed spaces at home and at work, especially in community transmission scenario.

These measures are encouraged to be followed by all individuals even in a zero-case scenario. They will be encouraged even when Samoa achieves its vaccination goal of 95 % of the eligible population as part of the "Do it All' approach until the pandemic has ended. The support will also be provided by the health for the community to support the implementation of RCCE interventions at the community level.

SITUATIONAL ANALYSIS

This section, while not exhaustive, highlights some of the vulnerabilities and risk factors Samoans face for COVID-19. This vulnerability is a driving factor for the continued State of Emergency and strict border controls. Conditions for lifting them partially or fully depend on several factors including 95% of the eligible population is vaccinated and the evolution of the pandemic. Persons 12 years old and above are eligible to be vaccinated.

Everyone is at risk for COVID-19, however, persons with underlying diseases are most-at-risk in particular for severe disease, hospitalization and death. Samoa's 2020 population census places its population at 216,000; an increase from 192,126 from the previous census. The Country Cooperation Strategy 2018-2022 (CCS) cited that persons 18-64 years were at high risk for NCDs (2013) with 85 % obese/overweight.

According to the Hardship and Poverty report 2016 (2013/2014 analysis of Income and Expenditure report) 4.3 % of the population in Samoa and 2.9 % of the population in Savai'i lived below the food poverty line; 10.2% of Samoan were vulnerable to falling into poverty; 13.3 % of the elderly lived below the poverty line; 22 % of children lived below the poverty line; 15 % lived in open fales (houses). The data are an indication of vulnerability and challenge to adhere to public health social measures that also require purchasing cleaning agents for washing hands, disinfecting frequently surfaces, and washing bedding. Isolation as part of home-based care during community transmission will be challenging for vulnerable Samoans as well as the average household size was 7-8 persons according to the Socio-economic Atlas 2016.

The Socio-Economic Atlas 2016 ranked the Samoa's Standard of Living as medium (ranked 105 of 187 countries on 2015 HDI) as 99% of the population had access to improved sanitization (private households using flush or pour-flush and ventilated improved pit latrine toilets). The Samoa Demographic Health Survey (DHS-MICS) 2019-20 Report shows that piped water into urban homes is 99 % and 98 % in rural homes.

During 2020, the health sectors in very large countries had been easily overwhelmed with COVID-19 cases prior to the availability of vaccines, dangers of rumours and misinformation, denial of services, lack of leadership, etc. In 2021, this situation continues with resurgences in cases due to the highly transmissible Delta Variant aided by early roll-back of public health prevention measures and continuing hesitancy and resistance to vaccination. Many countries report that their epidemic is one of the unvaccinated as more than 95% of those hospitalized are either unvaccinated or not fully vaccinated. With this in mid, Samoa continues to focus on building awareness of the benefits of vaccines and public health social measures while building its capacity to care for potential COVID-19 patients, through training in infection prevention and strengthening its stockpile of medications and consumables.

Samoa's system capacity is small and will be quickly overwhelmed should there be community transmission due to undetected cases. As at 31st December 2021, there were 79 doctors working in the public hospitals, 34 working in private clinics, 8 Chinese Medical Specialists and 11 House Surgeons; 106 enrolled nurses, 509 registered nurses and 92 registered midwives and 63 new nurses under the 2022 Nurse Orientation Program. Currently there are 33 beds in the isolation ward and 4 dedicated for high dependency patients. Samoa's health system capacity is small and will be quickly overwhelmed should there be community transmission due to undetected cases.

RCCE capacity continues to be built to communicate COVID-19 risk to the public and the importance of prevention and how to manage at the household and community levels should there be community transmission. Religious and cultural practice such as drinking kava where sharing one coconut shell cup used by all attendees; sharing communion from one cup/vessel; and shaking hands as the sign of peace as practised in some faiths place persons at risk. Social activities that result in congregating

such as bingo gathering, weddings, funerals and ceremony for bestowing matai titles, are also pathways for the spread of the virus and need to be in the public's consciousness.

Ministry of Health collaborates on RCCE with the Ministry of Women, Community and Social Development (MWCSD), Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs) and Faith Based Organizations (FBOs). From May to September 2020, Ministry of Health with the support of WHO implemented a Knowledge, Attitudes, Perceptions and Behaviours Survey (KAPB) alongside community education and outreach at the Community Leadership, village and households levels. The results of the KAPB are presented below juxtaposed against the results drawn from findings from the global perception analysis, of the COVID-19 Socio-behavioural trends as they pertained to Public Health and Social Measures (PHSMs), undertaken by Dalberg summarized in Annex 4 WHO, UNICEF IFRC and the Global Outbreak Alert and Response Network (GOARN) in the Covid-19 Global Risk Communication and Community Engagement Strategy for the period of December 2020 till May 2021.

Knowledge of signs and symptoms

The evidence shows that "basic knowledge of COVID-19 across populations is now common – including knowledge about COVID-19 symptoms". Globally, "64% of survey participants could correctly describe COVID-19 signs and symptoms". In Samoa, approximately 90% of respondents recognised fever, 85% cough and 60% shortness of breath as main symptoms of COVID-19, while 60% of males and 57% of females identified at least three ways coronavirus is spread.

Knowledge of preventative behaviours

"Globally, self-reported adherence to personal measures such as hand-washing, mask wearing or keeping distance tended to be high generally. This is thought to be due to be influenced by local COVID-19 trends and the extent to which PHSMs are enforced." Approximately 50 % of Samoans practised at least three preventative COVID-19 measures. Hand-washing scored highest at 89%; Covering coughs and sneezes - 73% and disinfecting frequently touched surfaces – 57%.

Knowledge on what to do if COVID-19 is suspected

The global evidence show that "knowledge of COVID-19 symptoms was seen to be crucial to trigger appropriate health seeking behaviour, however, it did not necessarily lead to testing". May 2020 global data showed that 93 % of survey respondents did not attempt to get tested while showing signs of COVID-19. This was also true for 98% of persons who were exposed to someone who might have tested positive for COVID-19. Sixty-two percent (62 %) of Samoans responded that they would go directly to the hospital; 61 % would call the COVID-19 Hotline; and 43 % indicated that they would stay at home and self-isolate.

Barriers identified by respondents

Global data suggest that the risk of food insecurity and income loss can influence people's compliance with public health social measures. In short, "compliance with PHSM measures that restrict economic activities is likely to be lower". Adherence to public gatherings were also found to be often poor and influenced by socio-cultural factors such as gatherings such as for religious events, weddings, and funerals. Depending on the context, religion, it was concluded, could become either a barrier or an enabler to seek healthcare. Globally pandemic fatigue was seen as a potential barrier to the continuation of practicing PHSM and this manifested in adherence to self-isolation being lower when compared to other personal measures to prevent COVID-19. Concerns were also noted about the overall economic impact on the household e.g. loss of livelihood for those who are vulnerable and needed to isolate and thus heightened their risk for infection.

In Samoa, when asked "Do you have everything you need to protect you and your family from COVID-19?" approximately 80% of respondents said they had soap and clean water for hand-washing; 60% had alcohol-rub; 55% had disinfectant or chloride; and 35 % identified a separate room for isolation. Very few respondents indicated that they needed supplies like masks and hygiene kits with

disinfectants. Some indicated that they needed more regular updates and awareness programmes on COVID-19, however, the majority of persons worried about imported cases, community outbreaks and being exposed via frontline workers.

How people prefer/would like to receive information

The responses in this section are also dependent upon what questions were asked, i.e. how information was received or preference of channels to receive information. The PICs use, and reported, a mix of preferred channels to receive information, however, TV and Radio were the main media mentioned in all responses as well as various online sources.

Globally, many countries reported that health workers and traditional media channels as well-trusted information channels. In the reporting countries, 50% of the general population trust health workers, 44% television, and 38% radio and newspaper. In Samoa, 82% of persons surveyed stated that they received COVID-19 information from television including from the top shows Tala Fou and Health of the Nation. Sixty-six percent (66%) received information from radio and 41% from International News. Approximately 72% indicated that they did not have a preferred channel for receiving information even though the two TV shows scored highest for the receipt for COVID-19 information.

Ministry of Health and UNICEF conducted a Rapid Formative Assessment for New Vaccines Introduction in Samoa in the last quarter of 2020. The main findings of the Rapid Formative Assessment included that:

(i) Awareness of COVID-19:

- Most people surveyed (N+455) had heard about COVID-19)
- 92% reported that it was a serious disease; and
- 86% were very concerned about the disease

(ii) Information Sources

- Television (89%)
- Radio (63%) and
- Social Media (51%).

(iii) Willingness to get vaccinated

People were more likely to intend to receive a COVID-19 vaccine:

- if they had previously received an adult vaccine (4.95 times more likely);
- if family members and friends wanted them to do so (6.10 times more likely); and
- when they received positive support from the community and religious leaders (3.98 times more likely).

(iv) Barriers to routine vaccination (proxy for COVID-19 vaccination) – 10% of sample reported

- Distance to clinic (1.33%)
- Waiting time (1.6%) and
- Clinic opening times (0.53%)

Bearing these results in mind, the following are important data and information to help to also shape the situational analysis and guide the response:

- 94.4% of the eligible population was vaccinated at for the first dose and 52.4% second dose during the 2-days lockdown on 23 & 24 September 2021
- 95.8% of eligible population was vaccinated for the first dose and 83% second dose during the 1 day intensified vaccination on 19th November 2021 accompanied by threats of village fines
- 93% of eligible population aged 12 years to 17 years was vaccinated at first dose and 71% for the second dose of Pfizer as of 2snd February 2022.

- there were urges in demand for vaccines during a brief period (1 week) when no vaccinations were conducted as the first batch of vaccines was fully utilized, and there was a delay in shipment of the second batch of vaccines.

The stakeholders consultation conducted on 17th November on the Draft RCCE Strategy revealed that:

- some villages do not have matais so there are gaps in reaching populations when organizing through that system

- the IEC messages are not reaching the ground. This point to the need to strengthen community engagement efforts and consult with communities including at the household level to understand issues and to inform messaging and support needed. This approach is especially important for loosely structured communities. Important partners who are already entrenched in communities should be engaged in this effort.

- Need to balance RCCE for COVID-19 with other health promotion activities. It was noted that prenatal visits had severely dropped, and the vaccination rates of pregnant women is low.

Challenges:

Despite the Ministry of Health and the health sector's concerns of risks posed by COVID-19 upon the health and well-being of the population, there are challenges that the health workers have experienced in implementing RCCE works. These include:

1. Uncertainty

Samoa is COVID-19 free and has not experienced the impacts seen in terms of death sickness, social and economic disruption as in other parts of the world,. As the pandemic continues to rage and social and economic disrutptions continues world-wide, there will be repercussions for Samoa including reunifcation of families due to travel restrictions, ability to seek medical treatment , limited work for those who usually seek employment oversears, decreased remittances from family abroad etc.

2. Pandemic Fatigue

It's been almost two years since the Samoa government implemented preventive measures, including a State of Emergency with strict border controls to respond to COVID-19. While this has helped to keep Samoa COVID-19 free pandemic fatigue has set in, which has put some pessure on the government and the health sector to lift restrictions on mass gatherings, reopen the borders, and extend opening hours for businesses.

3. Misinformation

Increasing misinformation about COVID-19 continues to spread creating fear, panic and loss of trust in science and evidence presented; and vaccine hesitancy. Much of this mis-information is home grown or influenced by family and friends outside of Samoa. Vaccination of 95 % of the population is the condition upon which government will consider opening the borders.

4. Hygiene

Practicing basic santation and hygiene are effective foredisease prevention including preventing coronavirus infection. People may have become complacent due to pandemic fatigue. Given that Samoa is COVID-19 free, social distancing in public places, cleaning hands and wearing masks are not common practices . This is evidenced by the recent outbreak in rotavirus.

Given the forgone situation analysis and perspective plans in 2022 to reopen borders; offer vaccines to 5 – 11 year; offer booster shots where indicated; and ensure that the Samoans are able to positively respond to varying COVID-19 scenarios and comply with all health social measures requires the implementation of the envisaged RCCE strategy as laid out in the following section. There is also a need to build and strengthen Emergency Risk and Crisis Communication in the emergency response system and the requisite action to do so have also been address in section three.

WHY RCCE IS IMPORTANT?

A clear and integrated Risk Communication and Community Engagement strategy and response is very vital for community uptake for essential public health and biomedical interventions to prevent and control the spread of the disease, it also ensures the dialogue and participation of all stakeholders and affected communities during preparedness, readiness and response.

The importance of dedicated attention to Risk Community and Community Engagement in a response has been illustrated in the past experience of many infectious diseases in Samoa such as Avian Influenza pandemic in 2008, H1N1 in 2009 and the Measles Epidemic in 2018 being the most recent. It is very important for RCCE activities to be proactively carried along with other interventions for not only COVID-19 pandemic but future epidemics and pandemics to work together with other experts to reduce illness and deaths, and minimize disruptions to daily lives of communities.

For COVID-19 pandemic, Samoa has been proactive in its response by having early health preventative measures not only through imposing restrictions on its borders including health screening operation, but raising general public awareness on COVID-19. A series of Capacity building awareness sessions were held in October to November 2020, to raise awareness on key principles of RCCE and its best practices. These sessions were concentrated on the preparedness phase so that every trained individual is well equipped on these tools not only to train more people on COVID-19 Risk Communication and its preventative measures; but to build resilience amongst the communities during pandemics.

It is highly believed that implementation of RCCE effectively will contribute in enhancement of:

(i) Health service preparations and planning
(ii) Community engagement and psychosocial support
(iii) Infection prevention and control
(iv) Non-pharmaceutical measures and or interventions
(v) Surveillance laboratory services and
(vi) Negotiating will and commitment.

NATIONAL COVID-19 RCCE STRATEGIC AGENDA

Vision:

Accelerating risk communication and community engagement as public health prevention and control measures to protect people of Samoa's health and wellbeing from potential epidemic or pandemic influenza

Mission:

Optimize national capacities through multi-sectoral and multi-disciplinary approaches to protect the health and wellbeing of the population from social, economic and psychological impacts of an epidemic or pandemic influenza

Outcome:

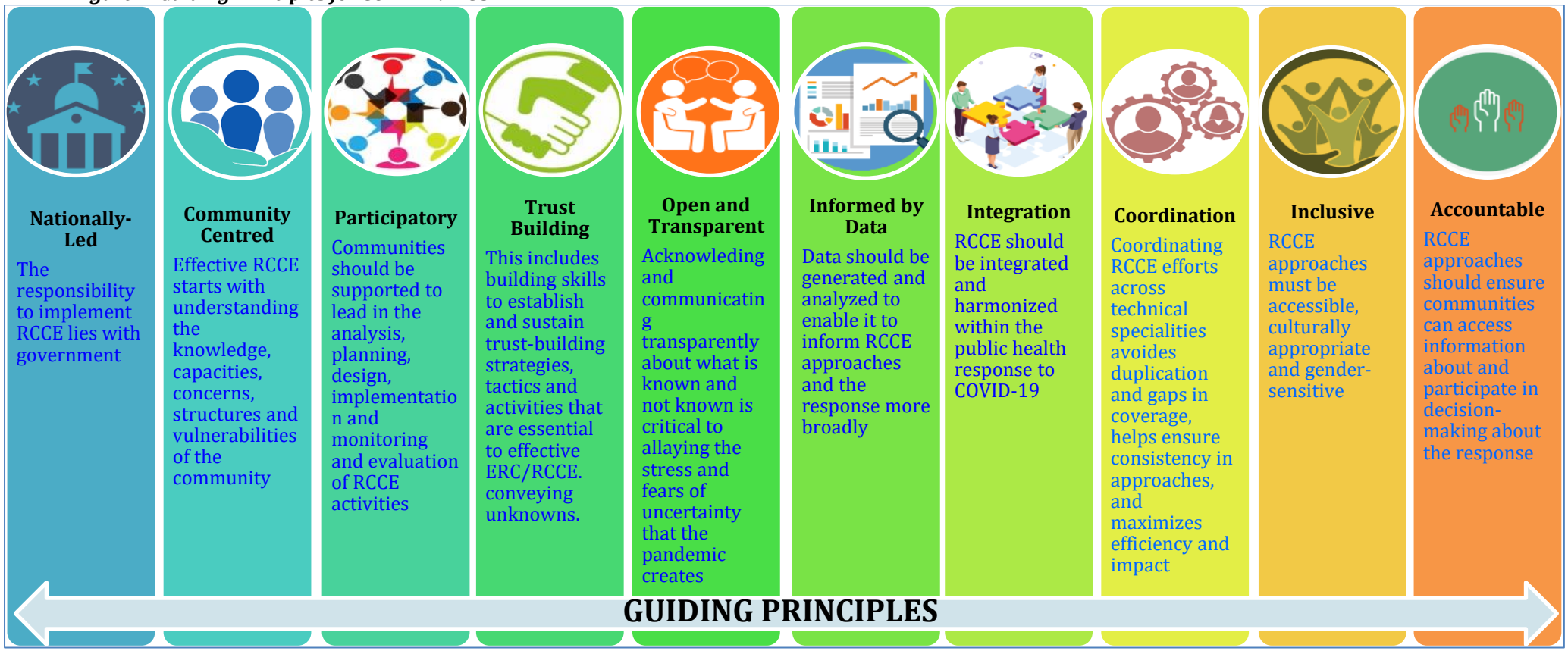
Samoa's Health and Emergency response systems have the capacity to deliver RCCE effectively

Given the challenges and vulnerabilities outlined it is important to anchor the COVID-19 RCCE Strategy in ERC/RCCE key principles and building blocks.

Guiding Principles

There is no one size-fits-all approach for effective risk communication and community engagement. Understanding our community is very crucial. Therefore, there should be guiding principles in place to guide RCCE activities and programs. The diagram below, presents core guiding principles adopted by the Ministry of Health and Samoa's health sector to guide the implementation of RCCE.

Figure 1: Guiding Principles for COVID-19 RCCE



Objectives:

The objectives of this strategy are to support the national goals of:

(i) 95% of eligible population 18 years and over in Samoa are fully vaccinated and understand COVID-19 risks and the benefits of COVID-19 vaccines

(ii) 95% of Samoans 18 years and over know how to protect themselves from COVID-19 and comply with public health measures to prevent community transmission and

(iii) 95% of Samoans aged 12 – 17 years old are fully vaccinated to protect them from the COVID-19

(iv) 95% of Samoans aged 5 – 11 years old are fully vaccinated to protect them from COVID-19

(v) 95% of the above eligible populations to receive booster doses

(vi) Communities and social, public and private sector institutions have COVID-19 preparedness and response plans that support prevention and mitigation of COVDI-19, including management during various outbreaks.

Outputs:

This strategy expected outputs include:

1. Data from Knowledge, Attitudes, Perceptions and Behaviour Surveys (KAPBS) and other rapid assessments on vaccines and public health social measures

2. Evidence-based RCCE campaigns, responsive to gender and vulnerabilities identified via KAPBS, support the achievement of national vaccination mandates for:

    - General population including pregnant and lactating mothers, and vaccine hesitant eligible population 18+ years old
    - Parents and caregivers of 5-11 and 12 – 17 years olds and
    - Populations eligible for boosters and third doses including front-liners and eligible general population.

3. Evidence based campaigns, responsive to gender and vulnerabilities identified in the KAPBS that support the implementation of national public health and social measures informed by solutions from the ground.

4. Health system capacity to monitor and respond to crisis and rumours arising from COVID-19 and COVID-19 vaccination.

5. Preparedness and response plans for COVID-19 outbreak in communities, social, public and private institutions, developed in collaboration with relevant public health emergencies response agencies.

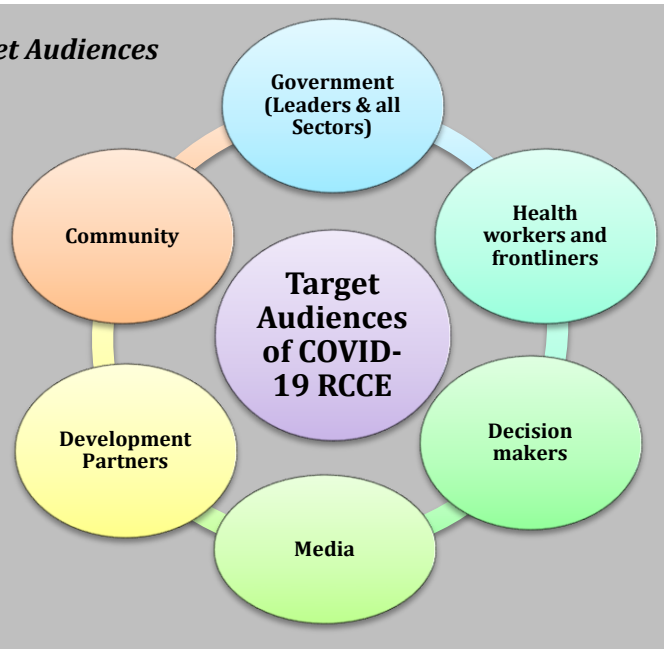
6. COVID-19 prevention and mitigation planning and sensitization sessions for communities, social, public and private institutions.

Target Audiences:

Against this background RCCE strategies must be tailored using evidence to target at-risk populations. In the context of COVID-19 pandemic, all of Samoa is viewed as being at- risk with selected populations at higher risk due to specific vulnerabilities such as health and living conditions, etc.

Figure 2 presents target audiences.

Figure 2: RCCE Target Audiences



Note:
In the context of COVID-19 pandemic, all persons are potentially at risk in the absence of preventive practices

Engaging the Most Vulnerable

While developing and implementing RCCE interventions and programs for COVID-19, our efforts prioritize those who are at a higher risk. These are presented in Table 1 below.

Table 1: List of at most-risk Populations of COVID-19

POPULATION GROUPS	RISKS
Health workers	Doctors, nurses, allied health professionals, community health workforce and others responding to COVID-19 are at a higher risk of developing the disease due to close personal exposure to COVID-19 confirmed cases/patients.
Older persons	Older persons at the age of 60 years and above are more likely to develop severe illness as a result of COVID-19. According to global COVID-19 situational reports, they have a higher fatality rate than other age groups. They may not be able to access health services and information. They may have difficulty caring for themselves as they depend on families or caregivers.
People with pre-existing medical conditions	People with underlying medical conditions such as cardiovascular disease, diabetes, chronic respiratory disease and cancer) have increased the risk of developing serious illness as a result of COVID-19, especially those with a compromised immune system.
Children and young population	Children and adolescents are particularly vulnerable to the socio-economic impacts and in some cases by pandemic mitigation measures such as school closures. Importantly, they will be infected with the virus if transmitted from adults as of now, they are not vaccinated due to unavailability in Samoa of COVID-19 vaccines children under 12 years old..
People with disabilities	People with disabilities are particularly vulnerable. Even under normal circumstances they are less likely to access healthcare and to participate in community life as they also depend on care-givers..
People with mental existing mental health conditions	People with existing mental health conditions may have difficulty understanding and following information about the situation and preventive measures. Stress and uncertainty about the pandemic may induce or worsen their conditions. Disruptions

POPULATION GROUPS	RISKS
	in mental health services may reduce access to services they need.
Pregnant women	Antenatal services may be disrupted when health services are overburdened. Frequent contact with health facilities for antenatal visits and needed medical checks can increase the risk of infection. The mRNA vaccines have been approved for pregnant women but are not available in Samoa as of the time of writing this document.
People living in overcrowded areas	There is a high risk of infection if people that live in cramped conditions without proper access to sanitation. Physical distancing may be difficult in overcrowded dwellings and where there is frequent movement of individuals between dwellings.

Regardless of audiences, everyone wants to know three key things during a public health emergency such as COVID-19.

1. **Public health emergency:** What has happened? How bad is it? Who is affected? Who is Responsible? What do you know for certain?

2. **Risk:** Is this dangerous? Are my loves ones and I at risk? Who is most affected? What increases and decreases my risk?

3. **Action:** What can be done to prevent getting sick? What is being done? What can I do to protect myself and my loved ones? What should I do if I, or one of my family members is sick? Who will take care of me or one of my family member if s/he becomes sick?

IMPLEMENTING THE RISK COMMUNICATION AND COMMUNITY ENGAGEMENT STRATEGY FOR COVID-19

Key Strategic Area 1: Coordination and Planning:

The Ministry of Health Samoa, as the health sector leader and national focal point for the International Health Regulations, is mandated under the Health Ordinance 1959 and the International Health Regulations 2005 to take the lead in RCCE and Emergency Risk and Crisis Communications (ER/CC). This requires the Ministry of Health to work closely with relevant partners from the community and government response agencies under the Health Ordinance 1959 and Disaster Management Act 2007, regional and international agencies under the International Health Regulations 2005 to strengthen RCCE.

However, at the national level, the Disaster Advisory Committee is the highest national body in charge of the National COVID-19 pandemic response in Samoa. This core structure of the Disaster Risk Management in Samoa is located in the Disaster Management Office and Disaster Advisory Council as the focal points to initiate the coordination and implementation of all four phases of disaster risk management cycle: (i) risk reduction; (ii) preparedness; (iii) response and (iv) recovery.

At the technical level, the Health Emergency Operation Centre mobilizes and builds capacity of the health workers from the three main areas of health (corporate governance and regulations; public health services and hospital and clinical services to:

(i) coordinate and implement a harmonized RCCE strategy;
(ii) strengthen the generation of COVID-19 Situational Reports and use evidence to inform the development of public health interventions including health advocacy programs; and
(iii) offer coordination and logistical supports for the implementation of the RCCE Strategy.

This includes building the capacity of all stakeholders to conduct RCCE at the national and community levels before, during and after an epidemic or pandemic like COVID-19 pandemic.

Samoa's Epidemic and Pandemic Planning Process for Health Sector

The Health Promotion Team in the Ministry of Health currently undertakes the RCCE functions and is also responsible for the implementation of numerous health advocacy and community engagement programs.

To build, ensure and support multi-sectoral/stakeholder ownership of the response, planning and implementation must be done with multi-sectoral stakeholders, especially those who lead in specific sectors. The Ministry of Health will, therefore, establish a multi-sectoral RCCE Committee to provide overall technical support and evidence-based guidance to the Health Emergency Operations Committee (HEOC) and National Emergency Operation Centre (NEOC). Coordination activities for RCCE, which must include key sector partners, ensures that important stakeholders are available for the planning and response and that diverse views and represented. Planning activities include research to inform the development of the overall communication strategy and plan, which will include specific, measurable, attainable, relevant, time-bound (SMART) objectives, activities, key messages and materials.

Actions

1. ***Establish the National RCCE Committee and develop ToR***
   Members should include representatives from the Ministry of health, Ministry of Education, Sports and Culture (MESC), Ministry of Prime Minister and Cabinet, Ministry of Women, Community and Social Development (MWCSD), Public Service Commission (PSC), Ministry of Public Enterprises (MPE), Faith-based Organizations (FBO), Community Based Organizations

(CBO), Non-Governmental Organization (NGO), WHO, UNICEF and other entities relevant to the achievement of the Risk Communication and Community Engagement Outcomes and Outputs.

Develop a TOR for the National RCCE committee to guide the roles and functions of the Committee including to:

(i) Support communities, sectors and stakeholders to develop costed COVID-19 prevention, preparedness and response plans to outbreaks
(ii) Support the implementation of thematic Sub-committees to progress the work of the RCCE (see below).

2. Establish RCCE Sub-Committee and develop Terms of Reference (ToR)

Establish RCCE Sub-committee with a Chair, Co-Chair and Terms of Reference with representation from key NGOs, FBOs and CBOs who can support the work of the RCCE sub-committee, which will focus on key outputs as per the below examples:

Example 1:

a) Sub-Committee: Community Preparedness for Outbreak Response
b) Members: MOH, MWCSD, Samoa Red Cross Society (SRCS), Adventist Disaster Relief Agency (ADRA), NOLA (focused on disability), SVSG (focus on violence women and girls).

Expected Outputs:

(i) Community preparedness and response plan that can be adapted by communities with form and informal structures
(ii) Costed plans for sensitization and planning sessions with communities to adapt the community response plan; prioritizing the most vulnerable communities and households. Plans will also include: community profiles of vulnerability, barriers and enablers to vaccination and PHSMs, processes to support the implementation and analysis of KAPBS, alignment of data capture tools among implementing partners, to streamline data capture and analysis
(iii) Establish district/community level RCCE working group.

Example 2:

a) Sub-committee for schools and education sector's preparedness for outbreak response
b) Members: MOH, MESC, MWCSD, Parents-Teachers Association, NOLA, UNICEF, WHO

Expected Outputs:

(i) Schools and education sector preparedness and response plan, aimed at avoiding school closure and to safely re-open schools that can be adapted by schools and other academic institutions
(ii) Costed plans for sensitizations and planning sessions with the education sector.

Example 3:

Other Sub-committees established will focus on support the development of outbreak response plans for other sectors – FBOs, Public Sector various private sector industries, etc. and concomitant advocacy activities as required.

3. National RCCE Committee & Sub-Committees Meetings

Host regular committee and sub-committee meetings and produce reports. This also serves monitoring and evaluation.

4. ***RCCE Costed Micro-Plan***
   Develop costed micro-plans that support addressing specific objectives and issues necessary to implement this strategy and to address issues that may arise over the lifetime of this plan.

5. ***RCCE Strategy Implementation Funding***
   Advocate for funding to support the implementation of the RCCE activities.

6. ***RCCE members Capacity Building***
   Build the capacity of RCCE members in both the National RCCE Coordinating Committee and Sub-committees through regular training, workshops or consultations including via briefings from HEOC, WHO and UNICEF Massive Open Online Courses (MOOCs), and updates on COVID-19 with the support technical partners such as WHO and UNICEF.

7. ***Crisis Communication Plans***
   Develop and implement Crisis Communication Plans and Communication for Development Plans.

8. ***Frequently Asked Questions***
   Develop Frequently Asked Questions (FAQs) on vaccines, public health social measures and other thematic related issues to facilitate training, talking points for spokespersons for responding to media and social media proactively and reactively.

9. ***Proper use of KAPBS Data***
   use the evidence from disaggregated data from KAPBS and rapid assessments to guide the development of key messages and information education communications materials for targeted groups.

10. ***Communications Clearance and Pre-Testing Procedures***
    Develop clearance and pre-testing procedures to ensure that all messages and communications materials are of high quality, revised are needed and are responsible to the target audiences.

11. ***Media and Social Media Strategies***
    Develop media and social media strategies to proactively drive education and advocacy efforts.

Key Strategic Area 2: Social Data Collection and Use

The RCCE Coordinating Committee shall ensure that all RCCE activities are evidence-based/informed. Under the leadership of the Director General, MOH divisions collaborate on risk communication and community engagement as indicated in the below table:

MOH DIVISIONS	COMMUNICATION FUNCTIONS
Laboratory	Notify the National Health Surveillance and International Health Regulations Division of a notifiable disease outbreak
National Health Surveillance and International Health Regulations	Conduct contact tracing, disease surveillance and prepare situational reports
National Health Programs, Wellness, Health Education and Health Promotion	Support risk assessment based on data and information received for the Surveillance and Health Information Services, and other risk assessments undertaken, lead and facilitate the development of RCCE IEC materials and public awareness programs to inform the public and response agencies of the disease outbreak.
Integrated Nursing and Patient Care Services	Provide information on nursing and patient care
Health Information Services, Monitoring and	Lead the data information collection, collation

MOH DIVISIONS	COMMUNICATION FUNCTIONS
Evaluation	and analysis for development of health statistical bulletins to inform policy advisories provided for the government's decision making
Health Information Technology and Communication	Lead and facilitate IT support required for implementing COVID-19 RCCE programs and other pandemic Responses
Health Protection and Enforcement	Provides support in coordinating and facilitating information and data collection on Healthcare Waste Management and Sanitation for RCCE purposes
Infection Control and Quality Assurance	Provide Infection Control information and AEFI reports for RCCE purposes
Finance and Procurement	Provide financial and procurement support for RCCE
Health Sector Coordination, Resourcing and Monitoring	Provide support in coordinating and providing resources to support the implementation of RCCE programs and activities
Human Resources and Administration	Assist with addressing HR issues related to RCCE
Strategic Planning, Policy and Research	Facilitate the development and review of RCCE strategies and policies

Collaboration among these divisions supports the interactive nature of RCCE where RCCE informs Risk Analysis and Risk Analysis informs Risk Communications.

Actions

1. ***Social Data Desk Reviews***
   Conduct desk reviews of existing social data, survey, studies, COVID-19 RCCE studies, immunization surveys, other formative research and identify gaps to inform RCCE studies and surveys or formative research that should be conducted to better understand community risk perception for PHSMs, COVID-19 vaccines, acceptance of vaccines, influencers etc.

2. ***Research Agenda***
   Develop a Research Agenda, with a costed implemented plan and funding and implementation partners identified.

3. ***Partnership in RCCE***
   Map partners that conduct complimentary research, and frequency and assess the potential for collaboration.

4. ***Analysis of Communities***
   Build an online repository of relevant research/studies and analysis of communities that should be updated regularly and ready to access and use for analysis during an emergency. Key variables should include:
   a. *Demographic* – age, sex, and gender distribution; education levels, disease patterns, vaccination coverage, infant mortality, malnutrition rates, literacy rates, vulnerable groups etc.

   b. *Cultural aspects* – existence /nonexistence of hierarchical structures, religion, social values, traditions.

   c. *Economy of communities* - livelihoods, wealth, poverty, economy type (commercial, fishing, agricultural, mixed, etc).

d. *Infrastructure* - assess structural and systemic capacity including human resources, technological and other physical resources that support the communications effort as well as physical infrastructure and industries nationally and at the community level. This includes communication, transport, essential services, community assets, housing type, government structures, resource base, water and sanitation and health care.

e. *Environment* - understand the existing communications, health and other capacities at all levels from nation, social/institutional, community and individual to respond to the emergency. Waterways, climate, flora and fauna, geology and landforms, access by land and sea are important to understand.

f. *Culture* - traditions, ethnicity, social values, religion, attitudes toward hazards and perception of their risk to the hazard, food and eating habits, power structures.

5. ***Local Capacity of RCCE Implementers***
   Map local capacity of companies to undertake RCCE work. Draft TORs and contract research agency to support the development and implementation of identified studies, surveys, formative research, rapid assessment identified from the desk reviews and feedback mechanisms.

6. ***Gender Balance***
   Ensure that all data capture tools are responsive to gender, equity and rights, and identify vulnerabilities, enablers and barriers that affect access to vaccines and adoption of PHSMs.

7. ***RCCE Rapid Assessment***
   Develop and implement rapid assessment data capture tools that can be quickly implemented online, via the COVID-19 Hotline, and in the communities and health facilities, including by partners. Rapid assessments will help to quickly understand issues arising and support real-time redress.

8. ***Social Listening***
   Conduct Social Listening via social media, help/Hot-lines, community feedback, and traditional media to analyze sentiments on PHSM and vaccines from the public and interest groups and provide reports to the HEOC with recommendations.

Key Strategic Area 3: Mass Media Plan

The RCCE Committee will ensure the development and implementation of a Mass Media Plan with evidence informed messaging. This will include printing and dissemination of information, education and communication (IEC) materials, and message dissemination through mass media and social media campaigns. The budget should include the printing of the IEC materials, distribution costs, costs for production of public service announcements (PSAs), broadcast costs and social media boosting costs.

Actions

1. ***Costed Mass Media Plan***
   Develop a costed mass media plan, for media placement of products based on research and channel analysis of audience preference and reach.

2. ***IEC Materials Development***
   (i) Develop budgets to support IEC materials development, testing and revision, production and dissemination of messages and printing of the IEC materials,

distribution costs, costs for production of public service announcements (PSAs), broadcast costs and social media boosting costs.

(ii) Develop, produce and disseminate information, education and communication (IEC) materials through mass media and social media campaigns. Ensure that they are tailored for targeted audiences, informed by evidence and address gender, equity and rights, and vulnerabilities.

(iii) Develop and adhere to clearance and pre-testing processes to ensure that quality products are produced that response to targeted audiences.

3. ***Capacity Building for MOH Media personnel***
   Strengthen capacity of RCCE staff and internal media personnel on developing ads, audio visual and recordings

4. ***Public Announcements***
   Contract agency to develop public service announcements PSAs/advertisements for TV and radio and social media.

5. ***Public Health Press Releases***
   (i) Develop of draft public press releases to support early announcement of events, emerging issues especially crises and Adverse Effects from Immunization (AEFIs).

   (ii) All draft public health press releases should be screened by the National RCCE Committee and submit to the Chair of HEOC for endorsement before releasing to NEOC, Cabinet and Government Press Release.

Key Strategic Area 4: Social Media Monitoring and Misinformation Management

The RCCE Committee will ensure implementation of social media monitoring, misinformation management and reporting and redress of issues arising in real-time. Tracking information regularly on both social media and mainstream media, including early in the onset of an emergency, and delivering quick responses to mitigate rumours and disseminating accurate information will be critical to maintain public trust.

Actions

1. ***Monitoring of Social Media and Mainstreaming of Media***
   Actively monitor social media and mainstream media to identify any anti-vaccine sentiment, fake information and rumours and other misinformation on COVID-19.

2. ***Management of Rumours and Fake News***
   (i) Respond to rumours, fake news early and in real time through sending accurate messages, having spokespersons speak to media etc. Responses should always be cleared by RCCE committee and HEOC chair before release to the public.

   (ii) Use pre-approved text from FAQs and inform sheets to improve response times.

   (iii) Build alliance with media networks in order to respond quickly to anti-vaccine sentiment, fake news etc. and assign a RCCE team member to undertake this function as a priority to all other functions.

   (iv) Train and authorize RCCE member/s to use FAQs to respond to rumours and misinformation in real-time.

(v) Collaborate with WHO and UNICEF to develop system that will assist with detecting fake news.

3. ***HEOC Daily Reports***
   Provide RCCE daily reports to HEOC from social media and media monitoring activities and with talking points to address issues to be addressed urgently.

4. ***Public Health Surveillance Dashboard***
   (i) Establish digital dashboards to report and share behavioural data and information.

   (ii) Collaborate with partners to adapt technological solutions for RCCE including software, dashboards for social media and monitoring.

Key Strategic Area 5: Crisis Communication/Emergency Risk Communication

Emergency Risk Communication (ERC) is an intervention performed before (preparedness), during (emergency onset), and after (recovery) in an emergency situation to enable the public to make informed decisions to protect themselves. ERC is one of the core capacities that all WHO Member States must build as signatories to the International Health Regulations 2005 (IHR).

Additionally, it is also a key component of global and country preparedness processes for an influenza pandemic, as part of the Pandemic Influenza Preparedness (PIP) Framework that has to be implemented specifically for epidemics and pandemics. The aim of an Emergency Risk/Crisis Communication Plan is to support the country to respond appropriately before, during and after an emergency event:

- ✓ communicate in a timely and transparent manner;
- ✓ coordinate communication to targeted audiences to allow them to make informed health decisions;
- ✓ engage with affected communities, maintaining two-way communication; and
- ✓ use effective communication channels and engage stakeholders.

The RCCE Committee will support the HEOC and NEOC's Crisis communication and support training personnel in Crisis Communication. It will ensure that

(i) its members know the Standard Operating Procedures (SOPs) and protocols developed to address possible adverse events following immunization (AEFI);

(ii) the process established for evaluating the situation, providing full information to the RCCE team to determine the public messaging;

(iii) subsequent efforts to monitor the situation; and

(iv) agreement on further communications.

The RCCE Committee should have a member from the AEFI committee on its team to facilitate understanding of key issues and fluid communication on AEFIs and early announcements to the public. Capacities to be effective in this area are:

Actions

1. ***Crisis/Emergency Risk Communication Capacity Building for Staff***
   (i) Domesticate the WHO Emergency/Crisis Communication Plan

   (ii) Conduct workshops on Crisis/Emergency Risk Communication, to develop and review plans and build the capacity of stakeholders at national and community levels involved in the emergency response.

(iii) Develop Standard Operating Procedures (SOPs) on what to prepare for crisis, during crisis and post crisis, prepare draft press releases. (*see draft template here*)

(iv) Implement the crisis communication plan as the situation demands (*align it to vaccine safety guidelines developed by WHO and see ERC planning document here for adaptation*)

(v) Identify key members from the surveillance and/or clinical teams who will ensure that timely and correct information is available to the RCCE team.

(vi) Identify and train spokespersons at national and subnational levels on how to communicate transparently to build trust in crisis situations.

Key Strategic Area 6: Advocacy and Community Engagement

The RCCE committee will plan and implement advocacy activities, sensitization sessions and events and materials to build the commitment of in-country partners and stakeholders for COVID-19 vaccination, public health social measures and developing stakeholder plans. Budget for events should include all costs for orientations to key stakeholders, printing of advocacy kits, venue costs etc. Key RCCE capacities in this are:

Actions

1. ***Capacity Building and Advocacy***
   (i) Conduct RCCE training and COVID-19 sensitization for the MOH and key stakeholders (bi-annually/annually). This will include training for Spoke-persons, MOH staff to build capacity to communicate with various publics and to produce quality of IEC materials from technical content, other government staff and Media, NGOs, FBOs, CBOs and other stakeholders. These sessions will also aim to receive feedback from key stakeholders on their needs and redress by the MOH, and to facilitate improved information exchanges.

   (ii) Build the capacity of community representatives and interested groups to assist MOH with dissemination of information at the community level.

   (iii) Develop a training plan to deliver COVID-19 RCCE capacity building for stakeholders and risk communicators.

   (iv) Conduct RCCE simulation exercises (bi-annual/annual) to test RCCE capacity and plans. This can be extended beyond the MOH to include sectors and communities.

   (v) Ensure that RCCE is a key component of simulation exercises that test the emergency and preparedness response system and coordination capacity and skills among all levels of the emergency response system.

2. ***Media Kit***
   Develop a specific media kit.

3. ***Advocacy Kit***
   Develop advocacy kits with print materials (including FAQs and key messages)

4. ***Promotion of RCCE National Communication Platforms***
   Create and promote RCCE national communication platforms to exchange knowledge and ideas, information, for discussion and connecting experts. This may include bi-annual/annual

symposia, national consultations, stakeholder and engagement with online communities of practice.

Key Strategic Area 7: Community Engagement and Social Mobilization

The RCCE Sub-Committee in collaboration with MOH RCCE team and each sector leading agency will facilitate the coordination of social mobilization activities and efforts targeted to community leaders and stakeholder groups in relation to COVID-19 vaccine and adoption of public health social measures and to develop outbreak response plans.

Actions

1. ***Community Engagement & Sensitization***
   (i) Engage, educate and sensitize communities, including with community leadership structures/mechanisms, FBOs, CBOs, and NGOs where existing on community preparedness and response plans, general COVID-19 education and discussions on community solutions.

   (ii) Leverage public events: sports competitions, cultural festivities etc., to engage communities in sensitization and awareness of vaccines and PHSM.

2. ***Community public health mapping***
   Conduct mapping of nongovernmental/community-based organizations operating in underserved communities, including those working with priority populations to ensure robust social mobilization and collaboration with communities.

3. ***KAPBS & Community Rapid Assessments***
   Implement KAPBS and community rapid assessments with relevant stakeholders in underserved and vulnerable areas, with a focus on marginalized groups, to build knowledge and support analysis of enablers and barriers to vaccination and adoption of PHSMs.

4. ***Community Education and Leadership***
   Conduct community education with community leadership and house- to- house, with a focus on vulnerable households, in collaboration with NGOs and CBOs and community leadership mechanisms.

Key Strategic Area 8: RCCE Capacity Building

The RCCE Committee will entrench capacity building as a continuous process where training is scheduled routinely and budgeted to refresh knowledge in RCCE, COVID-19 and new needs and issues identified and addressed including new COVID-19 related guidance, data and other information. It is important to conduct needs assessments to inform trainings aimed at reinforcing COVID-19 knowledge and service delivery skills of staff, government staff, institutions and community mobilizers. As this applies to COVID-19 vaccines and public health social measures, opportunities to strengthen capacity across appropriate areas of routine immunization implementation and diseases should be pursued.

Actions

1. ***RCCE Capacity Building Training Plan***
   (i) Develop a training plan to deliver COVID-19 RCCE capacity building for stakeholders and RCCE personnel. Key topics should include: RCCE for RCCE personnel, IPC, Crisis Communications, COVID-19 Vaccines and PHSMs among others.

   (ii) Build a cadre of RCCE personnel by inviting and identifying interested persons from MOH, other ministries, communities and students who are good orators to be trained and to form a core group of risk communicators.

2. ***RCCE Simulation Exercises***

(i) Conduct RCCE simulation exercises (bi-annual/annual) to test RCCE capacity and plans. This can be extended beyond the MOH to include sectors and communities. Ensure that RCCE is a key component of simulation exercises that test the emergency and preparedness response system and coordination capacity and skills among all levels of the emergency response system.

(ii) Support simulation exercises with stakeholders, sectors and communities as part of the outbreak response planning.

Key Strategic Area 9: Monitoring & Evaluation, Analysis and Reporting

All communications, strategies and plans, and information systems employed in ERC/RCCE must be consistently monitored and evaluated to understand their effectiveness, gaps, and good practices to be able to improve RCCE and programming. The RCCE Committee will develop plans and activities for the monitoring and evaluation of communication activities and the implementation of the RCCE Strategy. This will also include developing monitoring checklists and rapid surveys to assess the effectiveness of communication activities, and analysis of these as indicated in the section on social data collection.

Actions

1. ***Development of RCCE Monitoring tools***

(i) Develop monitoring and supervision checklists for activities

(ii) Integrate monitoring questions into the monitoring tools of overall program (rapid convenience surveys, monitoring checklists, post introduction evaluation etc.)

(iii) Establish community feedback mechanisms and use the feedback for program improvement.

(iv) Conduct survey to track progress against indicators, where necessary.

2. ***RCCE Analysis and Reporting***

RCCE team to regularly report to HEOC and provides feedback on its plans and results on audience engagement and RCCE analysis.

3. ***Costed RCCE M&E Plan***

Develop a costed plan that would determine the frequency of COVID-19 RCCE impact assessments to be conducted.

HEALTH SYSTEMS AND RCCE CAPACITIES

The MOH will ensure that Samoa's health and emergency response system is strengthened and has the following Emergency Risk Communication/Risk Communication and Community Engagement capacities to perform its key ERC/RCCE functions under this strategy. These capacities include:

1. **Analysis:** This is the ability to conduct socio-economic-political, cultural analysis, national and audience profiles to be carried out in the preparedness phase, updating continuously during the response and recovery phases.

2. **Communication:**
   - **(i)** **Strategic communication:** This is the ability to develop or update the national risk communications strategy using a multi-hazard approach focusing on the most likely and/or highest impact hazards foreseen for the country or its sub-levels.
   - **(ii)** **Translation communication:** This is the ability to build and sustain skills to transform scientific information into contextualized, culturally acceptable and understandable communication and information, education and communications products.
   - **(iii)** **Media Communications:** This is the ability to meet the demands of the 24/7 news cycles, to address public and political concerns. Strong skills and capacity are required including the development of media policies, strategies, SOPs and skills of spokespersons.
   - **(iv)** **Mass Media Communication:** This encompasses social mobilization; Mass production, use and dissemination of Information, Education and Communication (IEC) products and locally relevant strategies to reach the public with information they need.
   - **(v)** **Stakeholder and partner communication:** This refers to the skills, platforms and strategies for engaging and satisfying information and access needs of all stakeholders.

3. **Trust Building Activities:** This includes building skills to establish and sustain trust-building strategies, tactics and activities that are essential to effective ERC/RCCE. This includes developing and using skilled and credible spokespersons; being transparent even in times of uncertainty; and admitting mistakes; and conveying unknowns.

4. **Simulation exercises:** use simulation exercises (SIMEX), in the absence of a real emergency, to test and strengthen, ERC systems and skills, and table- top exercises to test SOPs and coordination.

5. **Coordination skills and capacity:** This is the ability to establish and use coordination mechanisms and protocols between national, local and international partners.

6. **Rapid assessment of stakeholders and audiences:** This is the ability to conduct, analyze and apply rapid assessments of stakeholder groups' preferences, beliefs, practices and traditions, using various assessment strategies, platforms and tools.

7. **Message development and revision:** This is the ability to test, contextualize and adapt pre-prepared messages and other core communication materials to meet stakeholder needs, and to address perception, fears and beliefs of different groups.

8. **Community engagement:** This is a mechanism that ensures that ERC/RCCE personnel are able to engage with communities using relevant strategies aligned to the local context to mobilize communities, understand their perspectives, gain feedback aimed at supporting their needs so they can take protections actions.

KEY HEALTH SYSTEM SUPPORT NEEDED TO IMPLEMENT THE RCCE STRATEGY

Governance and Leadership

Develop an ERC/RCCE policy to facilitate, integrate and build ERC/RCCE health and emergency preparedness and response systems (DAC, NEOC, HEOC). Develop, strengthen, or adapt SOPs to guide the internal and external RCCE coordination, planning, collaboration and implementation within MOH, with government ministries and with external stakeholders such as NGOs, FPO, CSO, including for data, and to support speaking with one voice and transparency.

Human Resources

A costed Human Resource plan is needed. Dedicated RCCE staff are needed or otherwise identify where responsibilities could be shared among units in the MOH and in the emergency response system and determine the collaborative arrangements to effect RCCE. A review of current HR capacity is needed to inform the appropriate complement of staff to undertake RCCE alongside health promotion activities.

Staff must be trained consistently including via WHO online MOOC courses in RCCE and on simulation exercises for epidemics, pandemics and outbreaks. Key responsibilities include:

- ✓ Policy setting and review;
- ✓ Planning for ERC;
- ✓ Planning, advocating and coordinating human, financial and other resources;
- ✓ Research, gathering and analysing information;
- ✓ Monitoring, evaluation, documentation and reporting;
- ✓ Operations management
- ✓ High-level guidance; and
- ✓ Training
- ✓ Stakeholder and Community Engagement
- ✓ Development of IEC Materials
- ✓ Social media communication and monitoring
- ✓ Media and graphic design

Financing

There must be a readily accessible source of funds, budgeted and available, to facilitate ERC/RCCE including for staffing, capacity building and training, simulation exercises, software and equipment, media and mass media communications including translation services, external production services where needed, monitoring and evaluation activities, including through surveys/studies and overtime expenditures and housing for personnel, etc.

Funding the RCCE response needs to assessed and a report developed for consideration of the HEOC through an a focused exercise aimed at gathering, analyzing the adequacy of existing resources, gaps and the impacts; how to access the external resources; and potential funding mechanisms. Key areas of focus are:

- ✓ Structural and non-structural expenses including information platforms and resources;
- ✓ Facilities and equipment need, including replacement and maintenance; and Funding, sources, and sustainability.

Partner support should engage to:

(i) Identify potential funding support and their requirements to facilitate efficient transfer of resources and

(ii) Identify budget lines in other ministries for ERC should also be established and pre-agreements reached on their purpose, management and use.

Technology

RCCE Technological Needs Assessment and Plan needs to be developed and key focus areas are:

- ✓ Conduct a technology needs assessment to inform investments in technology, software and hardware needed for RCCE functions.
- ✓ Develop a costed plan that would address procurement, maintenance and updates of technology, software and hardware for RCCE, and which serves other units and departments purposes.
- ✓ Ensure that there is a costed data plan to facilitate communication in the field to facilitate data collection via tablets, telephone surveys etc
- ✓ Invest in the technology, software and hardware needed to perform RCCE including publishing software for the development of IEC materials, desktop computers and laptops, tablets, phones, audio-visual equipment and other devices to facilitate field work.
- ✓ Determine which IEC outputs and technological needs should be outsourced and produced internally and externally and cost external production and outsourcing requirements /needs. 29
- ✓ Collaborate with partners to adapt technological solutions for RCCE including software, dashboards etc.

Information systems

- ✓ Continue to develop information systems to facilitate two communication to receive and disseminate information and intelligence from the ground.
- ✓ Invest in social listening and monitoring tools/software that can rapidly produce information and reports.
- ✓ Establish digital dashboards to report and share behavioural data and information.
- ✓ Collaborate with partners to adapt technological solutions for RCCE including software, dashboards for social and media monitoring etc.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT STRATEGY IMPLEMENTATION PLAN

The National COVID-19 RCCE Strategy Action Plan is divided into four Key Strategic Areas. These include: (i) Effective facilitation of community-led responses and improvement of quality and consistency of RCCE Approaches, (ii) Strengthening of RCCE evidence and innovation, (iii) Enhancement of national capacity on COVID-19 RCCE and (iv) Enhancement of RCCE coordination at all levels.

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 1: RCCE Coordination and Planning						
1.1 RCCE Committee Established	• Develop Terms of Reference for RCCE Committee (membership to be based on ability to contribute to achievement of RCCE outcomes)	RCCE Committee ToR in place	MOH Relevant Health Sector partners WHO	By end February 2022	Not required	
	• Conduct RCCE Committee meetings on regular basis	Evidence of RCCE Committee meetings RCCE sub-committees costed micro-plans produced		Ongoing	SAT20,000.00 for 5 years	GoS WHO
1.2 Thematic RCCE Sub-Committees established	• Develop ToR for Thematic RCCE subcommittees *(Assign RCCE committee members to relevant sub committees on their sector expertise and ability to contribute to the goals of the sub-committee)*	Sub-committees ToR developed	MOH with WHO support	By end of February 2022	Not required	GoS WHO

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
	• Conduct Thematic RCCE sub-committees meetings when required	Evidence of RCCE Sub-Committees RCCE sub-committees costed micro-plans produced			SAT20,000.00 for 5 years	
1.3 RCCE Committee/Sub Committees Capacity Building	• Conduct training on RCCE, Crisis Communication and Planning Spokesperson training, COVID-19 and ensure that they get certification in relevant RCCE and C4D training via UNICEF and WHO MOOCs	Training Agenda Developed Number of trainings completed by Committee/Sub-Committee members Evidence of Certification	MOH WHO UNICEF	Ongoing	SAT25,000.00 (ad-hoc basis)	GoS WHO UNICEF
1.4 Crisis Communication Management	• Develop Crisis Communication Plan	Crisis Communication developed, implemented and udpated	MOH WHO	asap	SAT30,000.00	GoS WHO
1.5 FAQs & IEC Materials	• Develop IEC materials such as FAQs, Briefing Notes, Talking Points to facilitate proactive and reactive social and media engagement for spokesperson/s	FAQs and IEC materials are evidence based and delivered on time	MOH WHO	Ongoing	SAT150,000.00 for 5 years	GoS WHO Other Devpt. Partners
	• Establish development and pretesting procedures for IEC materials	All IEC materials should be screened/approved by HEOC or DG	MOH	Ongoing	SAT100,000.00 for 5 years	GoS WHO Other Devpt. Partners
	Estimated Budget for 5 years				**SAT330,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 2: Social Data Collection and use						
2.1 Coordination of KAPBs, Research & Rapid Assessments	• Conduct desk review to identify gaps in data needed to inform RCCE	Research agenda developed based on desktop review	MOH	Ongoing	SAT25,000.00 for 5 years	GoS WHO Other Devpt. Partners
	• Develop a research agenda and timetable for implementation	Number of researches/studies conducted	MOH	Annually		GoS WHO Other Devpt. Partners
	• Develop ToRs for agency support to conduct research and other studies	ToR developed and in place Number of study reports produced, shared and results used to inform RCCE actions	MOH	By end of February 2022	Not required	
2.2 Social Listening	• Conduct social listening via helplines, community feedback and produce reports • Procurement of equipment and supplies required for social listening	Number of social listening reports produced and submitted Cost operation of helplines	MOH WHO UNICEF	Ongoing	SAT50,000.00	GoS WHO Other Devpt. Partners
				Estimated Budget for 5 years	**SAT75,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 3: Mass Media Implementation						
3.1 Mass Media Management & Monitoring	• Develop and implement annual costed Mass media plans for various media channels	Mass media annual costed plans are developed and implemented	MOH	asap	SAT250,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
	• Develop contract for contracted media agencies for media, social media, advertisements and PSAs	Number of contracted media agencies with signed contracts Number of IEC materials that were successfully produced	MOH	Ongoing		GoS WHO ADB Other Devpt. Partners
	• Develop IEC materials based on audience analysis and social data collected	IEC materials produced for targeted audiences	MOH Contracted agency/ies	Ongoing	SAT150,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
			Estimated Budget for 5 years		**SAT400,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 4: Social Media Monitoring and Misinformation Management						
4.1 Management of Rumours and Misinformation	• Identify and respond to rumours and misinformation identified in social and tradition media	Number of social media and media monitoring reports produced and submitted	MOH RCCE Committee	Ongoing	$50,000.00 annually	GoS WHO Other Devpt. Partners
	• Support spokeperson/s media responses with talking points to address rumours and misinformation	Number of talking points produced for MOH spokesperson/s	MOH RCCE Committee	Ongoing	Not required	
	Estimated Budget for 5 years				**SAT50,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 5: Crisis Communications/Emergency Risk Communication						
5.1 Crisis Communication Planning	• Identify key members from the surveillance and clinical teams to support and inform crisis communication	ERC/Crisis Communication plan developed and adapted Evidence of surveillance and clinical team members assigned to RCCE sensitized on the Crisis Communication	MOH	Ongoing	SAT25,000.00	GoS WHO Other Devpt. Partners
	• Provide Emergency Risk Communication Spokesperson training for relevant MOH staff and key partners	Costed Emergency Risk Communication training plan developed and implemented Number of key spokespersons and RCCEE committee members completed ERC Spokepersons trainings	MOH WHO	Ongoing	SAT65,000.00	GoS WHO Other Devpt. Partners
				Estimated Budget for 5 years	**SAT90,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 6: Advocacy and Stakeholders Engagement						
6.1 RCCE Advocacy Kits	• Prepare and print RCCE Advocacy Kits that contain updated IEC materials for planned engagement sessions and as the need arises	Advocacy Kits produced and disseminated	MOH WHO	Ongoing	SAT50,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
	• Prepare and print media kits that contain IEC materials for planned sessions as the need arises	Media kits produced and disseminated	MOH WHO	Ongoing	SAT50,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
6.2 Stakeholders Advocacy and Sensitizations Sessions	• Costed plans to facilitate conducting sensitization sessions on COVID-19 outbreak response planning and response with multi-sectoral stakeholders: ✓ Parliamentarians ✓ Media ✓ Development partners ✓ Public sector ✓ Private sector ✓ Community based organizations ✓ NGOs ✓ Professional and informal associations	Number of stakeholders session conducted and reported	MOH and partners	Ongoing	SAT100,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
				Estimated Budget for 5 years	**SAT200,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 7: Community Engagement and Social Mobilization						
Community Planning Meetings	• Sensitization sessions held with communities (prioritized vulnerable communities) on community planning or outbreak response to COVID-19	Number of vulnerable communities with outbreak response plans	MOH MWCSD CBOs FBOs	FY2022/23	SAT100,000.00	GoS WHO Other Devpt. Partners
	• Support communities in developing and implementing community outbreak response plans	Number of KAPBS and rapid assessment implemented and reports produced to inform community plans	MOH WHO MWCSD NGOs	Ongoing	SAT100,000.00	GoS WHO Other Devpt. Partners
Mapping of Community Partners and Activities	• Produce report of support provided to communities by partners and areas of response	Number of reports produced and approved	MOH MWCSD CBOs FBOs NGOs	Ongoing	SAT30,000.00 for 5 years	GoS WHO Other Devpt. Partners
Community education	• Implement community education with community leaders and households • Leverage community events for community education	Number of communities and households reached with education sessions	MOH MWCSD CBOs FBOs NGOs	Ongoing	SAT100,000.00 for 5 years	GoS WHO ADB Other Devpt. Partners
	Estimated Budget for 5 years				**SAT330,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 8: Capacity Building						

RCCE Capacity Building	• Develop a capacity building/training plan for MOH, Community and other stakeholders on various thematic areas:
	  • COVID-19 disease risk and vaccine benefits
	  • Public health social measures
	  • Sensitization on planning for outbreak response
	  • Crisis communication and C4D planning
	  • IPC skills and RCCE for health workers, schools, public and private sectors
		Costed RCCE training plan developed, funded and implemented
		
		Number of capacity building sessions held
		
		Number of discreet sectors engaged and trained
			MOH
			WHO
			UNICEF
				Ongoing	SAT100,000.00 for 5 years	GoS
						WHO
						ADB
						Other Devpt. Partners

RCCE Simulation Exercises	• Conduct health sector and community RCCE simulation exercises to test COVID-19 outbreak response plans	RCCE simulation exercises costed plans developed, funded and implemented Number of RCCE simulation exercises analysed and reported	MOH WHO UNICEF	Ongoing	SAT250,000.00 for 5 years	GoS WHO Other Devpt. Partners
	Estimated Budget for 5 years				**SAT350,000.00**	

OUTPUTS	RECOMMENDED ACTIONS	INDICATORS	IMPLEMENTING AGENCY/IES	TIMEFRAME	COSTING	SOURCES OF FUNDS
Key Strategic Area 9: Monitoring and Evaluation, Analysis and Reporting						
RCCE Monitoring Tools	• Develop monitoring and supervision checklists for RCCE activities	RCCE monitoring checklist developed, implemented and reported	MOH WHO UNICEF	Ongoing	SAT50,000.00 for 5 years	GoS WHO Other Devpt. Partners
	• Develop a costed RCCE M&E Plan that would determine the frequency of COVID-19 RCEE impact assessments to be conducted	RCCE M&E Plan developed, implemented and reported	MOH WHO UNICEF	FY2021/22	SAT50,000.00	GoS WHO Other Devpt. Partners
				Estimated Budget for 5 years	**SAT100,000.00**	

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